Revista Brasileira em Promoção da Saúde
ISSN: 1806-1222
rbps@unifor.br
Universidade de Fortaleza
Brasil

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O modelo brasileiro de assistência a pessoas com transtornos mentais: uma revisão sistemática da literatura
Revista Brasileira em Promoção da Saúde, vol. 26, núm. 1, enero-marzo, 2013, pp. 128-138
Universidade de Fortaleza
Fortaleza-Ceará, Brasil

BRAZILIAN HEALTHCARE MODEL FOR PEOPLE WITH MENTAL DISORDERS: A SYSTEMATIC LITERATURE REVIEW

O modelo brasileiro de assistência a pessoas com transtornos mentais: uma revisão sistemática da literatura

El modelo brasileño de asistencia para personas con trastorno mental: una revisión sistemática de la literatura

Systematic review

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ABSTRACT

Objective: *T*o evaluate the process of implementing the Brazilian psychiatric reform, especially regarding its impact on families' management of healthcare issues. **Methods:** *I*nterpretative research performed between August 2011 and January 2012, where symbolic interactionism was used as theoretical reference and Grounded Theory was used as the methodological reference. Initially, 49 articles on the subject were selected applying as descriptors mental health, psychiatric reform and psychosocial care, in SciELO, LILACS and university libraries' databases. Of these, 17 articles were excluded for being published prior to 2008 and 18 for having approaches not comprised in the scope of the study. **Results:** The power relationships in the treatment method were identified as causal conditions of the de-hospitalization process, which occurs in a context of deficiency in the network intended to replace psychiatric hospitals, therefore requiring the participation of patients' families in their reintegration at home and treatment. This strategy to deconstruct the psychiatric hospital-based model results in an excessive burden to the families. **Conclusion:** If, on one hand, the shift from hospitalization to in-home care, with embracement of the disease and of patients' suffering in their very social relationships, was to propose the recovery of patients' civil and human rights and their remaining into the society, on the other hand, it creates another series of problems, such as the emotional and logistical burden imposed on patients' families.

Descriptors: Mental health; Delivery of Health Care; Community Mental Health Care.

RESUMO

Objetivo: *Avaliar o processo de implantação da reforma psiquiátrica brasileira, especialmente no que concerne ao seu impacto na gestão familiar dos cuidados de saúde.* **Métodos:** *Trata-se de uma pesquisa interpretativa realizada entre agosto/2011 e janeiro/2012, em que se adotou como referencial teórico o interacionismo simbólico e como referencial metodológico a teoria fundamentada nos dados (grounded theory). Inicialmente, selecionaram-se 49 artigos com os descritores saúde mental, reforma psiquiátrica e cuidado psicossocial, nas bases SciELO, LILACS, e repositórios de universidades. Desses, 17 foram descartados por terem ano de publicação anterior a 2008, e 18 por terem enfoques não contemplados no escopo do estudo.* **Resultados:** *As relações de poder na forma de tratamento foram identificadas como condições causais do processo de desospitalização, que ocorre em um contexto de deficiência da rede substitutiva aos hospitais psiquiátricos, exigindo a participação das famílias no acolhimento e tratamento. Essa estratégia de desconstrução do modelo manicomial tem como consequência a sobrecarga das famílias.* **Conclusão:** *Se, por um lado, o deslocamento do eixo assistencial do tratamento para o acolhimento da doença e sofrimento do indivíduo em suas relações sociais propunha o resgate dos direitos civis e humanos e a manutenção do paciente na comunidade, por outro, a desospitalização criou uma série de problemas, como a sobrecarga emocional e logística imposta às famílias.*

Descritores: *Saúde Mental; Assistência à Saúde; Serviços Comunitários de Saúde Mental.*

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Received on: *05/30/2012*
Revised on: *08/23/2012*
Accepted on: *09/09/2012*

RESUMEN

Objetivos: *Evaluar el proceso de implementación de la reforma psiquiátrica brasileña especialmente con respecto a su impacto en la gestión familiar de los cuidados de la salud.* ***Métodos:*** *Se trata de una investigación interpretativa realizada entre agosto de 2011 y enero de 2012, en la que se adoptó como referencial teórico el interaccionismo simbólico y como referencial metodológico la teoría fundamentada en los datos (grounded theory). Inicialmente, se seleccionaron 49 artículos con los descriptores salud mental, reforma psiquiátrica y cuidado psicosocial, en las bases Scielo, LILACS y los repositorios de universidades. De estos, 17 fueron excluidos debido a que tenían el año de publicación antes del año 2008, y 18 por tener enfoques no contemplados en el alcance del estudio.* ***Resultados:*** *Las relaciones de poder en la forma de tratamiento fueron identificadas como condiciones causales del proceso de desinstitucionalización, que se produce en un contexto de deficiencias de la red sustitutiva en los hospitales psiquiátricos y que requiere la participación de las familias en el cuidado y tratamiento. Esta estrategia de deconstrucción del modelo manicomial tiene como consecuencia la sobrecarga de las familias.* ***Conclusión:*** *Si, por un lado, el desplazamiento del eje asistencial del tratamiento para la recepción de la enfermedad y el sufrimiento de la persona en sus relaciones sociales proponía un rescate de los derechos civiles y humanos y el mantenimiento del paciente en la comunidad, por otro, la desinstitucionalización creó una serie de problemas, como la sobrecarga emocional y logística impuesta a las familias.*

Descriptores: *Salud Mental; Prestación de Atención de Salud; Servicios Comunitarios de Salud Mental.*

INTRODUCTION

It is underway in Brazil the implementation of a new model of care for persons with mental disorders. This model derives from the articulations of the Psychiatric Reform Movement, with political, social and economic features, presenting a strong ideological orientation having de-hospitalization as main axis, with consequent deconstruction of the asylum-based model that prevailed in Brazil for many years. Law 10.216/2001, by initiative of the Executive Branch of Brazil, which rules on the protection and rights of people with mental disorders and redirects the mental health care model, has marked the start of a new time[1].

Thus, a model focused on specialized tertiary hospitals is turning to a community-based model, composed of a network of different services, with outpatient characteristics. Within this change, the focus of care is shifted from the treatment to the welcoming and sheltering attention, and the responsibility for humanization of the process and the costs involved are shared with families.

First references to mental health in Brazil date back to the nineteenth century, when it was allowed the construction of the first hospice, Pedro II, which received patients from the cellars of Santa Casa Hospital and a temporary facility that existed in Praia Vermelha, in the city of Rio de Janeiro. That institution was linked to the Church[2]. With the advent of the Proclamation of the Republic, the hospice became part of the public administration.

From then on, the first public policy for the mental health sector, which dealt with the creation of agricultural colonies, whose goals were to offer patients a productive occupation, greater contact with nature and a reduction in the high cost of this type of hospitalization. Hospitals like Juqueri, in São Paulo, and São Bento, in Rio de Janeiro belong to that period, the second being disabled later on as a result of epidemics of yellow fever and malaria[2].

In the early twentieth century, the Campaign for Sanitation, Health and Mental Hygiene was organized, led by Oswaldo Cruz together with the *Diretoria de Assistência ao Psicopata do Distrito Federal* (Board of Assistance to Psychopath of the Federal District); two more colonies were built in Rio de Janeiro: Hospital Pedro II and Juliano Moreira Colony. The model of agricultural colonies lasted until the 1950s, when a crisis arose due to their overcrowding, its high cost and the precariousness of assistance. The advent of psychotherapy, by reducing the extent of hospital stay, also contributed to dramatically decrease the number of resident patients. Thus, the institutionalization model gave its first signs of weakening[2].

The 1950s and 1960s were marked by constant revisions of the values and social customs, and some psychiatrists started arguing the prevailing psychiatric model (David Cooper, Davide Laing, Franco Basaglia and Gregory Bateson, for example), who were contrary to violent forms of treatments mental illness and, marked by ideas of the left and the counter-culture thinking, laid the foundations of anti-psychiatry[3]. Space of medical power par excellence, the hospital - treatment in closed regime - was questioned by its inefficiency, perpetuated alienation, dehumanization etc[4].

The 1980s and 1990s were particularly important in the discussions concerning the restructuring of psychiatric care in the country[5].

In Brazil, this movement was well represented by the psychiatrist Nise Magalhães da Silveira (1905-1999), who raised the question about methods of psychiatric treatment and advocated the use of other means of expression for those unable to use verbal language, having been one of the precursors of the activities of Occupational Therapy[3]. There is no denying the influence of Michel Foucault on some Brazilian intellectuals who were among the protagonists of such changes[4].

Discussions about the serious consequences resulting from institutional life, which opened the possibility of

changes in the mental health area, had as theoretical frameworks the 8th National Health Conference (1986), the 1st National Conference on Mental Health (1987), the Regional Conference on the Restructuring of Psychiatric Care, held in Caracas (1990), the 2nd National Conference on Mental Health (1992), and the 3rd National Conference on Mental Health (2001)[5]. Within the Caracas Declaration, Brazil was committed to promoting the restructuring of psychiatric care, reviewing the role of the psychiatric hospital, defending civil rights, human rights and the permanence of mental disorder carriers into their community[5].

In this context, the Psychiatric Reform Movement was strengthened, still underway in Brazil, as a historical, political, social and economic movement influenced by the ideology of dominant groups. According to those authors, this reform has de-hospitalization as main strands, with consequent deconstruction of the asylum and paradigms that support[6]. Moreover, the Federal Constitution of 1988 represented an important advance for public health in Brazil, since it promoted the emergence of a new model of care. As the *Lei Orgânica da Saúde* (Organic Health Law, number 8.080/1990) and the *Regulamento do Sistema Único de Saúde – SUS* (Regulations of the Unified Health System, Law number 8142/1990) were enacted, the principles of universality, equity, comprehensiveness, decentralization and single control, regional and hierarchical organization, and popular participation were incorporated into the public health field, in order to formulate strategies, monitor and evaluate the implementation of health policy[2].

Some years later, Law number 10.216/2001 was enacted, which addresses for the protection and rights of people with mental disorders, and redirects the mental health care model, now considered comprehensive and modern. This law states that the development of mental health policy is the responsibility of the State, with the participation of society and families of those with mental disorders[1].

The law also determines that the mental health care is to be organized in a network. This is the intersectoral coordination in the practice of care. It involves not only the various mental health services, but also the clinical services and non-clinical social dimension that permeate the lives of people with mental disorders[1]. The model that has been built has the merit of seeking humanization for the assistance provided and placing it in the context of SUS, recognizing that this type of patient is a citizen like everyone else and, therefore, needs not to be segregated. However, since families are partners in this model, they become impacted by having to hold part of the responsibility for the humanized treatment, along with the costs involved in the process.

The purpose of this article is to examine the implementation process of Brazilian psychiatric reform and its effects on family management of healthcare.

METHODS

This article presents the results obtained in the exploratory phase of a larger investigation, of 'outcome assessment' type, which aims at analyzing the compatibility of the socioeconomic characteristics of the families of people with mental disorders to the definitions of public policies for the mental health sector. Thus, this cutoff has the purpose of presenting the preliminary assessment of the process of implementing a new model of care for people with mental disorders in Brazil.

Evaluation of outcomes judges the effectiveness of a program, policy or plan, in order to know if the idea itself is valid or not, whether it can be generalized and in what situations[7]. For this, the inherent posture of the qualitative method for collecting and analyzing data was combined with the quantitative method in search of objectively measuring the results. In formative and outcomes assessments, the qualitative and quantitative designs are complementary, not antagonistic, forms of evaluation[7].

Therefore, it consists of an interpretive research, where the symbolic interactionism was adopted as a theoretical background and the grounded theory, as the methodological framework. The term 'interpretive research' derives from the basic recognition of the interpretative and cognitive processes related to social life, highlighted in these approaches[8]. Symbolic interactionism understands society as an entity composed of individuals and interacting groups (with themselves and others), taking as a basis the share of senses or meanings in the form of common understanding and expectations[8].

The grounded theory seeks to inductively build a theory about data through qualitative analysis, which, combined with other theories, may bring new knowledge to the area of the phenomenon[8]. The formulation of theoretical interpretations of data based on reality is a powerful means for its understanding and to develop interventional strategies and control measures[7].

The method is developed in three distinct and successive phases: data collection, coding procedures or data analysis, which is subdivided into open, axial and selective coding, and delimitation of the theory.

In the first phase, since it is a theoretical discussion, the bibliographic and documentary research was employed as the technique for data collection. Initially, 49 articles were selected from scientific databases SciELO, LILACS and institutional repositories of universities of Brasilia and

Alicante, between the months of August and October 2011, from the following keywords: mental health; psychiatric reform and psychosocial care. Of these, 17 were not included because their year of publication was prior to 2008, and 18 for having approaches not contemplated in the research scope. Among 14 articles that were referenced, two were selected despite having been published before 2008, due to their objectivity in addressing the impact of the new model of care on the family dynamics. This study employed as search tools Online Knowledge Library (B-ON) and Mendeley Reference Manager, of current use and held in repute within the academic environment.

To these articles was added the legislation on the subject, as well as technical reports of the Ministry of Health and the *Associação Brasileira de Psiquiatria* (Brazilian Association of Psychiatry). Advances in a given area, necessarily part of the knowledge of the state of art, that is, the previous contributions made on the subject under study[9]. Thus, viewing to perform a comprehensive literature search, though selective and analytical.

In the second phase, the constructs were categorized and relations were established between the various categories obtained.

Subsequently, the analysis of each category's frequency (univariate analysis) was performed, building up a demonstrative chart that consolidates the relationship between the type of approach and the various categories established. This procedure was added to the method in order to complement the qualitative data analysis.

In the last step, the core category and the subsidiary categories were identified, and their relations were checked. This constitutes the conclusion of the study.

RESULTS

a) Data Collection

Chart 1 consolidates the thinking about the implementation of the psychiatric reform in Brazil.

b) Coding or data analysis

b.1) Open coding

From the 39 events consolidated in Chart I was obtained the distribution by type of reference shown in Table I and the combination by categories demonstrated in Table II. The first noticeable point is that more than half (51.28%) of the references regarding the development of Brazilian psychiatric reform were negative, indicating that, despite its relevant social reach, its implementation experiences some difficulties. It is also clear, in the light of data consolidated in Table II, that only one category comprises more than 25% of the constructs shown in Chart I, and five of them include more than 80% of the constructs raised.

b.2) Axial Coding

The process of de-hospitalization is then identified as the core category for this analysis and the categories listed below as the most relevant:

a) Deficiencies in the replacement network for the psychiatric hospitals; b) Deconstruction of the asylum-based model; c) Involvement of families in sheltering care and treatment; and c) Power relations in the form of treatment.

Table III shows the relation between categories and types of reference. Five of these categories obtained references exclusively negative, two received exclusively positive references, one did not obtain any reference, nor positive nor negative, and the two remaining categories had positive and negative references, but the positive ones accounted for over 50% of the observations.

b.3) Selective encoding

The relations between the core category and the subsidiary ones can be identified, as comprised in Chart II.

c) Definition of theory

Power relations in the form of treatment were identified as causal conditions of the de-hospitalization process, which occurs in a context of deficiency in the replacement network for the psychiatric hospitals, requiring the involvement of families in sheltering care and treatment. Such strategy of deconstruction of the asylum-based model has the burden to families as a strong consequence.

Chart I - Constructs on the evolution of Brazilian psychiatric reform.

AUTHOR	YEAR	CONSTRUCTOS
A - Almeida	2010	Fragility of the entrance door; Lack of dialogue between different parts of the network; Lack of qualification, supervision, physical structure, medicines, support personal, quality listening, work overload and lack of a referral system in primary care.
B - Amorim and Dimenstein	2009	Deconstruction of psychiatric knowledge; Disorganization of the entrance door and lack of exit door; Lack of effectiveness in the network; Fragile and bureaucratic coordination between services; Risk of chronic institutionalization in other instances of the network, Citizenship rescue and reintegration within the family context.
C - Borba, Schwartz and Kantorski	2008	Importance of family in the treatment and reinsertion of patient into society; Importance of knowing the family universe and how families live and react to psychological distress; Influences of values, beliefs, knowledge and health promotion practices; Emotional burden on the family.
D - Cavalheri	2010	Change focus from the disease to the individual's suffering in his social relations; Demand of family commitment to the sheltering care and treatment of those with mental disorders; Family tiredness.
E - Franco and Merhy	2008	Productive restructuring of health services due to the change in the age profile of the population.
F - Gonçalves and Sena	2001	Political, social and economic aspect of the psychiatric reform and the ideological influence of dominant groups; Deconstruction of asylums and their supporting paradigms; Limitations of the family to solve the problems arising from de-institutionalization; Patient's return to the families without knowledge of their real needs and conditions; and Inability of psychiatric reform to promote the patient's reinsertion into the society.
G - Gozendo and Torres	2010	Human behavior in the face of certain situations defines the management style.
H - Redes	2009	Serious consequences of institutional life and changes in the mental health field; and Commitments made by Brazil in Caracas Conference.
I - Magaña	2011	Changes in the family model, with the incorporation of women into the paid labor market; Care for the sick has become a burden.
J - Marques	2009	Importance of the family in dealing with the mentally ill; Need for redefinition of roles and responsibilities within the family; Families' loneliness in dealing with the mentally ill; and Emotional burden on the family.
K - Oliveira	2011	Revision of values and social customs have led to the questioning of psychiatry; and Questioning the methods of psychiatric treatment
L - Sander	2010	Dehumanization, inefficiency and alienation of patients in psychiatric hospitals; The psychiatric hospital as a space of medical power; The influence of Michel Foucault on the psychiatric reform; and Influence of power relations on the form of treatment.
M - Vicia and Martins	2006	The family as a mediator of the society-patient relationship.
N - Xavier, Brito, Abreu, Moreira and Vasconcelos	2011	Importance of assessing the difficulties experienced by patients and families.

Table I - Types of reference to the Brazilian psychiatric reform.

TYPE OF REFERENCE	CONSTRUCTS	n	%
Positive references about the Brazilian psychiatric reform	B6, E1, H1, H2, K1, K2, L1, L2, L3 and L4	10	25,64
Negative references about the Brazilian psychiatric reform	A1, A2, A3, B1, B2, B3, B4, B5, C4, D1, D2, D3, F1, F2, F3, F4, F5, I2, J3 and J4	20	51,28
Other manifestations	C1, C2, C3, G1, I1, J1, J2, M1 and N1	9	23,08
TOTAL		39	100,00

Table II - Categories of the constructs on the evolution of Brazilian psychiatric reform.

CATEGORIES	CONSTRUCTS	n	%
Difficulties faced by the family with the de-hospitalization process	C4, D3, F3, F4, G1, I1, I2, J2, J3, J4 and N1	11	28,20
Deficiencies in the psychiatric hospitals replacement network	A1, A2, A3, B2, B3, B4 and B5	7	17,94
Deconstruction of the asylum-based model	F2, H1, K1, K2, L1 and L3	6	15,38
Participation of families in the process of sheltering and treating patients with mental disorders	C1, C2, D2, J1 and M1	5	12,82
The influence of power relations in the form of treatment	B1, L2 and L4	3	7,69
Political, social, economic and ideological aspects of the psychiatric reform	F1 and H2	2	5,12
Citizenship rescue and reintegration of mental patients to the family context	B6	1	2,57
Influence of values and beliefs in the restructuring of health services	C3	1	2,57
Change focus from the disease to the individual's suffering in his social relations	D1	1	2,57
Restructuring of health services due to changes in the age profile of the population	E1	1	2,57
Inability of psychiatric reform to promote the patient's reinsertion into the society	F5	1	2,57
TOTAL		39	100,00

Table III - Relations between the categories and types of reference to the Brazilian psychiatric reform

CATEGORIES	TYPES OF REFERENCE					
	POSITIVE			NEGATIVE		
	CONSTRUCTS	n	%	CONSTRUCTS	n	%
Difficulties faced by the family with the de-hospitalization process		0	0	C4, D3, F3, F4, I2, J3 and J4	7	100
Deficiencies in the psychiatric hospitals replacement network		0	0	A1, A2, A3, B2, B3, B4 and B5	7	100
Deconstruction of the asylum-based model	H1, K1, K2, L1 e L3	5	83,33	F2	1	16,67
Participation of families in the process of sheltering and treating patients with mental disorders		0	0	D2	1	100
The influence of power relations in the form of treatment	L2 e L4	2	66,67	B1	1	33,33
Political, social, economic and ideological aspects of the psychiatric reform	H2	1	50	F1	1	50
Citizenship rescue and reintegration of mental patients to the family context	B6	1	100		0	0
Influence of values and beliefs in the restructuring of health services		0	0		0	0
Change focus from the disease to the individual's suffering in his social relations		0	0	D1	1	100
Restructuring of health services due to changes in the age profile of the population	E1	1	100		0	0
Inability of psychiatric reform to promote the patient's reinsertion into the society		0	0	F5	1	100
TOTAL		10	33,33		20	66,67

Chart II - Relations between the central category and the subsidiary categories.

Causal Conditions:	**Power relations in the form of treatment**
Phenomenon:	The process of de-hospitalization
Context	Deficiencies in the psychiatric hospitals replacement network
Intervening conditions:	Involvement of families in sheltering care and treatment
Action strategies:	Deconstruction of the asylum-based model
Consequences:	Overload of the families

DISCUSSION

The Brazilian mental health policy regards the de-institutionalization as one of its basic principles. In the document 'Regional Conference on Reform of Mental Health Services: 15 years after Caracas', the Ministry of Health presents the de-institutionalization as the result of the implementation of clear, effective and safe mechanisms for reducing the number of psychiatric beds, while recognizing there have been social and cultural changes that have supported it[10].

The de-institutionalization represents, however, the deconstruction of the psychiatric knowledge, and not only the extinction of asylums. The sense of citizenship is opposed to the concept of mental illness, which imposes limits on the citizens' rights[11]. The focus of assistance provided to patients with mental disorders is no longer the disease and became the suffering of the individual in his social relations[12]. Another important point in the Brazilian psychiatric reform resides in the establishment of a replacement network able to compensate the drastic reduction in the number of psychiatric beds in the country. The Ministry of Health, by

means of SUS, is responsible for regulating and organizing that network, their actions and health services, in levels of increasing complexity, watching all around the country the principles of hierarchy and their regionalization[10].

The Ministry of Health also presents as parameters for organization of this replacement network the basic principles of SUS of universal access to free public health programs and services; the comprehensiveness of actions; equity in service provision; the political and administrative decentralization; and social control of actions performed by the users, workers, service providers, civil society organizations and educational institutions[10].

The network proposed by the Ministry of Health, based on the conclusions of the Third National Conference on Mental Health, held in 2001, is community-based and essentially public, composed by the *Centros de Atenção Psicossocial - CAPS* (Centers for Psychosocial Care), *Serviços Residenciais Terapêuticos - SRT* (Therapeutic Residential Services), Day-care Centers, Outpatient Mental Health Clinics and General Hospitals[10]. It is observed the complete exclusion of specialized tertiary hospitals - mental hospitals - from the aforementioned network.

For sheltering people in mental distress, it is crucial to articulate as a net various services replacing the psychiatric hospital[11]. Changing over from treatment to such sheltering care is perceivable. Madness is not a fact of nature, but of civilization, and the way madness is treated, in vogue since the 1960s, is influenced by the power relations[4]. Brazilian public policies for mental health are strongly influenced by this way of thinking.

Practice has shown disorganization of the various entrance gates and the lack of exit doors, so that the network desired by the Ministry of Health is not effective and the coordination between various departments is fragile and bureaucratic. Current practices lead to the risk of chronic institutionalization and chronic conditions within other instances of mental health network, reproducing the asylum model that one wants to escape from[11].

The research that examined the possibility of welcoming and treating the grave mentally ill within primary care in a reality in the Northeast of Brazil also pointed out the fragility of the system's entrance door and the lack of dialogue between the different parts that compose it. Repeatedly, therapists and managers of primary care argued that the network was not able to receive and treat patients with serious mental illnesses like schizophrenia; perhaps only mild or stable cases. Among the reasons raised, the lack of qualification, supervision, physical structure, medicines, personal, support, qualified listening, in addition to work overload and lack of a functioning referral system were mentioned[13].

Simply promoting de-hospitalization has created a series of other problems, such as the intensification of demands relating the families' commitment, without their proper instrumentalization, generating a strong sense of helplessness[12]. The family plays an important role as a partner in the care of patients with depression, but some important questions remain: what is necessary for the family to feel like a partner in the process of care? How does the family play the role of caregiver? What are its main needs?[14]. The intensification of the requirements for the commitment of families has changed decisively the course of their participation in sheltering care and treatment of mental disorders[12]. As a result of changes in the healthcare model, the family is of particular relevance both in view of care itself as in view of the return to social environment; therefore, it is essential to understand the family universe and how its members react and live with psychological distress[15].

The family, as the mediator par excellence between the society and the person with mental disorder, is responsible for continued and daily care, since the current trend is that health services act only in times of crisis[16]. There is then the need to redefine the roles and functions within the family, since it is known that its relationships become poor and little stimulants[14].

Just as it is not acceptable to stigmatize and exclude people with mental disorders, it is not correct to return them to families, as if they could solve the problems of everyday life, along with the difficulties caused by living, maintenance and care of the mentally ill. Social, economic, political, cultural, religious, individual and collective determinations should be valued[6].

This seems to be a major contradiction within the implemented model. The mentally ill is being returned to his family without proper knowledge of its real needs and conditions, especially concerning the caregivers, in material, psychosocial, health aspects and quality of life - issues that are deeply interconnected[6].

While that families would rather see their members at home than in hospital, they refer tiredness and exhaustion with daily burden[12]. The family does not understand the mentally ill's behavior, feels alone in the process and, therefore, claims on health professionals for support in defining communication strategies that facilitate the caregiver role[14].

The study of the impact of the current mental healthcare model on families identified three categories of discourse among the caregivers interviewed: the usurped self, where there is the caregivers' feeling of having been deprived of themselves to go on living the life of the mentally ill; the complexity of living intense and contrasting affections; and the unfulfilled demands of caregivers in expectation of

receiving help from mental health services. The feeling of helplessness arises from the new demands imposed without instrumentation to meet them[12].

In this context, the family is conceptualized as a system where values, beliefs, knowledge and practices direct the health promotion actions, both in terms of prevention and in treatment, and the care process defines the strategies in the face of any necessity[15]. This is a process similar to what occurs in small organizations, where this set of factors influences the human behavior relative to certain situations, and defines the management style practiced[17].

These factors are constantly evolving. The family model consisting of a breadwinner male and a homemaker female, responsible for the hygiene and home care, is changing with the incorporation of women into the paid labor market. As a result, tasks such as caring for the sick become a burden on them, especially in low-income families. This process required a paradigm shift in understanding the relationship between the users and the way healthcare is provided within these families[18].

The costs involved should also be considered as a relevant issue in family managing of healthcare, because it often implies the renunciation of paid work by a family member, increasing poverty and social vulnerability in these families; in the financial cost itself, since it involves transfers, purchase of medicines and other deals inherent to care; along with the physical and psychological impact on the caregiver's quality of life, which is expressed by physical and emotional exhaustion[18].

The paradigm shift in the mental healthcare model from treatment to sheltering care may not have been motivated only by humanitarian reasons. The change in the age profile of the population impacts on needs and costs involved in the provision of health services, which has caused a restructuring process, seeking a new production model relative to care in order to reduce its operating costs[19].

So, some models arise and gain space, both in public health as in the supplementary field, such as the *Programa de Atenção Domiciliar - PAD* (Home Care Program), established by the Ministry of Health Ordinance Number 2.029/11[20], and the *Programa de Internação Domiciliar - PID* (Home Admissions Program), created by the Ministry of Health Ordinance Number 2.529/2006[21], as well as other programs like *Programa de Volta para Casa* (Back Home), aiming at the social reintegration of people affected by mental disorders discharged from long hospitalizations, according to criteria defined in Law No. 10,708 of July, 31 2003[22], which include the payment of aid to psychosocial rehabilitation.

The Brazilian psychiatric reform has shown to be unable to support the reintegration of patients with mental disorder back into the society and is treated as simple de-institutionalization, which has reflected negatively on families[6].

The investigation of the difficulties experienced by users and family members shall meet the needs to tracing interventions and actions that can contribute to improvement in the quality of life of them both[23].

CONCLUSIONS

The history of mental health in Brazil can be divided into three phases: the first and longest one began in the nineteenth century and continued until the mid-twentieth century, characterized by the establishment and consolidation of the asylum assistance model; the second phase began in mid-twentieth century and lasted until 2001, characterized by deconstruction of care model hitherto prevailing, illuminated by the movement of anti-psychiatry; the third phase, which began in 2001 with the enactment of Law Number 10.216/01, lasts until nowadays, characterized by the definite break with the asylum model.

Psychiatric reform in Brazil followed a similar path to that taken by other countries, based on de-institutionalization, reduction of the number of beds in psychiatric hospitals and their replacement for other equipment within the primary and secondary care. Another striking feature was the shift of the care axis from treatment to the sheltering assistance; from the disease to the individual's suffering within his social relations. This article consolidated the results of the preliminary assessment of the implementation process of Brazilian psychiatric reform, especially as it relates to its impact on family management of healthcare.

In light of the study, the evaluation of this process is predominantly negative, being the difficulties faced by families with de-hospitalization its central issue.

The study showed that if, on the one hand, the change in the healthcare model sought to recover, through civil and human rights, the maintenance of the patient into the community, on the other hand, it created the problem of logistics and emotional burden for the families. From an emotional standpoint, tiredness and feelings of helplessness; from the logistical point of view, the transfer of a significant amount of treatment costs from the State to the families.

However, the deepening of this study is necessary and shall be important to get to know the real impact of the de-hospitalization process on family management of mental health care and whether the public policy for the sector is compatible with the socioeconomic profile of the population assisted by SUS - aspects not fully elucidated in the documents studied. The de-hospitalization process

resulting from the implementation of this new model of care for patients with mental disorders may lead to lack of assistance if such costs transferred to the families are incompatible with their socioeconomic profile.

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