

3. AMERICAS

3.1 The communitarian model of Fundación Rostros Nuevos

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About Chile

Chile is a country which in 2010 will celebrate its 200th birthday as an independent country. Located in the most southern part of South America, its population is 16.8 million inhabitants, 88% of whom live in cities, and it has a 95% literacy rate. The life expectancy is 74 years for men and 81 years for women. Approximately 12% of the population is over 60 years old and 13% of the whole population lives in extreme poverty.

Chilean society has one of the worst income distributions; life in cities is highly segregated according to the social and economical position of the population and there are few instances of encounters and coexistence for people and families who live in different neighbourhoods.

Since the return of democracy in 1990, the reduction of poverty has been significant, going from 40% to 13.7% currently. This reduction has come about mainly due to the significant economic growth experienced in the 90s and to the public policies focused on families who live in poverty.

Fundación Rostros Nuevos

Fundación Rostros Nuevos (“Rostros Nuevos” or the “Foundation”) is a non-profit private organisation subsidiary of Hogar de Cristo,¹ one of the most

¹ NGO founded in 1944 by Saint Alberto Hurtado (SJ) that takes in 45,000 people living in extreme poverty per day. With over 800 branches across the country, Hogar de Cristo is the principal charitable organisation in Chile and one of the most important in Latin America. Hogar de Cristo is a paradigm in the management of poverty and social exclusion.

important Latin American NGOs that strives for the final overcoming of poverty. Rostros Nuevos was founded in Chile in the middle of the 1990s in response to the need of helping homeless people with mental disability that came to sleep at Hogar de Cristo's hostels. Because of their mental condition these people required specialised and integral assistance.

With over 15 years of history, Rostros Nuevos currently takes in 530 adults with physical and mental disability living in extreme poverty and social exclusion ("users"). Rostros Nuevos fosters the personal development of its users through a comprehensive intervention in community spaces. It facilitates the social connection, participation and integration of its users. Likewise, Rostros Nuevos creates within the community awareness, commitment and co-responsibility towards this social reality so as to build up an inclusive and supportive country.

Rostros Nuevos began with two long-stay hostels which evolved into Community Support Programmes in parallel to the reform of mental health in Chile. Since then, approximately one thousand homeless people have benefited from the programmes run by Rostros Nuevos.

As a result, these people have recovered their human dignity, their ability to recognise themselves as persons and to love and establish relationships with others.

Through six types of intervention and ten social programmes, Rostros Nuevos gives its users housing support, occupational therapy, connection with social networks in welfare and health, spiritual advice, and connection with their families and the community. Rostros Nuevos focuses on the biological, psycho-social and spiritual dimensions of its users. The process of construction of society is rooted in the rights of its users, family and community.

The 530 people currently taken in by Rostros Nuevos have been able to overcome their homeless condition. Nowadays the users form part of the community, enter relationships with their neighbours and progressively exercise their citizen rights, with access to education and to work.

Advocacy Role

Rostros Nuevos has performed an advocacy role in areas concerning the inclusion and the rights of people with mental disability both in society and in the State. Rostros Nuevos promotes the consideration of these people and their acknowledgment as persons and rights-holders, rather than subjects of charity.

Rostros Nuevos has a close relationship of co-operation with the State. Moreover part of the services offered by Rostros Nuevos through its programmes is contracted by the departments dependent on the Health Ministry and the Planning Ministry, amounting to around 30% of their income. The remaining income is composed of monthly donations made by people, companies, benefactors and from their own business of Rostros Nuevos, thereby securing a stable and regular income.

That is to say, for each peso or monetary unit the State gives, the whole of society gives another two, which results in an interesting leverage of the fiscal resources worth repeating both in this social area as in others where non government institutions are willing to get involved.

Social Programmes

The Foundation owns two *Long Stay Homes*, where 100 people with severe incapacity live. These people require full-time 24 hour attention of a technical team due to their lack of autonomy or because they have a related physical incapacity.

The Foundation runs a *Transitory Residential Programme* that gives shelter to 50 women with mental incapacity who are on the streets (homeless) or at risk of becoming so, who are offered a provisional home solution while they are treated by the professional and technical team until they resume their social and family ties, or are moved to another unit.

In accordance with the Communitarian Psychiatry Model adopted by the Government, Rostros Nuevos has 8 *Protected Homes*, which are houses located in residential neighbourhoods where 12 to 14 people live with 24 hour supervision by a technical team.

There are 15 *Family Homes* which are also located in residential neighbourhoods, where 6 users live autonomously, supervised daily by a tutor.

Likewise, Rostros Nuevos offers economical and material support to around 21 people who live independently or with their families.

In relation to walk-in assistance, Rostros Nuevos has 5 *Day Centres* which welcome people who attend diverse activities and workshops daily, aimed at their socio-therapeutic rehabilitation.

The *Labour Rehabilitation Centre* allows its users to acquire working skills and abilities through protected and semi-protected workshops, with the purpose of accessing a job either within the institution or in an external enterprise. One hundred persons are trained yearly in these workshops. These workshops seek to attain the principle that “work as social inclusion can promote a process of articulate interests, needs and desires”.²

The *Family Support Programme* gives psycho-social support to families which have among their members someone with a psychological or mental health diagnosis living with them, thus avoiding hospitalisation and the breaking of emotional bonds. This programme has benefited more than 745 persons during its 5 years of existence, taking into account family groups.

This programme has a positive rehabilitating impact, since it strengthens the maintenance of family bonds which are broadened in the community. It is efficient in as far as it only costs US\$ 3 per person daily, versus US\$ 22 a day for sheltering one user in a protected home.

The *Mental and Psychiatric Communitarian Programme* is staffed by a multidisciplinary team of professionals and technicians who deal with the people who come to sleep at the Hogar de Cristo’s hostels, whom they diagnose, advise and link them to social networks. It is an assertive communitarian programme that takes its work into the streets and has a capacity to take care of 60 persons, with a daily cost per person of around US\$ 5.

² “La liberación de los Pacientes Psiquiátricos. De la rehabilitación psicosocial a la ciudadanía posible”. (“The release of Psychiatric Patients. About the possible citizens psychosocial rehabilitation”). Benedetto Saraceno, 2003

Thanks to an agreement with the Planning Ministry (Mideplan), this year in June the programme sees the start of *Mental Incapacity and the Street*. This programme trains psychosocial teams which execute Mideplan's Street Programme in an assertive communitarian methodology applied to mental health. The goal is to guide people on the streets and the homeless with mental health problems, to give them company, and provide the means to be diagnosed and gain access to specialised care, to pharmacological treatments and to therapeutic rehabilitation in coordination with the family and social nets.

Challenges To Rostros Nuevos

The work of Rostros Nuevos Foundation is increasingly focused on advocacy, aiming to have influence in generating and amending public policies to facilitate the inclusion of people with different disabilities, but also in the behaviour of society, as a necessary condition to attain this objective. The legitimacy of acting as spokesman is given by the experience in direct care during all the foundation's existence, its capacity to rethink and improve its operations, and the objective of offering better care to the people it shelters.

We are aware that the value of Rostros Nuevos' experience acquires more meaning if its models of intervention are copied on a large scale in order to generate a major impact on the population of more than 61,000 people who are excluded from our society.

Mental Health in Chile

In Chile there are 348,057 people with mental incapacity.³ 61,043 of them have moderate to severe incapacity and belong to the 25% of the poorest national population.⁴ Fifty four percent of this total has no access to specialised mental

³ First National Study on Incapacity in Chile. Fonadis-INE, 2004.

⁴ This information is gathered from the first Study on Incapacity in Chile carried out in the year 2004 by INE-Fonadis. This figure is the result of multiplying the 817.158 persons belonging to the low socio-economical group (table No.8 ENDISC), by the 16.83% resulting from adding the intellectual and psychiatric deficiencies belonging to the population with incapacities by the 45% resulting from taking into account the moderate and severe incapacities over the whole population with incapacities.

health care, not even once a year. The Public System takes care of 1,109 people in 24 homes and 113 protected homes in the country. There is a waiting list of more than 704 people with mental and/or psychiatric diagnosis awaiting inclusion in the Public System.

As opposed to other countries in the region, Chile has a Mental and Psychiatric Health Plan, implemented by the Health Ministry from the year 2000, thanks to which important changes have been brought about in approaching the mental health of the Chilean people. The model of communitarian psychiatry has gained space and demonstrated that it can achieve the rehabilitation and social inclusion of a large number of people with mental incapacity.

This Plan gathers the experience and best practice of recent years from several mental health teams, both from our country and abroad. Objectives and strategies are suggested to direct the assigned State resources towards efficient actions that will result in a higher level of mental health care for the Chilean people through a bio-psycho-social approach, promoting and stimulating human development, the active participation of all sectors, the quality of the given care and the communitarian model.

The fact that Chile ratified the United Nation's International Convention of Rights for People with Incapacity is proof of this progress.

Nevertheless Chile still has a big challenge ahead: to broaden and deepen public and private policies so as to include people with mental incapacity (mental and/or psychological) as full citizens with rights and obligations.

In designing and implementing public policies, people with mental incapacity are not a priority due to their lack of organisational capacity and no representation or lobbying capacities. It is an invisible population, undervalued in their capability to contribute to everyday life in the community; therefore they suffer stigma and a number of negative prejudices which make inclusion difficult.

The 2009 budget assigned by the State to Mental Health is a 2.91% of the whole budget assigned to Health,⁵ an amount which is much less than that assigned by other countries in the region: Uruguay 8%, Cuba 5%, Costa Rica 8% and the United States 6%. The Mental and Psychiatric Health Plan had in mind an increase of 0.5% to 1% per year in order to reach 5% by 2010. The report of WHO AIMS on the Chilean Mental Health System establishes that “this low proportional budget determines that several health resources indicators are under the average of the American region, especially in the case of psychiatric hospital bedding (18 for 100,000 inhabitants in Chile and an average of 26 for the rest of America); mental health nurses (1.7 in Chile in comparison with the 12.97 in the rest of America) and social workers (1.7 compared to 11.58)”.⁶

The lack of specialists is another weak factor in Chile. “In spite of the high prevalence of mental disorders, the curriculum in undergraduate studies in health professions devote only from 2% to 5% of their time to mental health”.⁷

Chile has an average of 4.7 psychiatrists for every 100,000 inhabitants.⁸ Argentina has 13; Brazil has 4.8; Uruguay has 22.9; and the average of European countries is 22.9.

In its turn, WHO AIMS states that “professionals in primary healthcare have poor access to mental health training and there are no systematic and continuous programmes for training mental health postgraduates, nurses and social workers”.⁹

One of the challenges faced by the National Mental Health Plan is creating a Human Resources Development Policy on this subject. It is not only a public matter. “In the private system, health insurance (ISAPRES) offers a very meagre coverage in mental health care and usually with a high joint payment”.¹⁰

⁵ www.dipres.cl, National Health Fund and Health Ministry.

⁶ Report WHO – AIMS on Mental Health System in Chile, page 55. Santiago, Chile, 2006.

⁷ Ibid, page. 52

⁸ Ibid, page. 45

⁹ Ibid, page. 52

¹⁰ Ibid, page. 20

WHO too informs that Chile lacks a Mental Health Law stating the political intention of the State to achieve the rehabilitation of people with mental incapacity: “Chile belongs to the small percentage of countries which have been unable to formulate a Mental Health Law.”¹¹

However, the Chilean mental health model is internationally valued and respected. During his participation in the International Seminar “America works to change the face of mental incapacity”, which took place in Chile in August 2009, Dr. Benedetto Saraceno WHO director of Mental Health and Drug Abuse, said Chile is one of the countries that WHO permanently cites in official documents as a model in the development of mental health, particularly on the item of primary care and its systematic efforts to reduce long stay beds in psychiatric hospitals.

Likewise, he maintained that the current challenge for national authorities is to further the secondary level of mental healthcare, giving as an example the development of community centres, “a good pattern to follow”, he said.¹² Among the strongest points of the Chilean Mental Health System is the development (from the year 2000) of an outpatient system; the drawing up of a new Regulation for Hospitalisation in Psychiatric Centres; the creation of a National Commission for the Protection of People with Mental Incapacity, and the ratification of the International Convention on the Rights of People with Mental Incapacity held by the United Nations. Currently a bill to give equal opportunities and the inclusion of people with mental incapacity, which will replace the current law 19284, and a bill concerning the Rights and Duties of the Health Patients, are in process in Congress.

There has also been progress in the guaranteed care of diseases such as depression, the onset of schizophrenia and addictions.

Doubtless one of the most significant achievements has been the closure of the long stay sections in Psychiatric Hospitals.

¹¹ WHO-AIMS report on the Mental Health System in Chile. Santiago, Chile, 2006.

¹² II International Seminar “America Works to Change the Face of Mental Incapacity”. WHO, OPS, Health Ministry, and Rostros Nuevos Foundation. Santiago, Chile, August 2009.

To conduct its study in Chile, WHO AIMS analysed 4 long stay Psychiatric Hospitals and one private clinic, all of which reduced by 22% the number of existing beds during the first 5 years of the implementation of the National Plan for Mental and Psychiatric Health. These were mainly in long stay (-38%),¹³ giving way to psychosocial rehabilitation, establishing ties with their families and fitting out Protected Homes and Rest Homes. In 2000 there were 1,270 available beds in psychiatric hospitals which were reduced to 781 by 2005.¹⁴

¹³ WHO - AIMS report on Mental Health System in Chile. Santiago, Chile 2006.

¹⁴ WHO - AIMS report on Mental Health System in Chile. Page 31. Santiago, Chile 2006.

3.2 Psychiatric Reform and Mental Health Policy in Brazil

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INTRODUCTION

The Brazilian Public Health System and Psychiatric Reform

The National Public Health System (SUS) was approved in the 1988 Federal Constitution after important health-related social movement mobilisation started in the 1970s, which fought to change the models of care and management in health practices, advocating collective health, delivery of equal services and supporting workers and health service users as leaders in the process of management and production of healthcare technologies. One of the SUS's most important principles is to guarantee broad social participation on the decisions related to health policies through municipal, state and national health councils and conferences.

Brazilian Psychiatric Reform started contemporaneously to a reform of the healthcare system led by social movement and was based on an acute criticism of the hospital-based model of care and also on the guarantee of psychiatric patients' human rights.

This process became a political and social process that was built by health professionals, health authorities, families and users of the mental health system, as well as members of universities.

The active participation of users and family members in the decisions had also contributed to the organisation of users and family associations and groups.

BRIEF HISTORICAL BACKGROUND

Criticism of the hospital-based model 1978-1991

A period where the Mental Health Workers Movement (MTSM) emerged, highlighting violence against mental health patients within the psychiatric hospitals and fighting for a good-quality public healthcare system to provide care. In 1987, two important meetings had occurred: the first Mental Health National Conference (Rio de Janeiro) and the second meeting of MTSM (Bauru, State of São Paulo) which adopted the phrase “For a society with no mental hospitals”. Some community-based mental health services were established, and also an important intervention occurred in 1989 in a psychiatric hospital which had a history of maltreatment and deaths of patients in the city of Santos (São Paulo State).

Also in 1989, Congressman Paulo Delgado submitted a bill to the National Congress proposing the regulation of the rights of people with mental disorders and the gradual abolition of mental hospitals in Brazil. It was the starting point for the Psychiatric Reform Movement fighting in the legislative field.

In 1988, the Federal Constitution created the SUS – National Public Health System, which is built on the government levels (Federal, State and Municipal) and also with an important role played by social control.

Implementation of the community-based services 1992-2000:

Several States passed bills setting forth the gradual replacement of psychiatric beds with an integrated network of mental health care. Within this period, the Brazilian Government had agreed on the Declaration of Caracas and the second National Conference on Mental Health was held.

From the legal perspective, the Ministry of Health had set an important rule to implement community-based care for mental health issues. In this context, the process of increasing the number of Centres for Psychosocial Care (CAPS) was intermittent.

Psychiatric Reform after the National Law 2001-2009

In 2001, Federal Law 10.216 was approved and provided new directions to mental health care, giving priority to community-based services and also providing principles to protect the human rights of people with mental disorders. Within the context of the enactment of Law 10.216 and the third National Conference on Mental Health, the mental health policy of the Federal Government, aligned to the Psychiatric Reform guidelines, was consolidated and became more sustainable and visible. This period was then characterized by two simultaneous movements: the implementation of a mental health care network to replace the hospitalisation-oriented model on one hand, and the surveillance and gradual and scheduled reduction of psychiatric beds on the other hand. The main policies of this period are described below.

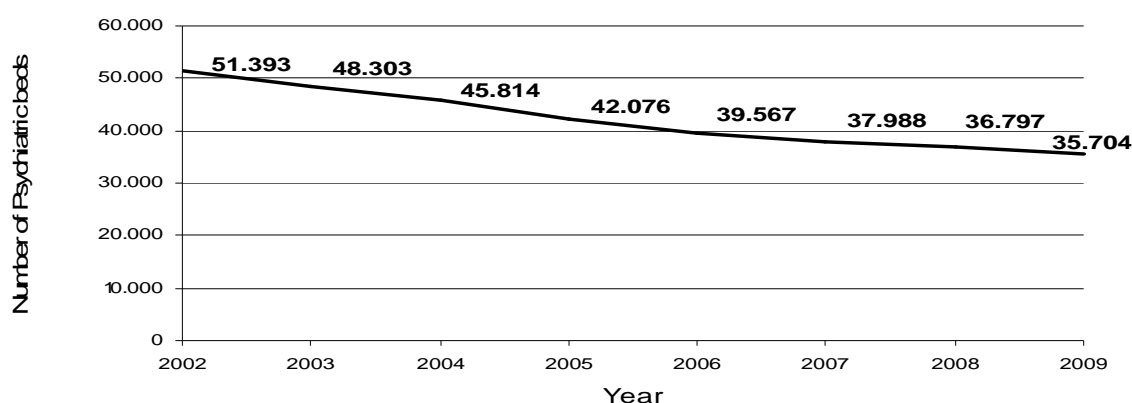
THE DEINSTITUTIONALISATION PROCESS

Reduction in the number of psychiatric beds

The process of reducing the number of beds in psychiatric hospitals and the deinstitutionalisation of individuals with a long history of hospitalisation became public policy in Brazil in the 90s and was highly encouraged in 2002.

The graph below illustrates the process of beds reduction since the second half of 1990s up to now:

SUS Psychiatric Beds per year (1996-2009)



(Sources: Until 2000, SIH/SUS. In 2001, adjusted SIH/SUS. In 2002-2003, SIH/SUS, General Coordination of Mental Health and State Coordination Units. In 2004-2005, PRH/CNES).

The National Programme of Evaluation of Hospital service/psychiatry (PNASH/Psiquiatria – an annual inspection of psychiatric hospitals to evaluate quality of care delivered and physical structure), and the Annual Programme of Restructuring of Psychiatric Hospital Care of SUS (PRH – a technical and funding tool to reduce the number of psychiatric beds in bigger hospitals and to provide more funds to smaller hospitals), has helped in reducing thousands of psychiatric beds in Brazil, closing several psychiatric hospitals and expanding community-based services.

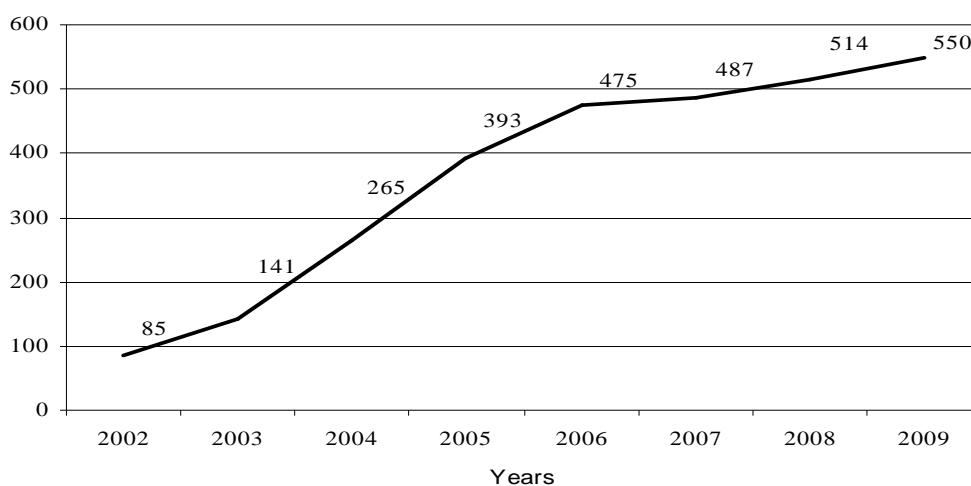
Psychiatric hospital beds are being reduced in all the states of Brazil, although at different speeds, and this process usually precedes the Reform process. From 2003 to 2009 the figures show a reduction of 15,000 psychiatric hospital beds.

Therapeutic residences

The implementation and expansion of therapeutic housing in Brazil is very recent. Therefore, the growth of these services – despite being a permanent process – moves at its own pace and generally follows the process of reducing psychiatric beds.

Currently, there are 550 therapeutic residences with around 2,950 residents. Estimates by the Ministry of Health point out that about 12,000 individuals who are currently living in psychiatric hospitals may benefit from the Therapeutic Residences.

Expansion of Therapeutic Residences from 2000 to 2009



(Source: Ministry of Health)

The Return Home Programme

This programme is one of the most effective tools for the social reintegration of individuals with a long history of hospitalisation. It was created by the Federal Law 10.708 which the President Luiz Inácio Lula da Silva submitted to the Brazilian Congress in 2003, when it was voted and enacted.

The Programme established a monthly rehabilitation allowance of R\$ 320,00 (approximately US\$ 178,00) to its beneficiaries. To be eligible for the Programme, three conditions apply: the individual should have been in a psychiatric hospital for more than 2 years before the law came into force; must be discharged from the Psychiatric Hospital, and must have been referred to a social reintegration programme. Currently, there are 3,445 individuals receiving the benefits of the Return Home Programme.

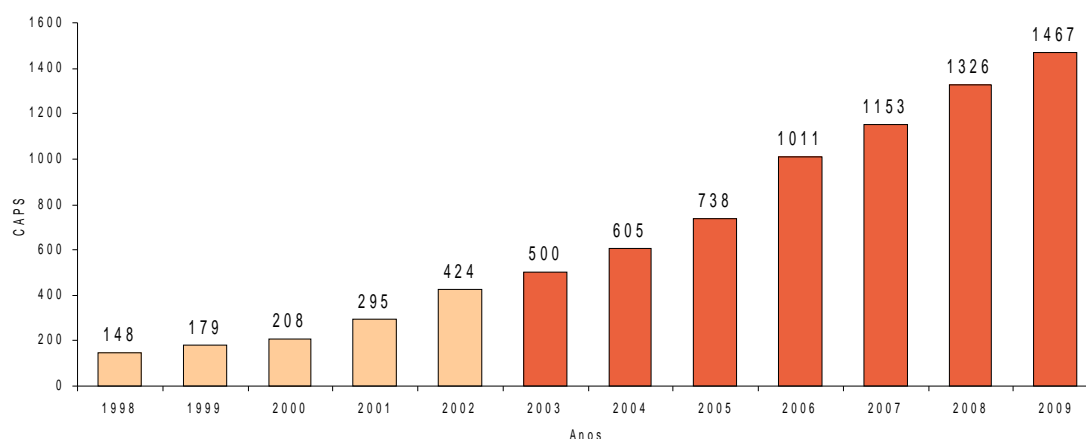
THE COMMUNITY-BASED CARE NETWORK

The strategic role played by CAPS

The Centres for Psychosocial Care (CAPS) play a strategic role in Brazilian Psychiatric Reform. The CAPS provide daily clinical care to individuals with serious and persistent mental disorders, trying to preserve and strengthen the users' social ties in his/her territory, thus avoiding psychiatric hospitalisation; promote the social inclusion of individuals with mental disorders by developing joined-up care, and oversee and support mental health care in the community. In other words, CAPS has the task of organising a network of care for individuals with mental disorders at the municipal level.

Since 2002, the Ministry of Health has been providing specific funds for these services and there was a huge expansion of CAPS in Brazil

Annual development of CAPS figures, Brazil, 1992-2009.



(Source: Ministry of Health)

Undoubtedly, the expansion of the CAPS network was crucial to the visible changes underway in the care of individuals with mental disturbance.

The implementation of daily care services has radically changed the picture of lack of assistance that used to characterise public mental health in Brazil.

Care coverage is gradually improving but, in fact, is still below the standard established by the Ministry of Health. Currently, Brazil has 1,467 CAPS, distributed through all Brazilian states.

The indicator CAPS/100,000 inhabitants provides information on the different kinds of coverage and expansion pace of CAPS in the states, besides showing local health authorities the need to expand the network (reference of 1 CAPS for each 100,000 inhabitants). Sixty percent of the Brazilian population has access to CAPS services.

There are 5 different types of CAPS: CAPS I (20,000 to 70,000 inhabitants), CAPS II (more than 70,000 inhabitants), CAPS III (more than 200,000 inhabitants – 24 hours), CAPSi (children and adolescents with mental disorders) and CAPSad (alcohol and other drugs), both for cities with more than 100,000 inhabitants.

Mental Health in primary care: cooperation with the family health programme

The development of the Family Health strategy during recent years is a definite development in SUS policy. In response to the commitment of integral healthcare, the Family Health Programme (PSF in Portuguese) that was established in the 1990s, aimed its work at promoting health and preventing diseases, reaching important outputs for collective health. Structured in Family Health teams (1 GP, 1 nurse and 6 community health workers), the Programme has already reached the whole country (30,000 family health teams and 232,000 community health workers). The experience of these Family Health teams has proved that everyday they have to deal with mental health issues.

Integration of mental health interventions within primary care is still a challenge. Around 30% to 40% of CAPS support the work of the Family Health teams. In 2008, the Ministry of Health approved a new policy and funding to increase shared care: a group of specialists would provide support for family health teams, including mental health issues. Currently, 30% of those support teams are mental health-related.

Specific policies – child/adolescent and substance misuse

A) Child and adolescent mental health

Acknowledging the gap within the public health system relating to child/adolescent mental health provision, the Ministry of Health established a specific policy to cover this need in 2003. The main aim is to increase mental health services for this group and support inter-agency strategies to provide integral care.

The National Forum of Children and Adolescents Mental Health was of utmost importance to the broad participation of civil society in the dissemination of proposals in the field of children's and adolescents' mental health and to the construction and consolidation of a specific health policy.

B) Substance misuse

In Brazil, the topic of consumption of alcohol and other drugs has been historically associated to criminality and anti-social practices, and also to “treatments” inspired by models of exclusion/separation of users from their social environment. The government initiatives were restricted to a few walk-in or hospital services, typically linked to university-sponsored programmes. There was no national policy in the scope of public health.

In 2002, the Ministry of Health started implementing the *National Programme of Integrated Community Care for the Users of Alcohol and other Drugs*, recognising the problem of the harmful use of substances as a public health issue, and building a specific public policy to provide care to individuals who consume alcohol or other drugs, within the scope of mental health.

There are three main components related to this policy: increase access to treatment, review current legislation, and expand and strengthen inter-sectoral interventions.

Since 2003, with specific funding available, community-based service provision (Alcohol and Drugs Centres for Psychosocial Care – CAPSad) had a five-fold increase (currently 223). There has been an effort to build capacity within other types of CAPS (ex: CAPS I and CAPS for children and adolescents) and to Family Health teams to offer care for substance misusers as well. In order to provide acute and emergency care related to drug consumption, the Ministry of

Health is leading a process to expand psychiatric beds in general hospitals. Harm reduction programmes are also promoted to reach vulnerable groups.

In 2006, there was an update on drugs legislation and imprisonment for personal use was abolished. Where drug treatment is concerned, the new legislation supports the need to provide interventions under the public health approach.

A specific policy on alcohol consumption was approved by the Federal Government in 2007. Following international recommendations, some interventions were adopted: improvement in treatment, reduction of physical availability, new drink-driving legislation and national media campaigns.

Social inclusion activities

One of the major challenges to Psychiatric Reform is how to strengthen work as a tool for social inclusion for service users. The Ministry of Health provides technical and financial support for associations and cooperatives of mental health users and their families. This programme is being developed together with the Ministry of Labour and Employment, in the context of solidarity-based Economy – as a movement to fight against social and economic exclusion.

Solidarity-based Economy aims at setting solidarity as a social rule and building collective and self-managed undertakings in response to the exclusion promoted by the market. Up to now, there are 382 initiatives of associations and cooperatives promoting social inclusion through work. In 2005, the Ministry of Health had established financial support to develop activities on a local level to increase social inclusion through work for individuals with mental health or substance misuse disorders. For the very first time, these initiatives started receiving federal funds.

Professional training and research

Since 2002 the Ministry of Health has been developing, the Permanent Programme of Human Resources Training for Psychiatric Reform. The programme provides support and funding to mental health training centres according to Psychiatric Reform, through agreements established with federal universities and local and state health authorities.

In the mental health field, there are regional public training centres covering almost all Brazilian states where 15,000 health professionals (mainly primary and secondary care) have improved their skills.

There are 6,003 psychiatrists in Brazil and 5,259 are working in the public health system. This number is still not sufficient and its distribution is unequal. The Ministry of Health has established a programme to increase the number of psychiatry-specialized training programmes, especially in regions where this gap is large.

Since 2005, the Ministry of Health, in partnership with CNPq (National Council on Scientific and Technological Development) has funded mental health research projects on primary care, community-based services, substance misuse and other subjects. This programme has invested US\$ 6 million since these grants started.

MENTAL HEALTH FUNDING

The change of mental health model of care in Brazil was followed by an important shift in funding ratios. In the 11 year period between 1997 and 2008, financial resources for mental health hospitals declined from 93% in 1997 to 37% to 2008; on the other side, funds related to community-based services have increased from 7% in 1997 to 63% in 2008.

MAJOR CHALLENGES TO PSYCHIATRIC REFORM

- **Accessibility and equity**
Reduce the gap related to child/adolescent and substance misuse community services
- Increase number of psychiatric beds in general hospitals
- Strengthen and expand mental health interventions in the primary care setting
Enlarge education strategies aimed at health professionals working in mental health, given the rapid expansion of the mental health public network
- Improve existing services evaluation and monitoring mechanisms

