DOI: http://10.18315/argumentum.v10i3.20696

ARGUMENTUM

ARTIGO

Mental Health Policy in Brazil and Paraguay: symmetries and asymmetries

Política de saúde mental no Brasil e no Paraguai: simetrias e assimetrias

Juliana DOMINGUES*
Maria Geusina da SILVA**
Vera Maria Ribeiro NOGUEIRA***
Filipe Silva NERI****

Abstract: This article presents and characterises the implementation of Mental Health Policy in Brazil and Paraguay based on *Policy Cycle* logic; Problem identification; forming the agenda; formulation; implementation and evaluation. To achieve this objective a wide bibliographical review, documentary research and data content analysis were carried out. The results of the research indicate that the implementation process in Brazil and Paraguay has gradually been consolidated across treatment networks and the Network of Psychosocial Care (RAPS), in the case of Brazil, and the Integrated Networks of Health Systems/Care Line in Mental Health (RISS) in Paraguay, presenting both symmetries and asymmetries apparent in the process of institutionalisation.
Keywords: Implementation. Policy Cycle. Mental Health Policy. Brazil. Paraguay.

Resumo: O objetivo deste estudo é apresentar e caracterizar o processo de implementação das Políticas de Saúde Mental no Brasil e no Paraguai a partir da lógica proposta pelo *Policy Cycle*: identificação do problema; conformação da agenda; formulação; implementação e avaliação da política.De maneira a atingir os objetivos propostos, realizou-se uma ampla revisão bibliográfica, pesquisa documental e análise de conteúdo no tratamento dos dados. Os resultados da pesquisa indicam que o processo de implementação no Brasil e no Paraguai vem se consolidando de maneira gradativa através de redes de atenção, a Rede de Atenção Psicossocial (RAPS), no caso do Brasil, e das Redes Integradas de Sistemas de Saúde/Linha de Cuidados em Saúde Mental (RISS) no Paraguai, apresentando simetrias e assimetrias nos seus processos de institucionalização.
Palavras-chave: Implementação. *Policy Cycle*. Política de Saúde Mental. Brasil. Paraguai.

* Doctor in Social Politics and Human Rights. Professor of the course in Social Service at the Universidade Federal da Integração Latino-Americana (UNILA), Instituto Latino-Americano de Economia, Sociedade e Política (ILAESP, Foz do Iguaçu, Brasil). Avenida Tancredo Neves, 6731, Bloco 04, Foz do Iguaçu (PR), CEP. 85863-220. ORC ID: <http://orcid.org/0000-0002-8080-8960>. E-mail: <juliana.domingues@unila.edu.br>.

** Doctor in Social Service. Professor of the course in Social Service at the Universidade Federal da Integração Latino-Americana (UNILA), Instituto Latino-Americano de Economia, Sociedade e Política (ILAESP, Foz do Iguaçu, Brasil). Avenida Tancredo Neves, 6731, Bloco 04, Foz do Iguaçu (PR), CEP. 85863-220. ORC ID: <http://orcid.org/0000-0001-9336-8055>. E-mail: <maria.silva@unila.edu.br>.

*** Doctor in Nursing. Collaborating professor at the Universidade Católica de Pelotas (UCPel, Pelotas, Brasil). R. Gonçalves Chaves, 373, Centro, Pelotas (SC), . ORC ID: <http://orcid.org/0000-0003-4158-1510>. E-mail: <veramrn@gmail.com>.

**** Graduate in Social Service at the Universidade Federal da Integração Latino-Americana (UNILA), Instituto Latino-Americano de Economia, Sociedade e Política (ILAESP, Foz do Iguaçu, Brasil). Avenida Tancredo Neves, 6731, Bloco 04, Foz do Iguaçu (PR), CEP. 85863-220. ORC ID: <http://orcid.org/0000-0002-0395-9423>. E-mail: <filipe.neri@aluno.unila.edu.br>.

Submitted on: 13/7/2018. Revised: 28/9/2018. Accepted: 18/10/2018.

INTRODUCTION

The issue of mental health has been gaining prominence in publications prepared by international health organisations, showing an increase in psychological disorders and the use of psychoactive substances, especially in Latin America.

Simultaneously, they have denounced an insufficient and low-capacity mental health care network, in addition to commonplace human rights violations, and has been recognised as a serious and growing health problem (ORGANIZAÇÃO PANAMERICA DE SAÚDE, 2013a).
In the late 1980s, this situation led the Pan American Health Organization (ORGANIZAÇÃO PANAMERICA DE SAÚDE) to carry out an assessment of psychiatric care throughout the continent, with repercussions on the subsequent convening, by the World Health Organisation (WHO), of the Conference on the Reorientation in Psychiatric Care, which took place in the 1990's. As a result of this process, the Caracas Declaration became a milestone in Latin America for the incorporation of a model of community-based mental health care with promotion, prevention, treatment and rehabilitation actions, with a view to a definitive breaking of historic maniacal, segregating and stigmatising practices across the continent (ORGANIZAÇÃO MUNDIAL DE SAÚDE; ORGANIZAÇÃO PANAMERICANA DE SAÚDE, 1990).

Brazil and Paraguay are signatories to the Caracas Declaration and implemented their National Mental Health Policies in 2001 and 2011 respectively, incorporating into their legal regulations the principles and guidelines of the new model of mental health care. In 2009 and 2011, Paraguay instated further Technical Cooperation Agreements with Brazil (PAHO, 2013b) to develop a new mental health policy for the country, as well as to understand the mental health interventions carried out by the Family Health Programme in Brazil.

The geographic proximity and the various integration processes carried out in Brazil and Paraguay through partnerships and agreements, especially the Technical Cooperation Terms for the formulation of the Mental Health Policy of Paraguay, led Domingues (2018) to inquire about symmetries and asymmetries in the processes of implementing this policy in each country. This became the object of study in the research that resulted in her doctoral thesis, entitled "The implementation of Mental Health Policy in the twin cities of Foz do Iguaçu (BR) and Ciudad del Este (PY)", which was presented in the Postgraduate Programme in Social Policies and Human Rights of the Universidade Católica de Pelotas (UCPel).

The analyses considered the temporal difference between the institutionalisation of Mental Health Policies in Brazil from 2001 and Paraguay from 2011 and the different political, economic and social processes that characterise their development histories. The study, therefore, is not comparative and its objective is to describe and characterise the process of implementation of Mental Health Policies in Brazil and Paraguay, based on *Policy Cycle* logic. The article builds on an intense literature review, characterised by the analysis of information from relevant studies published with a specific theme in order to summarise the existing body of knowledge and draw conclusions (COOPER; HEDGES, 2009), allowing it to establish depth on the subjects through mediations and to crystallise thoughts. Documentary research was

also carried out on the websites of the Ministries of Health of Brazil and Paraguay to access government documents and regulations on the composition of health and mental health systems in both countries (see Table 1).

Table 1 – Governmental documents and norms on health and mental health

Documents consulted in Brazil	Documents consulted in Paraguay
Declaration of Caracas, 1990.	Declaration of Caracas, 1990.
Federal Constitution of 1988.	Federal Constitutions of 1967 and 1992.
Ministry of Health Ordinance, 244/1992.	National Plan for Mental Health (1991-1993). Ministry of Health and Social Welfare, 1991.
Final Report of the 2nd National Conference on Mental Health. Ministry of Health, 1994.	An alternative in Mental Health Care and Decentralised Psychiatric Assistance. Ministry of Health and Social Welfare ,1997.
Mental Health Law 10.216/2001. Ministry of Health, 2001.	National Policy for Mental Health (2002-2006). Ministry of Health and Social Welfare, 2002.
Mental Health within the Unitary Health System: Centres of Psycho-social Care. Ministry of Health, 2004.	WHO Report – AIMS on the Mental Health system in Paraguay, PAHO, 2006.
Psychiatric Reform and Mental Health policy in Brazil: 15 years after Caracas. Ministry of Health, 2006.	Patriotic Alliance for Change. Republic of Paraguay. Government of National Unity, 2008.
Mental Health within the Unitary Health System: the new frontiers of Psychiatric Reform. Ministry of Health, 2011.	National Policy for Mental Health 2011-2020. Ministry of Health and Social Welfare, 2011.
Mental Health in Figures. Ministry of Health, 2012.	Health Systems in South America: challenges to integrity and equality. Ministry of Health and Social Welfare, 2011.
Implementation of the Healthcare Networks and other strategies within the Unitary Health System. Ministry of Health, 2012.	Norms and procedures in mental health care. Ministry of Health and Social Welfare, 2011.
Technical Cooperation between Brazil and Paraguay for the implementation of Mental Health Policy, PAHO, 2009 and 2011.	Technical Cooperation between Brazil and Paraguay for the implementation of Mental Health Policy, PAHO, 2009 and 2011.
Unitary Health System, Healthcare Network self-learning course. Ministry of Health, 2012.	Directory of Care Services for mental health in the Integrated Network of Health services. Ministry of Health and Social Welfare, 2015.
	Protocol to be applied in Family Health Units for the evaluation of the capabilities of persons diagnosed with mental incapacity. Ministry of Health and Social Welfare, 2016.

Source: Produced by the authors.

Content analysis was used in the treatment and organisation of documentary research material, in accordance with Bardin (1995), along with the description, grouping and analysis of the content of the legal frameworks, with the intention of extracting the main themes, aiming to establish the symmetries and asymmetries in the implementation of Mental Health Policies in Brazil and Paraguay. The following categories were analysed; Public Policy Cycle; Mental Health Policy; Service Networks in Health and Mental Health and Implementation.

Public policy evaluation criteria were used, especially the current *Policy Cycle* concept, developed from the theories of Dye (1984) and Frey (2000), to understand the dynamics of the process of implementation of the Mental Health Policy in Brazil and Paraguay.

1. THE PUBLIC POLICY CYCLE – *POLICY CYCLE*

Developments in knowledge production on public policy and their related processes currently comprises a wide and diverse theoretical collection, discussions on the subject of public policy evaluation began in the 1950's in the United States. Gradually, these evolving studies became more central in discussions, both in governmental and academic spheres. It confirmed itself as a field that could impact on the improvement of the public policy, promoting the progressive coming together of the academic sphere with public administration. This situation made it possible for the study of public policy development "to be institutionalised and developed, becoming recognised both by researchers and by policy makers[1] (SERAFIM; DIAS, 2012, p. 128).

Among the key studies on public policy process, the idea of *Policy Cycle*, initially developed by Lasswell (1951), has evolved to become the most shared perspective in current public policy studies, much of its output analyses "moments" or "phases" of the political process. Its contribution lies in highlighting the understanding that there are different stages in the process of constructing a policy, pointing out the need to recognise the specificities of each of these stages and thereby allowing a greater perception for interventions in the political process.

We will refer to the most current concepts of *Policy Cycle*, developed from the theories of Dye (1984) and Frey (2000), whose proposed five moments of interconnected, successive and dynamic cycles, as follows: 1) Problem Identification; 2) Forming the Agenda; 3) Formulation; 4) Implementation; 5) Evaluation.

The first step in policy development is the *identification of the problem* and the demonstration of its public relevance, this becomes the starting point for the generation of a public policy. Its recognition as a problem in the governmental sphere may or may not occur concurrently with events identified as problematic by civil society, there may be a variation in time between these processes.

The next stage of the Policy Cycle is called *agenda formation*, a decisive moment for the recognition of a problem and its incorporation into the agenda, although this does not necessarily indicate the development of a policy to solve it. Until this action takes place, different interests remain in dispute, demonstrating influences from different facets of political stakeholders that generate "[...] conflicts regarding any decision-making process that are subject to the influence of those who hold power over it and that seek to create or reinforce social and political values and institutional practices "(SERAFIM, DIAS, 2012 p. 129). *Agenda formation* triggers a series of negotiations in both the governmental sphere and the demands of the population so that the situation evolves to the next phase - *policy formulation*.

[1] Simon (1947) attributed the term "policy makers" to professionals who introduced the concept of limited rationality to the sphere of State public policy evaluation.

Policy formulation is the third stage of the *Policy Cycle*, characterised by the moment in which the detailing of the alternatives defined in the *agenda formation* takes place; organisation of ideas; resource forecasting, and expert opinion consultation create strategies that result in the success of the proposal (SECCHI, 2012).

Still on *Policy formulation*, some aspects, such as who decides what, when, with what consequences and for whom, are related "to the nature of the political regime in which one lives, to the degree of organisation of the civil society and the current political culture "(TEIXEIRA, 2002, p.2), highlighting not only the corporate projects in dispute, but also their perception of all the subjects involved in the formulation process. Under this logic, the *formulation* as well as its predecessor stages are characterised by processes of conflict, disputes of interest and forces of power.

The authors' proposal is based on the policy cycle adopted in this study and reveals that the different stages are continuously integrated and that, post *policy formulation*, new issues can arise on the same theme, requiring further interventions, and so the processes of *problem identification* and *agenda formation* are again stressed.

The same can be said about the fourth step: *implementation*, defined as the time needed to put a solution into practice. This phase involves a series of public administrative systems or activities: the managerial and decision-making system, information systems, policy implementers, logistical and operational systems (material and financial resources), among others (FARIA, 2012).

Policy implementation is a phase of the process stemming from political actions and is a fundamental step in which actions and results are produced that will serve as a basis for the following process of *evaluation* (TEIXEIRA, 2002).

In general, public policy *evaluation*, the fifth stage of Policy Cycle, aims to produce reliable and systematised data on planned actions in relation to the objectives achieved. Its goal is the identification of possible problems in formulation, implementation and management, allowing for the adjustments necessary to achieve the objectives initially proposed by the policy.

The *Policy Cycle* sequence proposed by Dye (1984) Frey (2000) presents the process in stages, evidencing the importance of such actions for the success of its institutionalisation. In this context, the development of studies on the implementation of public policies is strongly linked to the need to develop improvements in political-administrative processes that allow the development of management activities (RUA, 1998).

Although all stages of the policy cycle are important for the success of the proposed actions, *implementation* as an object of study has gained prominence since the 1970s with the publication of the work *Implementation*, developed by Pressman and Wildavsky (1973), which has come to be recognised as a crucial dimension in explaining success or failure in the design of public policies.

The most recent studies on implementation have demonstrated that during the process of formulating and implementing public policies the effects of different forms of political power, distribution and redistribution of power are notable. These conflicts within the process of policy implementation, result, in many cases, in the need for adaptations in order to meet their outcomes (FARIA, 2005). Although implementation is just one stage of the *Policy Cycle* its importance cannot be reduced to a simple administrative phase, given the complexity of the actions, interests and actors involved. These characteristics cause initial propositions to be modified, rejected or expanded depending on the political and economic interests at stake, and it is under such a logic that we will present the symmetries and asymmetries of the implementation of the Mental Health Policy in Brazil and Paraguay.

2 SYMMETRIES AND ASYMMETRIES IN THE IMPLEMENTATION OF MENTAL HEALTH POLICY IN BRAZIL AND PARAGUAY UNDER *POLICY CYCLE* LOGIC

The incorporation of the mental health theme into the government agenda in Brazil and Paraguay has taken different paths when considering their institutional deployment, development and the temporal differences in the two countries. Whilst preserving the individuality of each country, there are processes that make them similar and, in a way, unified regarding the orientation of psychiatric care in Latin America.

In detailing the implementation processes of these National Mental Health Policies, we evidence their symmetries and asymmetries but do not intend to compare them. Brazil institutionalised its Health Policy Mental from 2001, whilst in Paraguay this took place a decade from 2011, so a direct comparison would be impossible. This ten-year gap in the implementation of mental health policy has brought Brazil to a different place in relation to its neighbour in all stages of the institutionalisation process.

The first element that unifies mental health actions in both countries relates to the Declaration of Caracas, a landmark instrument in the process of reorienting psychiatric care in the countries of Latin America issued in the 1990s, to which Brazil and Paraguay became signatories, accepting the responsibility for constructing a community-based mental health care network, so ending the long-term institutionalisation of people with psychic disorders.

The second unifying action took place in 2009, with the Technical Cooperation Agreement, in which psychiatric care representatives in Paraguay visited to learn the good Brazilian mental health practices, with a view to incorporating them into their mental health policy. In 2011 this agreement was reaffirmed to understand the Brazilian Family Health Programme (PSF) and how it related to the network of mental health services. As a result of this interaction, the PSF was incorporated into Paraguay's primary health care network. Currently, Family Health Units form the part of Mental Health Policy in Paraguay responsible for mental health care in the primary health network.

The issue of mental health care in Brazil emerged as an important theme, associated with the country's re-democratisation process after twenty-one years under military dictatorship, which ended in 1985. Before, during and after the military dictatorship in Brazil, the Sanitary Reform movement had already been discussing the need for various changes, such as the expansion of the concept of health, universality, equity, decentralisation, social control, and

other related issues. The peak of the movement took place at the VIII National Health Conference held in 1996, when the Final Report was approved, almost in its entirety, and became the framework for the institutionalisation of the right to health, guaranteed by the promulgation of the Federal Government Constitution in 1988 and consolidated through the creation of a Unified Health System (SUS).

The First National Mental Health Conference, held in 1987, took place as a follow-up to the VIII National Health Conference, and played an important role in the construction of mental health care in the country, formulated and organised by the Antimaniacal Struggle Movement in the late 1980's, which was made up of professionals, family members, and psychiatric care service users.

Simultaneously, the Sanitary Reform and the Antimaniacal Struggle Movement stimulated discussions about the need to promote a reform in the country's mental health care and promoted the First National Conference on Mental Health in 1987, which deliberated on the changes psychiatric care.

Objectively, we can identify that the first stages of the implementation process: the identification of the problem, forming the agenda and the formulation of mental health policy in Brazil, occurred through manifestations of civil society and through the Sanitary Reform and Antimaniacal Struggle movements, in a context marked by broad popular participation in the process of building a Democratic State of Law in Brazil.

The creation of Law 10.216 / 2001 follows a pattern contrary to that of most Latin American countries that firstly create policies and subsequently approve a Mental Health Law. Brazil carried out these two actions jointly, approving the Mental Health Law in the country, making the State responsible for the development of mental health policy, assistance and promotion of health actions for people with mental disorders.

In the case of Paraguay, following the trend of most Latin American countries, the creation of Mental Health Policies in the years 2002 and 2011 was carried out without the existence of a mental health law; currently there is a bill for regulation, but with no forecast of when it will be approved (PARAGUAY, 2011). The lack of this legal mechanism impacts the entire development of the mental health policy in the country, especially in relation to the government obligation for the creation and expansion of the network as well as in the absence of normalisation on the period of hospitalisation and the protection of the human rights of mental health service users.

In Paraguay, the dictatorial regime lasted thirty-five years, ending in 1989, creating a process of re-democratisation in an economic and political scenario marked by high levels of poverty and social inequality. In this adverse context, the right to health was guaranteed in the 1992 Constitution and the National Health System was established in 1996 and reformulated in 2005.

> Paraguay is one of the poorest countries in Latin America. The troubled political history of this country, governed since its independence by oligarchies and the military

> that came to power through successive coups, was the key factor in perpetuating the high degree of misery and backwardness of its society (SPRANDEL, 2000, p. 310).

As far as mental health is concerned, since 1917 the Psychiatric Hospital located in Asunción has been the only institution in the country specialised in mental health, and there are no records of any legal regulations to guide mental health actions. The first governmental proposal for mental health in the country was formulated in 1991, prior to the promulgation of the 1992 Constitution, in response to the negotiations held at the Caracas meeting for the reorganisation of psychiatric care in Latin America.

The National Mental Health Plan (1991-1993) guided mental health actions in general, pointing out the need to expand the care network and the indispensability of an evaluation of psychiatric care across the country, which was completed in 1997. The evaluation showed that psychiatric care in Paraguay was not compliant with the new guidelines for psychiatric care in Latin America, especially regarding ending the hospital-centred model, which at that time remained the only referral destination for health care in the country's single psychiatric hospital. The creation of the first Therapeutic Community is identified in the same year as the publication of the evaluation, in agreement with the Caracas proposals.

> In the process of transition to Democracy in Paraguay, mental health has been gaining importance and the Department of Mental Health of the Ministry of Health and Social Welfare, has had the goal of creating Decentralised Units of Mental Health in the Regions, following the objectives of the Declaration of Caracas, to promote the Restructuring of Mental Health Care and the Reform of Psychiatric Care, assistance that was always centralised in the Psychiatric Hospital, headquarters of the Chair of Psychiatry of the Faculty of Medical Sciences of the UMA, and that did not accompany the advances of this discipline (PARAGUAY, 1997, P. 18).

Until 2002, the theme of mental health remained secondary in *problem identification* and *incorporation into the government agenda*, and Paraguay was part of the 40% of Latin American countries without a mental health policy. Faced with this situation and being pursued only by mental health workers who were evidencing the need for improvements in mental health care, that was still centralised in the Psychiatric Hospital, the first mental health policy was formulated with the participation of health professionals from all regions of Paraguay, especially physicians and psychiatrists, but without the participation of civil society (PARAGUAY, 2011). No records have been found on its implementation; however, its content pointed to the change from a hospital-centred model to a medical-centred one.

In 2003, Paraguay received the first visit of the Inter-American Commission on Human Rights (IACHR), followed by emergency intervention to protect the lives and health of more than four hundred people, including two children, who were hospitalised in the Psychiatric Hospital. Paraguay received a precautionary warning that required urgent improvements in the conditions of the hospital and in the creation of a network of outpatient services, to be fulfilled within five years. This event was characterised as "the first time that the Commission called for the immediate adoption of critical measures to combat a series of abuses committed in a psychiatric institution" (HILMANN, 2005, p.1).

This situation put the country in the sights of the Commission, which returned to Paraguay in 2004, 2009 and 2010 to verify the mental health situation and they imposed four further precautionary measures and an agreement to extend the deadline for adaptation and consolidation of the mental health system, forcing the state apparatus to include mental health more intensively in the country's agenda of priorities.

The *identification of the problem*, the *incorporation in the agenda* and the *formulation of the mental health policies* in the years 2002 and 2011, in Paraguay, have distinct characteristics. Regarding the institutionalisation of the policy of the years 2002, we identified in all its first three stages that there was no participation by civil society, neither in the form of denunciations of the mistreatment of patients, nor in the process of formulation of its content. It was mostly prepared by physicians and psychiatrists, with the participation of a small number of other health professionals. Pushing for improvements in mental health care at the Ministry of Health and Welfare was performed solely by health professionals.

These initial processes changed with the implementation of the Mental Health Policy of 2011, given that the interventions of, and sanctions applied by, the Inter-American Commission on Human Rights have driven the Ministry of Health and Welfare in the building of a Mental Health Policy that includes the thoughts of users, friends, family members, workers and managers in mental health. Since 2009, three were held in different regions of the country to discuss proposals that would go on to form the basis of the current policy.

> In 2009, three Regional Forums were held, involving mental health professionals, members of civil society, universities, municipalities, governors, family associations and mental health volunteers: First Regional Forum held in the city of Pedro Juan Caballero, on May 6 and 7, 2009, in which 93 people participated. Second Regional Forum held in the city of San Juan Bautista, Misiones, on May 27 and 28, 2009, with the participation of 72 people. Third Regional Forum held in the city of Coronel Oviedo, on June 1 and 2, 2009, 82 people participated (PARAGUAY, 2011, p.17)

In this second moment of policy implementation, *identification of the problem* was driven by the first intervention of the IACHR in 2003, denouncing the conditions in which inmates of the Psychiatric Hospital and which raised visibility within society regarding the state of mental health care, this was widely publicised by the media and had never been seen before in the country. This situation pressured the government apparatus to include the theme in the agenda of priorities of the country, providing and creating conditions for the formulation of the National Mental Health Policy (2011-2020), carried out with the unprecedented participation of several social segments, and not only the professionals related to health and mental health.

In Brazil, implementation took place with the approval of the Mental Health Law in 2001, initiating the process of construction of the policy. Numerous meetings of workers, users and family members are gradually outlining proposals to broaden and improve the care network. The government apparatus is also present in this process, with the creation of ordinances, decrees, operational norms and other documents that give legitimacy, form, organisation and direction to actions and mental health services.

The principles and guidelines of the Mental Health Policy, in addition to meeting the proposals of the World Psychiatric Reform, endorsed in Latin America by the Declaration of Caracas in the 1990s, are also guided by the doctrinal and organisational principles of the Unitary Health System (SUS). Furthermore, the Mental Health Law prohibits the construction of psychiatric hospitals and the policy creates mechanisms to promote the deinstitutionalisation of long-term residents by creating a service network that serves the users in the community in which they reside. Mechanisms to control psychiatric hospital admissions, human resources training and innumerable encounters among workers, relatives and users of mental health have been created, strengthening the collective struggle for a society without psychiatric asylums (BRAZIL, 2015a).

In the institutional legal framework, the service structure is widely scattered across a diverse range of documents developed by the Ministry of Health, in partnership with the General Coordination of Mental Health, Alcohol and other Drugs of the Department of Strategic Programmatic Actions, of the Secretariat of Health Care, of the Ministry of Health. There is a forecast of actions and services by number of inhabitants, by level of Care (basic, specialised, urgency/emergency and hospital), physical structure and human resources that each clinic must offer in relation to the complexity of care , regulation and control of psychiatric hospital admissions and funding, providing clear guidance on the individual and collective responsibility of each of the components that make up the psychiatric care network, which includes services to users of psychoactive substances.

The creation of the Health Care Network (RAS) is derived from PAHO's initiative for the renewal of primary health care of 2010, with the publication of Series 4 of The Renewal of Primary Health Care in the Americas - Integrated Networks of Health Services: Concepts, Policy Options and Road Map for Implementation in the Americas. Brazil incorporated the recommendations and adapted the proposal of the Integrated Health Services Networks (SUSIS) to the SUS, creating the RAS and the networks that constitute it (DOMINGUES, 2018).

The formal, legal standardisation of this new form of SUS organisation was consolidated with the issuing of Administrative Rule no. 4279, December 2010. Based on this reorganisation, the Psychosocial Care Network (RAPS) was created within the framework of RAS and included in it, bringing a new structure in the functioning of the services.

> The Psychosocial Care Network - RAPS is made up of the following components: Basic Health Care; Strategic Psychosocial Care; Emergency and Emergency Care; Transient Residential Care; Hospital Care, complemented by Strategies of Deinstitutionalisation and Psychosocial Rehabilitation. Each component has the services at all levels of attention, as well as the development of strategic actions in the processes of deinstitutionalisation and psychosocial rehabilitation (BRAZIL, 2015b, p.12).

At the level of basic health care, mental health care is the responsibility of the Basic Healthcare Units, the Family Health Support Centres (NASF), and the Street Offices and the Centre for Coexistence and Culture, regulated by specific ordinance (BRAZIL, 2015b).

In specialised Care, now called Strategic Psychosocial Care, the Psychosocial Care Centres, CAPS, continue to be a central point of reference and, in emergency situations, the Mobile

Assistance Service (SAMU), the First Aid Units (UPA) and the Stabilisation Room work together with the hospitals and the basic health units to integrate Care.

The RAS and RAPS were institutionalised so that users, professionals and other groups both understood and were placed within the organisation of the network at their different levels of Care. This reordering would not make sense if the major goal of network implementation, i.e. the communication and interaction between institutions and professionals, was not reached.

The next step taken by the Ministry of Health, after the creation of the Networks, and more particularly of the RAPS, was the publication of a document called Matriculation in Mental Health, which was a new mode for producing health in which two or more teams, in a process of shared construction, implement a proposed pedagogical-therapeutic intervention for users, with a view to contributing to the improvement of their mental health. In addition to publishing the document explaining Matriculation, the Ministry of Health opened invitations to municipalities that wished to consult on the process of implementing RAPS and Matriculation in Mental Health.

The current process of implementation of Mental Health Policy in Brazil resides in a time of transition between the model of care delivered until the end of 2010 and the one proposed with the creation of RAS and RAPS. The new proposal brings changes in the structure of mental health care, broadens the service offering and guides the actions and responsibilities of each component within the structure. In addition, RAPS incorporate new services, such as Reception Units and Stabilisation Rooms, which will require the Municipalities to invest financially as well as in human resources and training of the entire health network so that care takes place according to the rationale of RAS and RAPS.

The first Mental Health Policy of Paraguay, created in 2002, provided for the implementation of community mental health services that integrated different programmes of psychiatric care. This decentralisation to be accompanied by financial and human resources investments, the development of intervention protocols for the most relevant problems in mental health and the prevention of alcohol and drug use through the creation of mental health legislation that integrates health services and promotes the protection of human rights of users. The entire content of the policy is recorded in five pages and does not detail, by levels of Care, which services to create, what human resources will be needed, how will capacity building and other issues guide the implementation process, there is a lack of written detail on the impacts of this policy on mental health care in the country.

> The National Policy of Mental Health of Paraguay has as General Objective of improving the Mental Health of individuals and groups, without distinction of race, religion, gender, age, political ideology or economic and social status, to interact with each other and with the environment, in order to promote the subjective well-being, the development and optimal use of psychological potentials, cognitive affective, relational achievement of individual and collective goals, in accordance with social justice, the common good and the protection of Human Rights (PARAGUAY, 2002, p.17).

The second Mental Health Policy of Paraguay (2011-2010) had its primary processes designed after the interventions of the Inter-American Commission on Human Rights and its content is more detailed than the previous policy, especially in directing that the implementation of actions in mental health, at different levels of care, will occur through the ISDN. The policy has as guidelines and principles, quality of life and health with equity, preserving universal access, integrity of actions and the participation of civil society as a protagonist in the processes of social control. It views the subjects from an integrated perspective as a biopsychosocial being and is sustained by the values of: Respect for Life and Diversity; Humanisation of Care; Quality in Care; Responsible Citizenship; Technical Competence; Solidarity, Perseverance and Confidentiality.

> Within the framework of Public Policies for Quality of Life and Health with Equity, they claim for the area of mental health, a long-delayed sector, stating: "a model of Care capable of giving a sufficient and coherent response, a model that dismantles any type of exclusion, converting the struggle for the health and well-being of the people into a State Policy (PARAGUAY, 2011, p.17).

The mental health model foreseen in the current policy proposes community health care promotes inclusion while seeking to organise with key stakeholders those processes that emerge in community contexts and the best way to care for those suffering from mental illness. To achieve this, actions in mental health would be implemented through the RISS, which provide a pathway for mental health care. The creation of RISS follows the guidelines for basic care reform in Latin America, which even uses the same name - RISS - to designate this new form of organisation.

The incorporation of the RISS as a new proposal for the organisation of the National Health System has been progressively implemented since 2013, through the Institutional Strategic Plan 2013-2018, approved by Resolution S.G. N°. 52, of February 2014, by the Paraguayan government. In the RISS, there is a pathway of mental health care in which services are provided at each level of care, with Family Health Teams - consisting of one doctor, one nurse, one nursing assistant and five community health officers - designed to carry out education, prevention, treatment and rehabilitation at all stages of life (PARAGUAY, 2011).

Specialised Care should be given by Community Mental Health Centres (1 for every 15 Family Health Units), preferably annexed to Specialty Ambulatory Centres or to general and district hospitals and other places with adequate physical resources. The Community Health Centres must have a mental health team, although the Mental Health Policy does not detail the number of professionals in each area, which should be composed of psychologist, paediatric psychologist, social worker, occupational or craft therapist, clinical doctor and psychiatrist, providing Care in accordance with the demands of mental disorders resulting from violence or use of psychoactive substance or sequelae of human rights violations, and should be carried out with the support of the Family Health Teams (PARAGUAY, 2011).

The RISS also provides an Accident/Emergency Care Network and Hospital Care Network. In the first, the record states that all emergency services of the country will be prepared to meet the demands, without describing what they are, and that the Centre of Regulators will have a qualified doctor in mental health to give guidance to professionals and users. In

Hospital Care, the directive is that all referrals are to be based on the Manual of Clinical Management of Mental Disorders in Primary Care, and 10% of the General Hospital beds should be used for psychiatric admissions. The Policy also presents two small items on Care for users of psychoactive substances and the creation of so-called Substitute Homes, with spaces for long-term residents.

The need to provide subsidies for the implementation of this new mental healthcare proposal as expressed in the Mental Health Policy of Paraguay led the Ministry of Health and Social Welfare to publish manuals and protocols to be used as guiding frameworks for actions in mental health: Mental Health Care Standards and Procedures (2011), Clinical Management of Mental Disorders in Primary Health Care (2011) and the Guide to Criteria for Admission of Persons with Mental Disorders (2013). In Paraguay the content of these manuals has been produced in the form of training programmes to be delivered by the country's current mental health management across all Health Regions.

FINAL CONSIDERATIONS

Having presented the implementation pathways of the National Health Policies of Brazil and Paraguay, we conclude that the symmetries in their implementation processes are concentrated in the directives and principles of the guidelines proposed in the Latin American scenario through the Declaration of Caracas and the incorporation of the reorientation of the Mental Health Care proposed by PAHO, introducing the Health Networks in the directing of services.

With regard to its asymmetries, we first emphasise the fact that Brazil institutionalised its Mental Health Policy based on a Mental Health Law, making it legally responsible for its implementation by the government in a context of social mobilisation, while in Paraguay the law is still passing through Congress and social movements did not have a leading role because of the long period of dictatorship experienced by the country.

In Brazil, the political and social particularities seen in the process of democratisation, associated with the period of consolidation during the organisation of a Unitary Health System, allowed the creation of a set of legal devices (norms, decrees, ordinances) and other documents referring to mental healthcare that underlie, amplify and constantly update Mental Health Policy.

In Paraguay, due to the relative newness of the Mental Health Policy and all the processes that the country has lived through, the legal-normative apparatus of mental health care is concentrated in the current National Mental Health Policy (2011-2020) and in the manuals and guideline protocols (three in full) in effect. There are still many gaps in understanding on how to implement the actions in psychiatric care provided for in the policy.

The lack of direction and detail of the actions in the Mental Health Policy in Paraguay further highlights the issues surrounding the processes of promotion, prevention, treatment and rehabilitation of users of psychoactive substance, mentioned in a very superficial way in the content of the whole Policy of Mental Health of Paraguay. The lack of a Mental Health Act is a major obstacle to improving the care of people with mental illness in the country.

BIBLIOGRAPHY

BARDIN, L. **Análise de conteúdo**. Lisboa: Edições 70, 1995.

BRASIL. Ministério da Saúde. **Reforma Psiquiátrica e política de Saúde Mental no Brasil**. Documento apresentado à Conferência Regional de Reforma dos Serviços de Saúde Mental: 15 anos depois de Caracas. Brasília [DF]: OPAS, 2015a. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/Relatorio15_anos_Caracas.pdf>. Acesso em: 12 nov. 2017.

BRASIL. Ministério da Saúde. **Implantação das Redes de Atenção à Saúde e outras Estratégias da SAS**. Brasília (DF), 2015b. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/implantacao_redes_atencao_saude_sas.pdf>. Acesso em: 12 nov. 2017.

COOPER, H., HEDGES, L. Research Synthesis as a Scientific Process. In: H. COOPER, L. HEDGES J. VALENTINE (eds.). **The Handbook of Research Synthesis and Meta-Analysis**. 2. ed. New York: Russel Sage Foundation, 2009.

DYE, T. R. **Policy Analysis**: what governments do, why they do it, and what difference it makes. Tuscaloosa: University of Alabama Press, 1984.

DOMINGUES, J. **A implementação da Política de Saúde Mental nas cidades gêmeas de Foz do Iguaçu (BR) e Ciudad del Este (PY)**. 2018. Tese (Doutorado em Política Social e Direitos Humanos)–Programa de Pós-Graduação em Política Social e Direitos Humanos da Universidade Católica de Pelotas UCPel, Pelotas, 2018. Disponível em: <http://pos.ucpel.edu.br/ppgps/wp-content/uploads/sites/5/2018/04/Tese_-_Juliana_Domingues.pdf>. Acesso em: 20 maio 2018.

FARIA, C. A. P. **A Política de Avaliação de Políticas Públicas.** Revista Brasileira de Ciências Sociais, São Paulo, v. 20, n. 59, p. 97-109, out. 2005. Disponível em: <http://www.ufpa.br/epdir/images/docs/paper44.pdf>. Acesso em: 20 set. 2017.

FARIA, C. A. P. Implementação: ainda o "elo perdido" da Análise de Políticas Públicas no Brasil? In: FARIA, C. A. P. (Org.). **Implementação de Políticas Públicas**: teoria e prática. Belo Horizonte: PUC Minas, 2012.

FREY, K. Políticas públicas: um debate conceitual e reflexões referentes à prática da análise de políticas públicas no Brasil. **Planejamento e Políticas Públicas**, Brasília (DF), n. 21, p. 211-259, jun. 2000.

HILMANN, A. A. **Los derechos humanos y la exclaustración: un triunfo para el continente americano.** Revista Panamericana de Salud Pública, v. 18, n. 4-5, Whashington, oct./nov.2005. Disponível em: <http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1020-49892005000900018>. Acesso em: 29 jun. 2018.

LASSWELL, H. D. The Policy Orientation. In: LERNER, D.; LASSWELL, H. D. (eds.). **The Policy Sciences**: Recent Developments in Scope and Method. Stanford: Stanford University Press, 1951.

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). 14 nov. 1990, Caracas; Venezuela, 1990.

ORGANIZAÇÃO PANAMERICANA DE SAUDE (OPAS). **WHO-AIMS**: Informe de la Evaluación de los Sistemas de Salud Mental en América Latina y el Caribe utilizando el Instrumento de Evaluación para Sistemas de Salud Mental de la Organización Mundial de la Salud. Washington, DC: OPAS, 2013a. Disponível em: <http://www.paho.org/per/images/stories/FtPage/2013/WHO-AIMS.pdf>. Acesso em: 12 mar. 2017.

ORGANIZAÇÃO PANAMERICANA DE SAUDE (OPAS). **Cooperação Técnica entre Brasil e Paraguai para a implantação do Programa de Saúde Mental, 2009 e 2011**. Brasilia (DF), 2013b. Disponível em: <http://www.ensp.fiocruz.br/portal-ensp/informe/site/arquivos/anexos/3145acbce74222e09c33ac1c895786251eff328a.PDF>. Acesso em: 20 set. 2017.

PARAGUAY. Ministerio de Salud Pública y Bienestar Social**.** Dirección de Salud Mental. **Política Nacional de Salud Mental 2011-2020**. Assunción, 2011. Disponível em: <http://www.paho.org/par/index.php?option=com_docman&view=download&category_slug=publicaciones-con-contrapartes&alias=333-politica-de-salud-mental&Itemid=253>. Acesso em: 20 set. 2017.

PARAGUAY. Ministerio de Salud Pública y Bienestar Social. Dirección General de Programas de Salud. Dirección de Salud Mental. **Política Nacional de Salud Mental 2002-2006**. Assunción, 2002.

PARAGUAY. Ministerio de Salud Pública y Bienestar Social. Departamento de Salud Mental. Organización Panamericana de Salud, Unidad de Salud Mental Regional. **Una alternativa en la Atención de Salud Mental y de la Asistencia Psiquiatrica Descentralizada**. Assunción, 1997.

PRESSMAN, J. L; WILDAVSKY, A. B. **Implementation**: how great expectations in Washington are dashed in Oakland: or, why it's amazing that Federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes. Berkeley, Los Angeles: University of California Press, 1973.

RUA, M. das G. **Análise de políticas públicas: conceitos básicos.** In: RUA, M. das G.; CARVALHO, M. I. V. de (Orgs.). **O estudo da política**: tópicos selecionados. Brasília (DF): Paralelo 15, 1998.

SECCHI, L. **Políticas públicas**: conceitos, esquemas de análises, casos práticos. São Paulo: CENGAGE Learning, 2012.

SERAFIM, M. P.; DIAS, R. de B. Análise de política: uma revisão de literatura. **Cadernos Gestão Socia**l, Salvador, v. 3, n. 1, p. 121-134, jan./jun. 2012. Disponível em: <http://www.periodicos.adm.ufba.br/index.php/cgs/article/viewArticle/213>. Acesso em: 20 set. 2017.

SIMON, H. A. **Administrative Behavior**: a study of decision-making processes in administrative organization. New York: Macmillan, 1947.

SPRANDEL, M. Una Identidad de Frontera y sus Transformaciones. In: COLECCIÓN Signo. Tradução: Laura Abramzón. Buenos Aires: Ediciones Ciccus, set. 2000.

TEIXEIRA, E. C. O papel das políticas públicas no desenvolvimento local e na transformação da realidade. **Cadernos da AATR – BA**, Salvador, 2002. Disponível em: <http://www.dhnet.org.br/dados/cursos/aatr2/a_pdf/03_aatr_pp_papel.pdf >. Acesso em: 12 ago. 2017.

Juliana DOMINGUES: Contributed to the concept and outlining of the article, documental and bibliographic research, data analysis and interpretation, wording and critical revision of the article. The research that resulted in this text did not receive funding from any academic body or development agency.

Maria Geusina da SILVA: Contributed to the concept and outlining of the article, documental and bibliographic research, data analysis and interpretation, wording and critical revision of the article. The research that resulted in this text did not receive funding from any academic body or development agency.

Vera Maria Ribeiro NOGUEIRA: Contributed to the concept and outlining of the article, documental and bibliographic research, data analysis and interpretation, wording and critical revision and, finally, the approval of the published version. The research that resulted in this text did not receive funding from any academic body or development agency.

Filipe Silva NERI: Contributed to the data analysis and interpretation and the wording of the article. The research that resulted in this text did not receive funding from any academic body or development agency.
