

# “Pay attention when turning a corner”: an overview of mental health policies in Brazil

Igor Euflauzino, Maria Alice Silva Ferraz de Araújo, Naomi Sordan Borghi

Federal University of Lavras, Brazil

## Abstract

**Introduction:** Brazilian’s history of psychiatric care is complex and has some dark periods, but the country managed to get international recognition for its mental health policies in the last years. Those have been currently suffering setbacks.

**Purpose:** Review the historical context of mental health in Brazil, assessing the changes made after 2016, and carry out a critical analysis of the current inclination.

**Methodology:** literature and narrative review using official governmental documents.

**Results and Discussion:** Through its history, Brazil’s had ups and downs in the care of mental health patients. After almost 30 years of policies that are centered around the individual, and not only the individual’s disease, the hospitalocentric model of care has been subtly making its comeback, together with normatives that revoke rights before acquired and corroborates with segregation of the mentally ill.

**Conclusions:** The current changes in the Mental Health politics are not walking alongside the line with movements responsible for the implementation of a biopsychosocial care. It provokes and invites us to continue fighting for fair health programs and for the continuation of the Universal Health System.

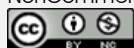
## Keywords

Mental health, mental health policies, psychiatric care

### Address for correspondence:

Naomi Sordan Borghi Federal University of Lavras, João Lacerda St., 440/402, Retiro, Lavras-MG, Brazil. e-mail: [naomi.borghi@estudante.ufla.br](mailto:naomi.borghi@estudante.ufla.br)

This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License (CC BY-NC 4.0).



©Copyright: Euflauzino, Ferraz de Araújo, Borghi, 2021

Licensee NDSAN (MFC- Coordinator of the NDSAN), Italy  
doi: <https://doi.org/10.32437/mhgci.v4i2.122>

Submitted for publication: 10

June 2021

Revised: 20 September 2021

Accepted for publication: 15

October 2021

## Introduction

Brazilian’s history of psychiatric care is complex and has some quite dark periods. Asylums were created at the end of the 19th century, and ended up sometimes serving as a lock up for the mentally ill as well as unrequired personas for the society back them. These places dealt with lack of structure and specialized health care workers, and the lack of full understanding of how the diseases worked and how to treat them only made it for a worse line of care. Around the 1970’s, with delations of superlotations, lack of sanitary

conditions and even plain violence in asylums getting to public attention, the country found itself in the position of discussing new mental health politics, establishing therapeutic models that were both respectful and effective to the patients with psychiatric comorbidities. The need to surpass the old way of treating mentally ill patients brought the subject to discussions in the legislative, administrative and economic scopes, transforming itself in a important political point in Brazil in the 1980’s.

By the same time, discussions and popular movements about a sanitary reform had started in

the whole country, culminating in Universal Health System (SUS)'s creation and establishment, in 1988. SUS is a complex health system that ensures full, universal and free access for the entire population of the country, including matters regarding mental health care. With the installation of this new format, Brazil started to close asylums and psychiatric bed in hospitals, and started to develop a line of care structured in the Psychosocial Care Network. This new structure deals with mental health without enclosure patients for decades in hospital beds, giving the patient the possibility of treatment through the Center of Psychosocial Attention, with longitudinal follow-up, the Residential Therapeutic Service, which brings the doctor inside the patient's home for visits, as well as entries in the Family Doctor's practice, Emergency Rooms and Psychiatric clinics. (Cavalcanti, 2019; Health Ministry, 2019)

Although there was a lot of challenges in establishing this new line of care, especially with fewer resources and a massive population in need of attendance, Brazil ended up getting international recognition for its new care network for mental patients, implementing health policies and successfully maintaining them for over thirty years. (Almeida & Lennon, 2010) Even between some resistances from opposed political parties over the years, there was an overall consensus over the psychiatric reform that took place in the country, making sure the system, while terribly underfunded, was still effective. However, in 2016, the government began to show a break in the relationship with such policies through regulations, ordinances, resolutions and other documents with proposals that led to a more inpatient than outpatient treatment approach. (Almeida, 2019) The changes brought by those documents shine light in the subtle dismantlement of a more humanistic line of care for mental patients, and makes for a deep overview of mental health politics in Brazil in the past and future to come.

## Purpose

To review the historical context of mental health in Brazil through the years, and assess the changes in mental health politics that came after 2016. To understand the development and functioning of the Brazilian mental health support network, in addition to its benefits and weaknesses, and mainly, to carry out a critical analysis of the new mental health policies and how they interfere in the care and services already established.

## Approach

This article considers documents that serve as substrate for the paradigm shift that affects and sickens the Brazilian health system, such as

Constitutional Amendment No. 95 (EC 95), which converges to dismantling and subtly contributes to the solidification of a hospitalocentric, archaic and iniquitous model; resolutions of the Inter-Management Tripartite Commission of SUS; technical notes and any other official mechanisms concerning the research. However, given the dynamism of the contexts that make up the scenario where dismantling is institutionalized, the study is also based on the scientific literature by accepting previous analysis carried out by other authors. Sometimes, their arguments resort to historical research, addressing movements such as the psychiatric reform and the anti-asylum struggle, and sociological, understanding that the current government uses a neoliberal pretext to undermine popular achievements relevant to Brazilian public health (such as those crystallized at the II National Conference on Mental Health). It also includes analysis of the most varied discourses to understand the framework.

At last, it is emphasized that the collection that supports the synthesis below is not unpretentiously diverse. The heterogeneous nature of the former seeks to fill gaps that would not be filled only by normative texts. It is important to remember that political policies come from conflict and debate between subjects of various groups, being a social construction with disputed interests. Formal policies are made from a social context in mind, and it's resulted from clashes of positions and world views. In the end, politics are a live form, expressing momentary and dynamic agreements, exposing the historical contexts of each society (Mattos & Batista, 2015)

Thus, the discursive character and the free interpretation of intentionally selected information necessarily culminate in the making of a literature, historic and narrative review.

## Results and Discussion

Initially, mental health in Brazil was based on a hospice-hospitalocentric system that is more focused on the mental illness itself than it is on the individual, emphasizing the treatment on social segregation. The milestone for the implementation of this model in Brazil takes place with the inauguration of the Hospício Pedro II in Rio de Janeiro, which would become an example to spread throughout the country. However, this model generated the exclusion of individuals already marginalized from society, and created the stigma of "crazy" (Guimarães & Rosa, 2019; Guimarães, Borba, Larocca & Maffum, 2013)

In this line of care, asylums couldn't provide a cure or symptom control for patients, serving merely as a place to exclude those who were

outside social standards, such as the mentally ill themselves and drug addicts, but also epileptics, prostitutes, homosexuals, among others. (Romash, 2019, Arbex, 2013) In addition to not receiving effective treatment, patients were deprived of their autonomy and were subjected to the therapeutic measures of the time, which, in addition to being invasive and without evidence of benefits, had a more punitive than therapeutic nature. Then, complaints of low quality of care and frequent occurrence of human rights violations began to be disseminated (Guimarães et al., 2013).

From 1978 onwards, individuals who until then were silenced began to gain space in the public sphere, even more so with the Federal Constitution of 1988, responsible for bringing social security to the country, allowing the working classes and those unable to work to initiate discussions about their interests. After the reconsolidation of Brazilian's democracy in the late 80's, there was margin for the reorganization of mental health policies, since the Constitution had already placed health as a "right of all and a duty of the State" (Guimarães & Rosa, 2019).

With health as a constitutional right, the government started a sanitarial and health reform and, within it, the Brazilian Psychiatric Reform (BPR). This movement consisted of expanding the mental health care team - that is, transcending psychiatry and the biomedical character of the specialty, building interdisciplinarity with the help of psychology, social work, sociology and other areas - and guaranteeing the rights of those who live with a mental disorder (Ramos, 2020). This required the downfall of the current hospitalocentric model, as well as the deinstitutionalization of asylum patients and the rise of substitute mechanisms, such as the Psychosocial Care Centers (PCC), which currently occupy the window of secondary care in the Psychosocial Care Network (PCN) (Duarte, Vertelo, Mariano & Marincek 2021). Legally, psychiatric hospitalization is only an option if substitute services fail to assist the subject (Brasil, 2001) and in extreme cases with risk to the patient's life or those around them. Even so, this hospitalization would take place in psychiatric beds located in general hospitals, in detriment of what was established by the model prior to this community care, which admitted and encouraged beds in monovalent hospitals, favoring asylum foundations (Trapé Campos & Gama, 2015).

Until the emergence of Law No. 10.216 in 2001, which constitutionally subverted the order in force at the time and regulated a significant portion of the claims made during the anti-asylum struggle, some events were fundamental to the impulse of the BPR, such as the second Mental Health Conference in 1992. Although several milestones

make up the gradation that culminated in positive structural consequences, the aforementioned event reinforced the democratic character of the reform by admitting the participation of society, including health service providers, users and their families, as well as other sectors involved. (Duarte et al., 2021).

On the other hand, the ongoing dismantling of Brazilian public health implements measures such as Constitutional Amendment 95/16, justified by the need to "guarantee the efficiency of public spending, while seeking to show fallaciously that it is possible to 'do more with the same resources'" (Mario & Barbarini, 2020) by establishing a "spending ceiling", making it progressively impracticable to maintain equity in health care for the Brazilian population as it weakens the Universal Health System and, proportionally, submits part of the care to the private sector. It should also be noted that, parallel to the general underfunding of the system, the budget for mental health in Brazil is still very small: from 2001 to 2016, the Ministry of Health invested annually, on average, 2.4% of the total health budget in mental health - less than half of the 5% recommended by the World Health Organization (WHO). (Oliveira, 2017).

As if the PCN was still marching through baby steps, not due to the lack of effort of the segments responsible for the BPR, from 2016 onwards, a legal setback began to be formalized. Among the dismantling routes, some normative documents stand out, starting with ordinance MS 3.588. This misrepresents the function to which the PCC were designated as it determines the existence of a specific center capable of attending urgencies and emergencies of drug addicts, in order to break the limits of these services that, originally, should serve as secondary support to the primary care attention in Brazil. The recommendation that these centers be implemented around the drug use scenes violates the territorialization principle of SUS and goes against the community organization of the PCN itself. The addicts center ends up taking the user off the streets periodically, without the compromise of establishing the longitudinal line of care that PCCs provide by taking into account the entire life context of the patient, that goes far beyond their use scenery. In addition to the financing (or "financial incentive") of this service that disfigures the legitimate PCCs, it is also attacked by the reintroduction of the biomedical paradigm that gradually overcomes the individual's integrity and health as a biopsychosocial (Cruz, Gonçalves & Delgado, 2020)

The GM ordinance no. 3,992, published, as well as ordinance MS 3,588, in december of 2017, also provides for aspects that directly affect all services publicly offered by SUS. The text institutes a budget

that values the autonomy of local managers without adequate delimitation regarding the application of these resources. In this way, the municipalities can, if they so decide, strengthen and finance services that are not in line with those desired by the psychiatric reform, such as monovalent hospitals and institutions that favor hospitalization as a therapeutic modality. Still, "resources destined to mental health can be reallocated in other areas of health" (Cruz et al., 2020).

Resolutions n. 35 and 36 of the Tripartite Inter-Management Commission seem to intend to regulate and ensure the proper use of resources destined to care in medium and high complexity, as well as assigning a deadline for the manifestation of managers regarding the realization of these services and obliging them to present "care production registered in health information systems" (Brasil, 2018). It is postulated that the absence of records or the presence of services that are not in operation should lead to "suspension of the transfer of funding resources". Based on these resolutions, ordinance no. 3,659 issued by the Ministry of Health determined the suspension of "transfers of financial resources destined to the monthly funding incentive of the components of the Psychosocial Care Network" (Brasil, 2018), mainly including PCC's and Therapeutic Residential Services.

It is also crucial to remember that, concurrently with the suspension of these resources, there is an incentive to register private therapeutic communities in a transitory residential regime for drug addicts in a notice published in 2018 by the National Secretariat for Policies on Drugs. The traditional, outdated and ineffective proposals generally associated with therapeutic communities are highlighted, which permeate the use of "religious practice and abstinence as the only possible 'treatments' for users and people who use alcohol, crack and other drugs" (Ramos, 2020), discarding any real and scientifically "therapeutic" possibility within the communities.

There are also punctual attacks and setbacks, when it comes to the subjects of the Brazilian Psychiatric Reform. Ordinance 2434, published by the Health Ministry in August 2018, increases in the daily rate for admissions to psychiatric hospitals with a time longer than 90 days, something that was previously refuted in the 90's and early 2000's.

Finally, although not officially published, a technical note from February 2019 concludes a series of essays carried out in the legal sphere to return to the asylum paradigm. In addition to corroborating the presence of day hospitals in the PCN, it includes a psychiatric hospital and specialized outpatient units in it. These types of services are important and appreciated in the

network; however, "their creation, disconnected from a specific territory and without adequate integration with the Psychosocial Attention Centers and other community devices, will inevitably lead to a fragmentation of the system and a disappearance of a continuity care". (Almeida, 2019) The description of fragile strategies in the treatment of addictive disorders again reinforces "an emphasis on institutional approaches and a systematic subordination of integrative community-based approaches" (Almeida, 2019).

Presidential decree n. 9,761 then approved the National Policy on Drugs. Although its goal is to be harmonized with the National Policy on Mental Health, it does not mention, for example, harm reduction as a therapeutic possibility to individuals who live with substance addiction. Furthermore, paradoxically, it dares to include in the same article the aim to welcome in a therapeutic community and promote the social reintegration of people with problems arising from the use of alcohol and/or drugs. Thus, the set of measures implemented until then towards a disastrous past, which did not deserve to be contemplated after two decades of law n° 10,216, has been in force. The description of fragile strategies in the treatment of addictive disorders again reinforces "an emphasis on institutional approaches and a systematic subordination of integrative community-based approaches". (Almeida, 2019)

Recently, at the end of 2020, the government agenda included a proposal to revoke several mental health ordinances published from 1991 to 2014, to carry out a remodeling and implementation of changes in mental health in Brazil. This proposal became known as "Repeal" and generated great commotion in social media for favoring the hospitalocentric model, supporting the increase of psychiatric beds in hospitals and in therapeutic homes. In addition, other examples of setbacks that the revocation brings are: extinction of the Back to Home Program, which started in 2003, supporting the social reintegration of psychiatric patients, and also of the Street Clinical Offices Program, launched in 2011 with the objective of providing medical care for homeless individuals; decreased supervision of psychiatric beds and discouraged transfer of hospital patients to community services and the flexibilization of voluntary admissions without the need to notify the Public Ministry. Although this proposal has not yet been approved, it is of great concern, since the latest ordinances are already going against the principles of the BPR and the repeal represents a threat to the psychosocial mental health model

and the anti-asylum struggle in Brazil. (Polaiewicz, 2021; Antunes, 2020)

### Limitations of the study:

The choice of a research method permeates the understanding that the object of study does not include the objectivity aimed at only systematizing a literary review. Politics, from the speeches of its formal representatives to its normative instruments, such as ordinances and laws, is the result of discourse. It is considered that every statement is inserted in a context, which, in the political sphere, is a social context. Campos and Furtado (2020) highlight “the potential of using narratives to study situations in which the mediations between experience and language, structure and events, subjects and collectives, memory and political action are of interest”, corroborating the impossibility of the subject's absence before the analysis of the collected texts. Thus, it is intended to carry out a critical reading of the ordinances that have progressively instituted a retrograde mental health policy in Brazil.

### Conclusions

Undoubtedly, the BPR was responsible for building a system that, despite being underfunded and, therefore, full of gaps, walked alongside the Universal Health System's principles and guidelines. The PCN and the community care model consider the subject and intend to assist all those who suffer, taking into account their psychosocial and economic individualities, aiming, and, above all, those who in most need. The expansion of therapeutic communities centers - from 10,586 to 23,382, according to the federal government's official website published on September 2021 -, as well as the large funding made available to these institutions, is an attack not only on the health of the Brazilian population, but to democracy. The segregation and punishments that must affect the portion of the population that tends to be “welcomed” by these entities is based on the need to corroborate the marginalization of groups that are, before being marginalized, weakened. Defending the BPR is defending the access of any individual who lives with a disorder to humanized, scientifically based and, ultimately, in fact therapeutic care.

The “Repeal”, although not yet approved, provokes and invites us to continue fighting for fair health programs. As Brazilian singer Gal Costa warned in 1969, in a song written by Caetano Veloso and Gilberto Gil during the military regime:

“Pay attention when turning a corner // Attention, it is necessary to be attentive and strong”.

### Conflict of interest

The authors declare no conflict of interests in regards to this review.

### References

- Almeida, J. M. C (2019). Política de saúde mental no Brasil: o que está em jogo nas mudanças em curso. *Cadernos de Saúde Pública*, 35 (11). <https://doi.org/10.1590/0102-311X00129519>
- Almeida, J. M. C. & Lennon, M. H. (2010). Mental Health Care Reforms in Latin America: An Overview of Mental Health Care Reforms in Latin America and the Caribbean. *Psychiatric Services*, 61 (3).
- Antunes, A. (2020). *Vem aí o golpe de morte na Reforma Psiquiátrica?*. Escola Politécnica de Saúde Joaquim Venâncio/Fiocruz. Recuperado de
- Campos, R. T. O. Saúde mental no Brasil: avanços, retrocessos e desafios. *Cadernos de Saúde Pública*, 35 (11). <https://doi.org/10.1590/0102-311X00156119>
- Campos, R. T. O & Furtado, J. P. (2008). Narrativas: utilização na pesquisa qualitativa em saúde. *Revista Saúde Pública*, 42 (6), 1090-1096. <http://repositorio.unifesp.br/bitstream/handle/11600/4705/S0034-89102008000600016-pt.pdf?sequence=3&isAllowed=y>
- Cavalvanti, M. T. (2019). Perspectivas para a política de saúde mental no Brasil. *Cadernos de Saúde Pública*, 35 (11). <https://doi.org/10.1590/0102-311X00184619>
- Cruz, F. O. C. Gonçalves, R. W. & Delgado, P. G. G. (2020). Retrocesso da reforma psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019. *Trabalho, Educação e Saúde*, 18 (3). <https://doi.org/10.1590/1981-7746-sol00285>
- Decreto n. 9.761, de 11 de abril de 2019. Aprova a Política Nacional sobre Drogas. Brasília, DF: Presidência da República. Disponível em [http://www.planalto.gov.br/ccivil\\_03/\\_ato2019-2022/2019/decreto/D9761.htm](http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2019/decreto/D9761.htm)
- Duarte, B. P. S., Vertelo, G. A. D., Mariano, J. L. P. & Marincek, D. F. (2021). Política de saúde mental no Brasil: histórico e análise do seu contexto atual. *Revista Atenas Higeia*, 3 (2), 17-23. <http://www.atenas.edu.br/revista/index.php/higeia/article/view/116>
- Edital de credenciamento - senad n. 1/2018. (2018, 24 de abril). Torna público a abertura do processo de credenciamento para a contratação de serviços especializados de acolhimento de pessoas com transtornos

- decorrentes do uso, abuso ou dependência de substâncias psicoativas, em regime residencial transitório e de caráter exclusivamente voluntário. Diário Oficial da União, Seção 3. Disponível em [http://www.mds.gov.br/webarquivos/arquivo/cuidados\\_prevencao\\_drogas/EditalCredenciamentoSENAD\\_n\\_012018.pdf](http://www.mds.gov.br/webarquivos/arquivo/cuidados_prevencao_drogas/EditalCredenciamentoSENAD_n_012018.pdf)
- Guimarães, T. A. A. & Rosa L. C. S. (2019). A remanicomialização do cuidado em saúde mental no Brasil no período de 2010-2019: análise de uma conjuntura antirreformista. *O Social em Questão*, 21 (44), 111-138. <https://www.redalyc.org/articulo.oa?id=552264340005>
- Guimarães, A. N., Borba, L. O., Larocca, L. M. & Maftum, M. A. (2013). Tratamento em saúde mental no modelo manicomial (1960 a 2000): histórias narradas por profissionais de enfermagem. *Texto Contexto Enfermagem*, 22 (2), 361-369. <https://doi.org/10.1590/S0104-07072013000200012>
- Governo Federal do Brasil (2021). Com 492 centros habilitados, Governo Federal abre mais de 13 mil novas vagas em comunidades terapêuticas. Ministério da Cidadania, Brasília. Recuperado de <https://www.gov.br/cidadania/pt-br/noticias-e-conteudos/desenvolvimento-social/noticias-desenvolvimento-social/com-492-centros-habilitados-governo-federal-abre-mais-de-13-mil-novas-vagas-em-comunidades-terapeuticas>
- Mario, C. G. & Barbarini, T. A. (2020). A perversão da agenda da saúde pública brasileira: Da saúde como direito universal à cobertura universal em saúde. *Revista Estado y Políticas Públicas*, (14), 69-91. [https://revistaeypp.flacso.org.ar/files/revistas/1590800091\\_69-91.pdf](https://revistaeypp.flacso.org.ar/files/revistas/1590800091_69-91.pdf)
- Mattos, R. A. & Baptista, T. W. F. (2015). *Caminhos para Análise das Políticas de Saúde* (1. ed.). Porto Alegre, RS: Rede UNIDA.
- Munoz, S. I. S., Takayanagui, A. M. M., Santos, C. B. & Sweatman, O. S. (2002). Revisão sistemática de literatura e metanálise: noções básicas sobre seu desenho, interpretação e aplicação na área da saúde. In *Anais Eletrônicos*. Ribeirão Preto. Recuperado de <https://repositorio.usp.br/item/001378493>
- Nota técnica n. 11/2019-CGMAD/DAPES/SAS/MS (2019). Esclarecimentos sobre as mudanças na Política Nacional de Saúde Mental e nas Diretrizes da Política Nacional sobre Drogas. Brasília, DF: Ministério da Saúde. Disponível em [http://www.mds.gov.br/webarquivos/arquivo/cuidados\\_prevencao\\_drogas/obid/legislacao/nota\\_saude\\_mental.pdf](http://www.mds.gov.br/webarquivos/arquivo/cuidados_prevencao_drogas/obid/legislacao/nota_saude_mental.pdf)
- Oliveira, E. F. A. (2017). *Gastos da política de saúde mental e os rumos da reforma psiquiátrica* [Tese de doutorado]. Universidade Federal do Espírito Santo. [https://repositorio.ufes.br/bitstream/10/8776/1/tese\\_11140\\_Edineia%20F.%20A.%20Oliveira.pdf](https://repositorio.ufes.br/bitstream/10/8776/1/tese_11140_Edineia%20F.%20A.%20Oliveira.pdf)
- Polakiewicz, R. (2021). Saúde mental: revogação de portarias. *Pebmed*. Recuperado de <https://pebmed.com.br/saude-mental-revogacao-de-portarias/>
- Portaria n. 2.434, de 15 de agosto de 2018. Altera a Portaria de Consolidação n. 6/GM/MS, de 28 de setembro de 2017, para reajustar o valor das diárias de internação hospitalar acima de 90 (noventa) dias do Incentivo para Internação nos Hospitais Psiquiátricos. Brasília, DF: Ministério da Saúde. Disponível em [https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2018/prt2434\\_20\\_08\\_2018.html](https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2018/prt2434_20_08_2018.html)
- Portaria n. 3.588, de 21 de dezembro de 2017. Altera as Portarias de Consolidação n. 3 e n. 6, de 28 de setembro de 2017, para dispor sobre a Rede de Atenção Psicossocial, e dá outras providências. Brasília, DF: Ministério da Saúde. Disponível em [https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588\\_22\\_12\\_2017.html](https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588_22_12_2017.html)
- Portaria n. 3.992, de 28 de dezembro de 2017. Altera a Portaria de Consolidação n. 6/GM/MS, de 28 de setembro de 2017, para dispor sobre o financiamento e a transferência dos recursos federais para as ações e os serviços públicos de saúde do Sistema Único de Saúde. Brasília, DF: Ministério da Saúde. Disponível em [https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2017/prt3992\\_28\\_12\\_2017.html](https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2017/prt3992_28_12_2017.html)
- Ramos, V. H. F. (2020). O desmonte da política de drogas no Brasil e a luta (des)antimanicomial. *Revista Serviço Social em Debate*, 3 (2), 76-95. <https://revista.uemg.br/index.php/serv-soc-debate/article/view/4856/3559>
- Resolução n. 35, de 25 de janeiro de 2018. Estabelece prazo para manifestação dos gestores que receberam recursos de implantação de serviços de atenção à saúde de média e alta complexidade e não implantaram e efetivaram o seu funcionamento. Brasília, DF: Ministério da Saúde. Disponível em [https://bvsmms.saude.gov.br/bvs/saudelegis/cit/2018/res0035\\_06\\_02\\_2018.html](https://bvsmms.saude.gov.br/bvs/saudelegis/cit/2018/res0035_06_02_2018.html)
- Resolução n. 36, de 25 de janeiro de 2018. Define o prazo para os gestores enviarem manifestação ao Ministério da Saúde e define a suspensão da transferência dos recursos de custeio referente às habilitações dos serviços de atenção à saúde de média e alta complexidade que não estejam em

funcionamento ou não apresentem a produção assistencial registrada nos sistemas de informação em saúde considerando as políticas de atenção à saúde. Brasília, DF: Ministério da Saúde. Disponível em [https://bvsms.saude.gov.br/bvs/saudelegis/cit/2018/res0036\\_06\\_02\\_2018.html](https://bvsms.saude.gov.br/bvs/saudelegis/cit/2018/res0036_06_02_2018.html)

Romash, IR., Vynnyk, MI. (2019) Dynamics of indicators of social functioning in case of metabolic syndrome in patients with paranoid schizophrenia on the background of atypical

neuroleptic agents application and improvement comorbidity. Art of medicine. 4(12):102-9.

Trapé, T. L., Campos, R. O. & Gama, C. A. P. (2015). Mental Health Network: A Narrative Review Study of the Integration Assistance Mechanisms at the Brazilian National Health System. International Journal of Health Sciences, 3 (3), 45-53. <http://dx.doi.org/10.15640/ijhs.v3n3a5>