

Financing public mental health: a case study of Rio de Janeiro (2019 to 2022)

Financiamento da saúde mental pública: estudo do caso do Rio de Janeiro (2019 a 2022)

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ABSTRACT Mental health in the Unified Health System has experienced a dispute between disease-centered care and socio-environmental determinants. The study of state co-financing of the Psychosocial Care Network in Rio de Janeiro (2019 to 2022) aimed to explain how theoretical-conceptual elements about mental health were relevant in interfederative financing decisions in this period. A review of federal and state regulations of the Intermanagement Committees (Bipartite and Tripartite), technical notes and Fala.BR site was carried out. The documents demonstrated the interfederative rupture in relation to territorial and community-based mental health care. During this period, while the Ministry of Health directed its agenda towards outpatient and specialized care, Rio de Janeiro increased the state's financial resource for mental health by R\$ 175 million to strengthen Psychosocial Care Centers and Therapeutic Residential Services qualified or eligible for qualification. The deinstitutionalization of asylum survivors and the expansion of the care network for crisis situations are results found in Rio de Janeiro. The conclusion of the study suggests the construction of an interfederative monitoring methodology for public mental health financing so that the delivery of care is increasingly closer to the needs of citizens and territorial vulnerabilities.

KEYWORDS Mental health. Healthcare financing. Health policy.

RESUMO A saúde mental no Sistema Único de Saúde vive uma disputa entre o cuidado centrado na doença e os determinantes socioambientais. O estudo do cofinanciamento estadual da Rede de Atenção Psicossocial no Rio de Janeiro (2019 a 2022) visou observar como elementos teórico-conceituais sobre saúde mental foram relevantes nas decisões de financiamento interfederativo nesse período. Realizou-se revisão de normativas federais e estaduais das Comissões Intergestores (Bipartite e Tripartite), notas técnicas e consultas ao Fala.BR. Os documentos demonstraram a ruptura interfederativa com relação ao cuidado da saúde mental de base territorial e comunitária. Nesse período, enquanto o Ministério da Saúde direcionava sua agenda para o cuidado ambulatorial e especializado, o Rio de Janeiro ampliou o recurso financeiro estadual à saúde mental em R\$ 175 milhões para fortalecer Centros de Atenção Psicossocial e Serviços Residenciais Terapêuticos habilitados ou elegíveis para habilitação. A desinstitucionalização de sobreviventes dos manicômios e a expansão da rede de cuidados de atenção às situações de crise são resultados encontrados. A conclusão do estudo sugere a construção de metodologia de monitoramento interfederativo do financiamento da saúde mental pública para que a entrega do cuidado esteja cada vez mais próxima das necessidades dos municípios e das vulnerabilidades territoriais.

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PALAVRAS-CHAVE Saúde mental. Financiamento da assistência à saúde. Política de saúde.



Introduction

The mental health care model in the Unified Health System (SUS) has experienced a dispute between the disease-centered care and the care centered on social-environmental determinants. In Brazil, this dispute has affected decisions on management and funding¹. In the international ambit, the World Health Organization (WHO) alerts to the need of investment on mental health assistance. In the mental health atlas, WHO suggests that this type of investment should reach the amount of 5% of the total expenditure on health². Currently, the discussion about the access to mental health care has an influence in high, middle and low-income countries³. It is a concern that relates the productive capacity of humanity (years of life lost – YLL) with the difference between the delivery of services and the prevalence of mental disorders.

The global alert based on epidemiological and economic references has been called mental health gap care according to the Mental Health Gap Action Program (mhGAP)⁴. In 2006, the international movement ‘Nothing About Us Without Us’⁵, also named specialists by experience, was recognized by the United Nations Organization (UN) regarding the rights of people with disabilities to work, leisure, job, school and health. The understanding of social inclusion for humanity’s sustainable development gained space in the 2030 Agenda, inducing funding practices with this regard⁶ and against stigma.

Brazil has registers in its history that bring mental suffering to the clinical field and in the setting of public mental health there is the presence and dispute of two models of care: that from the perspective of specialized and hospital-centered care; and that of care in freedom by means of territorial and community-based services. This dispute, which is intensified according to the political understanding in the management cycles, can be observed in the decisions about the direction of the financial resources employed: in the

perspective of collective health and in the medical-industrial complex^{7,8}. Additionally, the mental health care delivery investigated in this article had as central and conceptual references the guidelines of SUS: universality, integrality and equity, as well as the Brazilian Psychiatric Reform and the anti-asylum struggle. The fundament of this choice is based on evidences related to different historical-political moments, which in this article are chronologically and pedagogically divided in three cycles.

The first cycle

The historical landmark of the beginning of the anti-asylum struggle occurred in 1987, through the Charter of Bauru⁹, when workers, family members and persons with mental health issues organized themselves against the treatment in psychiatric asylums. This movement founded the national discussion on the right to mental health with dignity and non-exclusion, taking a stand against the logic of hygienist and colonialist care¹⁰. In parallel, the 1988 Federal Constitution created the SUS.

In this context, for the understanding of SUS financial operationalization, two important laws of 1990 should be mentioned, which involve the Union, states and municipalities: Law No. 8,080, of September 19, 1990, referring to the organization and functioning of services¹¹; and Law No. 8,142, of December 28, 1990¹², which provides for community participation in the SUS management and inter-governmental transfers of financial resources¹². The description of the regulation of common and specific attributions of municipalities, states and federal administration (Union) and their annual budget and financial management has an ascendant logic, i.e., from the municipality up to the Union. Furthermore, the health councils are defined as deliberative instances regarding the formulation of health policies responsible for management supervision, including the economic-financial aspect¹³.

The second cycle

In the first decade of the twenty-first century, the National Policy on Mental Health (PNSM) was created by Law No. 10,216, of April 6, 2001¹⁴, which provides for the protection and rights of persons with mental disorders and redirects the model of mental health assistance, ensuring the right to mental health care and the substitution of psychiatric asylums by territorial and community-based services, named Psychosocial Care Centers (CAPS). In the first ten years of the PNSM, there was a significant expansion of these services¹⁵, whose qualification and funding shifted from local experiments to the logic of SUS and public mental health.

The third cycle

In the second decade of the twenty-first century, there was the creation of the Psychosocial Care Network (RAPS), described in Ordinance No. 3,088, of December 23, 2011, which establishes the RAPS¹⁶ and regulates the broadening of the scope of mental health care network. The services of RAPS are: primary health care, CAPS (in its different modalities), urgency and emergency network, residential care of transitory character, hospital care and deinstitutionalization strategies. At that time, the norm aimed at updating the discussion on mental health care, considering, besides the RAPS specific services, also non-specific mental health services. In addition, it is important to mention that the Ordinance presents a device external to the scope of SUS: the therapeutic communities. The insertion of this care model in the RAPS, which is based on moral and religious treatment, has also been causing political and financial dispute and, although it is not a central subject of this study, it is an element considered contradictory in the construction of ensuring the right to mental health care with dignity¹⁷. Furthermore, it is worthy of note that this inclusion in a technical norm by the Ministry of Health (MS) reflects

the underlying dispute over public financing of mental health care, as well as the political dispute regarding the model of care³⁴.

Still in this cycle, amid the political and fiscal crisis in Brazil, there was the promulgation of the Constitution Amendment No. 95, of December 15, 2016, which alters the Constitutional Transitory Dispositions Act, to establish the New Fiscal Regime, determining other measures, establishing the spending cap of SUS in the period from 2018 to 2036¹⁸. The Union's general spending cap prevented new criteria of transfer from fund to fund between federal, state and municipal levels, worsening the chronic under-financing of SUS¹⁹. Following this sequence, and still in this cycle, there was the publication of Ordinance No. 3,588, of December 21, 2017, which modifies the Consolidation Ordinances No. 3 and No. 6, of September 28, 2017, to provide on the RAPS²⁰.

This is one more example of the conflict in the ambit of the federal government and its political alliances. Created during the crisis of the presidential management cycle, the RAPS retrieve the logic of centralization, hospitalization and outpatient mental health care. The act removes the logic of psychosocial care, which had just been initiated in the previous decade, and reinserts in its guidance the strengthening of the specialized and hospital-centered model. Furthermore, through the political-financial decisions on the federal level, it was observed the intensification of the systematic disqualification of the implemented mental health public services, especially the CAPS, which substitute the psychiatric asylums for the care in an open community setting²⁰.

These three cycles briefly demonstrate the existing tension between the different political trends regarding the SUS and public mental health.

In the face of the history of disputes and the experience of divergent interfederative interlocution regarding the mental health care model, this study aims to observe how relevant theoretical and conceptual elements were for

the decisions on interfederative financing. The intention is to favor the construction of methodologies for more transparent monitoring of the financing of mental health systems. The specific objectives are: 1) to study the co-financing of RAPS in the State of Rio de Janeiro (ERJ) in the period 2019-2022, with financial support from the state to municipal territorial and community-based health services; and, 2) to observe the aspects of this interfederative experience involving the Union, state and municipalities in the ambit of SUS, of the Psychiatric Reform and in the defense of the right to care with dignity, being inclusive and listening to the current needs.

Material and methods

This case study of Rio de Janeiro on the financing of public mental health care, in the period 2019-2022, had its object of interest in the context of a recent past. Therefore, the readings were open to new elements that emerged during the study, which is exploratory, qualitative, and descriptive, using bibliographic, documental, and secondary data research.

Data triangulation was conducted by means of bibliographic review, regulations published by the MS, Tripartite Inter-managers Commission (CIT), and Bipartite Inter-managers Commission (CIB), in the period 2019-2022; and data collected on the Co-financing, Foment and Innovation of the Psychosocial Care Network (COFI-RAPS) in the same period. The analysis of data regarding financing of public mental health systems considered the regulation bases of SUS and the interfederative pact with financial inter-dependence between the federal, state and municipal administrations, the Brazilian Psychiatric Reform and the Anti-Asylum Struggle. Therefore, observations were made regarding the effects of the decrease or increase of transfers fund to fund through the partial closure of new qualifications in the System of Support to Health Policies

Implementation (SAIPS) of some mental health services, especially the CAPS and the Therapeutic Residential Services (SRT).

The questions used in the comparison between federative and autonomous entities of the same public mental health system were: did the action or the state or federal regulation have a financial impact on the public mental health system? What is the relation between the decision-making about the financing of public mental health services of SUS, CIB, and CIT? Does the state or the federal regulation strengthen the assurance of care in freedom in the logic of substituting hospital-centered services by territorial and community-based devices, according to the PNSM?

The bibliographic review of international articles was performed on PubMed using the keywords: “mental health”, “health care financing” and “health policy” in the period between 2020 and 2023. There were 84 integral and open access articles found; 13 were selected, of which only 2 on Latin American countries^{21,22} and 1 on South Africa²³. Among the other selected articles, ^{24,25} are on mental health resources in poor or developing countries. The other 8 articles are on how the most developed countries deal with the social and cultural issues in mental health care for the social adaptation of persons suffering due to matters related to immigration²⁶, indigenous culture²⁷, unemployment²⁸ or other situations of vulnerability²⁹⁻³³. The search of national articles was conducted on BIREME website, considering the same parameters and including the keyword “*Sistema Único de Saúde*” (Unified Health System). There were 24 references found, of which 8 texts dealt with the issue of the construction of the Brazilian mental health model. Thesis were excluded, and articles written between 2017 and 2018 were kept for their relevance on the subject and relating to: ethics in mental health³⁴, deinstitutionalization³⁵, precariousness of mental health labor^{36,37}, alcohol and other drugs³⁸, COVID-19³⁹, expenditure with health and analysis of financing^{40,41}.

In the review of technical documents on health and mental health financing in the ambit of SUS, the following searches were made: 1) on the federal level, on the websites of the MS⁴², National Council of Health Secretaries (CONASS)⁴³ and CIT⁴⁴; and, 2) on the state level, on the websites of Rio de Janeiro State Secretariat of Health (SES-RJ)⁴⁵, Council of Municipal Secretariats of Health of the State of Rio de Janeiro (COSEMS RJ)⁴⁶ and CIB⁴⁷. The identified gaps of information were requested, based on the law on access to public information, via e-mail and/or through the website Fala.BR⁴⁸.

The research used sources of public assess and in the terms of the Law No. 12,527, of November 18, 2011. For this reason, it was not registered or evaluated by a research ethics committee, according to the Resolution No. 510, of April 7, 2016.

Results and discussion

The results are divided into federal, state and interfederative ambits: federal level, when

data are related to the MS, Conass, and CIT; state level, when published and shared data were produced by the Psychosocial Care Coordination of SES-RJ, Cosems RJ, and CIB; and, interfederative level, when the results compare the answers on federal and state ambits regarding the key issues of the study. The observation of these three levels is important for the understanding of interfederative financing of public mental health in the ambit of SUS and PNSM, but also considers the autonomy between the federative entities.

Federal level

On the federal level, two inquiries were made to the MS through the website Fala. BR (file numbers: 25072.021262/2023-90 and 25072.026866/2023-22)⁴⁸; one inquiry via e-mail to Conass; and one access to CIT website to verify the agreed or informed agendas in the study period. As a result, there were 11 regulations in the form of laws, decrees and ordinances that mention the RAPS in period from January 1, 2019 to December 31, 2022 (*box 1*):

Box 1. National regulations related to mental health and psychosocial care (2019 to 2022)

1. Law No. 13,819, of April 26, 2019, which establishes the National Policy for the Prevention of Self-mutilation and Suicide, to be implemented by the Union, in cooperation with the states, the Federal District and the municipalities.
 2. Law No. 13,840, of June 5, 2019, to provide for the National System of Drugs Public Policies, and the conditions of care of drug users or addicts and to address the financing of drugs policies.
 3. Decree No. 9,761, of April 11, 2019, which approves the National Drugs Policy.
 4. Decree No. 10,225, of February 5, 2020, which establishes the Steering Committee of the National Policy for the Prevention of Self-mutilation and Suicide, regulates the National Policy for the Prevention of Self-mutilation and Suicide and establishes regulations regarding mandatory notification of self-inflicted violence.
 5. Ordinance No. 37, of January 18, 2021, which redefines the register of Primary Care and Mental Health Teams in the National Register of Health Establishments (CNES).
 6. Ordinance No. 1,108, of May 31, 2021, which readjusts the value of psychosocial rehabilitation aid, established by Law No. 10,708, of July 31, 2003.
 7. Ordinance GM/MS No. 1,684, of July 23, 2021, which revokes Section X of Chapter III of Title VII, the Art. 1,040 and the Annex XCI of the Ordinance of Consolidation GM/MS No. 6, of September 28, 2017.
 8. Ordinance No. 1,836, of June 24, 2022, which establishes in exceptional and temporary character, federal financial incentives of spending and investment for the expansion of access to care of anxiety and depression (mood disorders) by child and youth people to face the impacts arising from COVID-19 pandemic, and provides other measures.
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Box 1. National regulations related to mental health and psychosocial care (2019 to 2022)

9. Ordinance No. 4,596, of December 26, 2022, which suspends the transfer of financial incentive to monthly spending of Specialized Reference Units in General Hospitals, forming part of the Psychosocial Care Network (RAPS), due to low occupancy of mental health beds in general hospitals.

10. Ordinance No. 375, of August 5, 2022, which updates, in the National Register of Health Establishments (CNES), the specialized service of Psychosocial Care, including the Hospitalization Treatment for Mental Disorders and Chemical Dependence.

11. Ordinance No. 596, of March 22, 2022, which revokes Section XII of Chapter III of Title VIII, Art. 1,049 to Art. 1,062, of the Ordinance of Consolidation GM/MS No. 6, of September 28, 2017, and the Section II of Chapter III, Art. 64 to Art. 74, and Annexes XXXVI, XXXVII, XXXVIII, XXXIX, XL, XLI and XLII of the Ordinance of Consolidation GM/MS No. 5, of September 28, 2017.

Source: Fala.BR⁴⁸.

In addition to the information and considering the key issue on its financial impact, the MS informed that the SAIPS had closed the registration of proposals for qualification/incentive for all its components in December 31, 2019 and re-opened on January 18, 2021 for qualification and incentive of CAPS. On March 10, 2021, the system was closed for all incentives and open for qualification of CAPS, Mental Health Beds in General Hospital, and Mental Health Multi-professional Team. On January 27, 2022, there was another interruption for the register of new proposals of incentive and qualification for all components. The opening and closure of the SAIPS were justified as being due to the liability of registered proposals, which had already surpassed the capacity to absorb the financial impact of Medium and High Complexity (MAC) estimated costing. In this period, no guidance was published to support health managers and professionals⁴⁸.

In the inquiry to Conass on mental health care in the period 2019-2022 and the inter-federative relations, the national council points out: the context of social distancing and COVID-19 pandemic; and the technical format used in the ambit of the MS for decision-making in the federal ambit. In 2020, by means of meetings held at the Secretariat of Health Labor and Education Management of the MS (SGTES/MS), started the revision and/or revocation of several ordinances published throughout the RAPS

institution, with questionings directed to the community-based model. In this ambit, the group conducted by SGETS considered the closure of SAIPS in its relation for qualification of services according to the priorities elected by the technical area of the MS and without the participation of state managers.

The period was marked essentially by the defense of psychiatry and psychiatric hospitals³⁵. Meanwhile, the discussions about the publications made were not taken to inter-managers' agreements forums, as foreseen in the organization of SUS. This included Ordinance GM/MS No. 4,596/2022⁴⁹, which suspended the transfer of financial incentive for monthly costing of the Specialized Reference Units in General Hospitals, which belong to the RAPS, due to the low occupancy of mental health beds in general hospitals, disregarding the justifications and corrections of bed occupancy registers presented by municipal/state managers.

According to information collected from the inquiries made to Conass, via website and e-mail, also from reading the regulation, the effect of the ordinance, with no previous agreement at CIT, struck 118 general hospitals, with a total amount of 633 mental health beds⁴⁹, which penalized managers and caused the lack of assistance to SUS users in territories where beds for crisis care were available. This ordinance is an unfolding of Ordinance No. 3,588/2017, which established a minimum bed occupancy rate of 80% and conditioned it to the financial transfer for

costing. In the analysis, the expansion of induced hospitalization beds characterized one further step in the resumption of hospital-centrism, which is opposed to the directives of the Brazilian Psychiatric Reform and the PNSM. The Ordinance No. 4,596 was revoked in the third meeting of CIT, in March 2023⁵⁰.

The third source of information in the federal ambit was the website of CIT⁴⁴, where two reports on mental health actions in the period were found. The first one, in August 2020 (Mentalize Program); and the second, in August 2021 (Multipliers Training Course on Urgency and Emergency in Mental Health), both scheduled as reports by SGTES/MS, according to the summaries of the agendas.

On the federal level, after reading the norms and comparing the answers from the MS, Conass, and CIT's website, it was observed that:

1. None of the publications had tripartite agreement or discussion with the managers of the national territory;
2. In ordinances on financial incentives, it is possible to observe the specific tendency of expansion of specialized services, e.g.: ambulatories and psychiatric hospitals, which use as central conceptual reference evidence-based psychiatry, centered exclusively on the medical care drawing on a psychiatric diagnosis;
3. Revocations were directed to ordinances that provide structure to the discontinuity of the logic of substituting the hospital-centered model by the territorial and community-based model, hence contradicting the PNSM and the strengthening of the characteristically multidisciplinary services of psychosocial care;
4. In these revocations, it is noticeable the intention of de-financing the SRT and beds in general hospitals, structuring services for the movements of deinstitutionalization in psychiatric asylums and long hospitalizations;
5. In the decree that approves the National Drugs Policy, although in the description of its implementation the competence is of the National Secretariat for Drugs Care and Prevention, of the Ministry of Citizenship, and of the National Secretariat for Drugs Policy, of the Ministry of Justice and Social Security, it is noticeable that, contrary to the decision of excluding this agenda from the MS, the ordinance has as central aspect the interventions in health, always having as reference the specialized and psychiatric health services;
6. The publication of these norms suggests that decisions made on the federal level systematically disregarded all type of social participation and that of managers on the territory, as recommended by the interfederative management of SUS; and, by means of decisions made about financing considering the type of service and contrary to Law No. 10,216¹⁴, induced the return to mental health care in the logic of hospitalization and specialized outpatient service;
7. The management strategy of the study period displaced the mental health agenda from the technical field to the labor management department placed in the SGTES/MS. In this space of interlocution, only managers from the MS and specialists had the right to vote on the solutions proposed, whereas the representatives of the tripartite discussion were invited in the agenda. The form of discussion elected by the SGTES Commission induces the perception that those invited were received to be informed of the internal decisions of the MS, which dismantled the management of psychosocial care on the national level, giving continuity to actions of de-financing that had preceded that moment⁴⁰.

State level

On the state level, inquiries were made to the websites of SES-RJ, CIB, control agencies, and the Legislative Assembly of the State of

Rio de Janeiro (ALERJ), always considering the key issues of the study. For the period, the research identified the publications relating to the financing of the RAPS, such as resolutions⁵¹⁻⁵⁴ and technical notes⁵⁵⁻⁵⁷ (box 2).

Box 2. State regulations on mental health and psychosocial care (2019 to 2022)

1. Resolution SES No. 1,911, of September 23, 2019, which creates the State Co-financing of foment and innovation to the Psychosocial Care Network, named COFI-RAPS, and with the amount of R\$ 28,953,995.53.
 2. Resolution SES No. 2,129, of September 16, 2020, provides continuity to COFI-RAPS with the amount of R\$ 47,010,079.50.
 3. Resolution SES No. 2,429, of September 9, 2021, provides continuity to COFI-RAPS with the amount of R\$ 44,990,528.50.
 4. Instructional Note to the 92 municipalities on equity and psychosocial care.
 5. Technical Note on the supervision in mental health (COFI-RAPS indicator).
 6. Technical Note on matrixing (COFI-RAPS indicator).
 7. Resolution SES No. 2,712, of May 6, 2022, and provides continuity to COFI-RAPS with the amount of R\$ 55,000,000.00.
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Source: Own elaboration based on legislation of the State of Rio de Janeiro⁵¹⁻⁵⁷.

The four resolutions agreed upon in CIB by the COFI-RAPS in the ERJ in the period of four years (2019 to 2022) presented a total amount of R\$ 175,954,603.53. The first Resolution SES No. 1,911, of September 23, 2019⁵¹, created the initial modalities; the criteria for the services in the tripartite mode for the already qualified services; and bipartite for those that awaited publication or had their approval suspended by the MS, with their technical projects approved on the state level. According to the resolution, the targets of the state financing were territorial and community-based services: CAPS I, II, II, Child and Youth CAPS (CAPSI) and Alcohol and Drugs CAPS (CAPS AD II e III); Reference Hospital Service for the care of individuals suffering from mental disorder (beds in general hospitals); SRT; Adult and Child-Youth Healthcare Host Units (UA)⁵¹.

Some aspects stand out, such as: the financing of mental health beds in general hospitals for smaller municipalities, which did not receive the federal resources due to limitations on the minimum and maximum number of beds per health establishment, according to the federal regulation in force at the time; in

2020, the resolution of COFI-RAPS included the Law No. 141, of 2012⁵⁸, in the recitals; in 2021, in the third year of COFI-RAPS, stands out the creation of technical notes on planning and the indicators of resources by ERJ (supervision⁵⁶ and matrixing⁵⁷). Furthermore, as from 2021, municipalities could accredit the technical projects of services that awaited the approval from SAIPS/MS; in the fourth year of COFI-RAPS, in 2022, the reach of co-financing was of 100% of the eligible municipalities, and the Coexistence Centers (CECO) were included in the state financing⁵⁴.

In the inquiry to the website of CIB-RJ⁴⁷, it is possible to verify the increase of the mental health agendas at CIB with technical data, presentations, agreements and accreditation of services. In 2019, there were 14 items identified; in 2020, there were 20 items; in 2021, there were 42; and in 2022, 76 items. In addition, the Psychosocial Care Coordination informed that all documents and agreements taken to CIB were discussed in the groups that conducted the RAPS with managers of the 9 regions of the ERJ and in the state ambit.

Besides the mental health norms published by the state management, other publications made by Alerj and by the Public Prosecutor were observed:

1. Resolution GPGJ No. 2,464, of 2022, by which means the Public Prosecutor of ERJ created the Task Force to work on the process of deinstitutionalization of psychiatric patients and adults with disabilities⁵⁹;
2. State Law No. 9,557, of January 12, 2022, which alters the Law No. 8,154, of November 5, 2018⁶⁰;
3. State Law No. 9,323, of June 14, 2021, which creates the state policy of the CECO of RAPS in the ERJ⁶¹.

In addition to the abovementioned laws, it is worthy of mention that the Parliamentary Front in Defense of the Psychiatric Reform, together with workers' movements and management professionals, instructed the creation in 2018 of the State Law No. 8,154⁶² and the Complementary Law No. 183⁶³, which establish the assurance of the financing resource, determining that the State uses in the RAPS 0,25% of the State Fund to Combat Poverty and Social Iniquities, being one of the bases of state co-financing. In 2023, this parameter was revised by the Complementary Law No. 210, of July 21, 2023⁶⁴.

On the state level, through reading the publications and norms related to the field of psychosocial care in the period, it was observed that:

1. The COFI-RAPS was a state financing modality structured in the ambit of SUS and drawing on the precepts of the psychiatric reform, the anti-psychiatric asylum struggle and the care in the community ambit;
2. The inclusion, as considered in 2020, of the Law No. 141 in the state regulation was an important element in the alignment of the

interfederative mental health public policy, as it adjusts the understanding of resource utilization in relation to the temporality issue of its utilization and form of accountability. The technical base strengthened the relation with the laws of SUS on health expenditure accountability. As from this juridical solution to ensure the continuity of COFI-RAPS, the ways of municipally responding about how the resource was used became: the Annual Management Reports (RAG), the monitoring of the Outpatient Health Actions Register System (Raas), and the Hospital Data System (SIH) of SUS; besides the strong technical interlocution carried out by the institutional technical support in the groups conducting the RAPS in the nine regions of the ERJ. The act produced the alignment of its schedule to the federal financing of services already implemented, in a logic financed by the three entities and respecting the unicity of the Brazilian health system⁵⁸;

3. The state law of the RAPS' financing and the support from agencies of control and assurance of the right to territorial and community care;
4. The COFI-RAPS innovates with the inclusion of bipartite resources for mental health beds in general hospitals, contemplating the logic of crisis care on the territory, especially for municipalities with less than 150 thousand inhabitants, and the CECOS, which became part of the co-financed services in 2022;
5. The amount of municipal services, which had already been suffering from the resources freeze, was kept or expanded (*table 1*). Stands out the creation of 44 units of SRT and 18 community-based services, essential items in the processes of deinstitutionalization and management of crisis in freedom;
6. The municipalities of Tanguá, Rio de Janeiro, Volta Redonda, São Gonçalo, Nova

Friburgo, Três Rios, Petrópolis and Campos dos Goytacazes had, altogether, 10 psychiatric asylums closed, and the financial values destined to the private asylums were, by means of CIB agreement, redirected to the municipalities that received the survivors of long-term psychiatric hospitalization, for the strengthening of inclusive mental health care. The total amount of patients of long-duration permanence in psychiatric asylums was reduced from 822 to 0 (except for the Psychiatric Hospitals of Treatment and Custody of the Secretariat of Prison Administration – SEAP, which were the only institutions that expanded the number of hospitalized individuals) (table 2);

7. The outcomes of this assessment of COFI-RAPS demonstrate the importance of inter-sectoral partnerships conducted in the state ambit to ensure financial resources, reaching its 9 regions and almost 100% of the 92 municipalities of the ERJ, which currently has an estimate population of 17,463,349 inhabitants;

8. Considering the population, the RAPS of ERJ received from the state government, annually, an average of R\$ 2.51 per inhabitant of the state for the existing services of RAPS with National Register of Health Establishments.

Table 1. Municipal services of public mental health financed or co-financed by the state in the ambit of the specific psychosocial care network and the Unified Health System

Type of Service financed/Cofi-Raps	Year			Expansion of services as from 2020
	2020	2021	2022	
CAPS I	47	48	47	0
CAPS II	52	52	52	0
CAPS III	5	5	7	+2
CAPSI	31	32	34	+3
CAPS AD II	22	22	23	+1
CAPS AD III	6	7	7	+1
SRT	168	185	202	+44
UA Adult and Child-youth	0	0	3	+3
CECO*	NSA	NSA	8	+8
Mental health beds**	229	253	251	+22

Source: Own elaboration based on the Psychosocial Care Coordination/SES (May 2023).

NSA = not applicable, because at the time these were not yet contemplated by COFI-RAPS; * Not financed by the Ministry of Health;

** Where there are less than 8 beds, the financing is bipartite (municipality and state); In the year 2019, COFI-RAPS coverage was of 6 months, thus it does not to appear on the table. In the years 2020, 2021 and 2022, there was annual coverage.

Table 2. Evolution of de-institutionalization process of long-term patients and closure of psychiatric asylums in the State of Rio de Janeiro (2019 to 2024)

Municipality	Institution	Patients per year	
		2019	2024
Campos dos Goytacazes	Abrigo João Vianna	14	Closed
Niterói	Hospital Psiquiátrico Jurujuba	33	0 LS
Niterói	Hospital de Tratamento Psiquiátrico e de Custódia Henrique Roxo (SEAP)	74	50 persons in conflict with the law

Table 2. Evolution of de-institutionalization process of long-term patients and closure of psychiatric asylums in the State of Rio de Janeiro (2019 to 2024)

Municipality	Institution	Patients per year	
		2019	2024
Nova Friburgo	Clínica Santa Lúcia	107	Closed
Petrópolis	Clínica Santa Mônica	123	Closed
Rio de Janeiro	Hospital de Tratamento Psiquiátrico e de Custódia Roberto de Medeiros (SEAP)	39	125 persons in conflict with the law
Rio de Janeiro	IMAS Juliano Moreira	131	Closed
Rio de Janeiro	IMAS Nise da Silveira	35	Closed
Rio de Janeiro	IMAS Philipe Pinel	8	0 LS
Rio de Janeiro	Instituto de Psiquiatria da Universidade de Brasil	7	0 LS
Rio de Janeiro	Centro Psiquiátrico do Rio de Janeiro	Without information	0 LS
Rio de Janeiro	Hospital Municipal Jurandyr Manfredini	4	Closed
São Gonçalo	Clínica Nossa Sra. das Vitórias	188	Closed
Tanguá	Clínica Ego	29	Closed
Três Rios	Clínica Psiquiátrica Boa União	103	Closed
Vassouras	Casa de Saúde Cananéia	40	Closed
* Total number of long stay (LS) patients, including patients in conflict with the law		935	175
Total number of long stay (LS) patients		822	0 LP

Source: Own elaboration based on the Psychosocial Care Coordination/SES and SEAP (May 2024).

* Resolution 487, of the National Council of Justice, of February 2023, determines the closure of the Psychiatric Hospitals of Treatment and Custody of the Secretariat of Prison Administration (SEAP). The Resolution provides that those hospitals will be extinct and that persons in conflict with the law, mental suffering and unaccountable shall be accompanied by SUS.

Interfederative level

In the comparison between the actions proposed at the two management levels, the analysis highlights differences regarding the understanding of the mental health care model. Although the two levels of management mentioned the scarcity of resources and the care gap, according to the induction made by the mhGAP, it can be stated that for the same SUS there were two radically different models of care management regarding the initiative and merit. In the federal ambit, there was a strong induction to the valorization of the care model based exclusively on diagnosis and by means of specialized outpatient care. For example, the study that mentions the discussion on mental

health gaps having as central reference the prevalence of common mental disorders in youth and adolescents⁴¹, without necessarily considering the resources of health care networks in the Brazilian territorial and community-based⁴⁰ model, but rather the international references of care directed to poor and developing countries.

This perception was accentuated when reading on the lack of agreements in CIT. In the international literature review, there is a perception of the same tendency observed in First World countries³⁰ in the development of governmental policies for mental health systems³¹. However, there are challenges in relation to the most vulnerable, such as residents in rural areas, unemployed persons, indigenous and immigrants, for

their difficulty to adapt to the system found in the barriers of access to health²⁸.

From the state viewpoint, exactly the opposite is observed in relation to the concepts that base the logic of its financing model. Drawing on the documents found^{51,59,62}, there was an evident technical partnership of the SES-RJ with Alerj, the Public Prosecutor's Office and the Public Defender's Office as determinants for the construction of this financing process and with a construction based on the care gaps observed in the territory of ERJ. In addition, the technical area of SES-RJ performed on the strengthening of de-centralized services in articulation in the territories, regions, the groups conducting the RAPS, CIB, and Cosems RJ, in defense of RAPS' resources ordering and according to the model of territorial and community-based psychosocial care⁵⁴⁻⁵⁶, in consonance with the PNSM. It was also observed that this performance had as priorities: the continuity of the processes of deinstitutionalization, the attempt to qualify the crisis care on the territory, and the support to existing municipal services, which awaited the national financing to expand the number of services of SUS and reduce the humanitarian gaps in the field of psychosocial care, already observed in studies that assess the models of mental health care in Brasil^{1,40} – in a state whose past slavery model⁶⁵, whose current social differences and the territory marked by daily violence are elements that collaborate towards the mental suffering of its population.

These situations enable to observe a radical experience in the ambit of SUS and its federative operability, drawing on the defense of two models of care that dispute financing and power. Effectively, they are opposed by the induction they conduct. One is based on the assurance of the right to care in freedom, according to the principles of the Brazilian psychiatric reform, the anti-asylum struggle, and the international conventions on human rights. The other has its nature related to the rationality of the medical-centered and hospital-centered diagnosis,

and delivers mental health care drawing on universalized protocols and centralized services, without involving the territory or recognizing its needs³⁶.

In other words, the outstanding opposition in the dispute over the model of care, i.e., specialism versus community care, is not resolved, because it is often restricted to the idea of 'better treatment in mental health'. Furthermore, the construction of this financing agenda puts into practice other issues, such as addressing what it is about to live in society observing the differences and respecting them, to include them, thus ensuring the right to citizenship and life in freedom.

This experience seems to be Latin American, and Brazilian, with a specific geographic localization below the Tropic of Cancer; it is also presented by articles from countries like Chile²² and South Africa²³, where the discussion on the model of mental health care is associated to historical reparations. Perhaps the answer to the beginning of the end of this dispute should be in the long history of forced immigration and the constitution of the population that forms Brazil today, bringing with it the collective marks and traumas of colonialism. In this sense, the impasse between specialism and community care is not restricted to the treatment, but is related also to the decision-making for the reduction of financial gaps regarding mental health care, which relates to mental suffering as a construction marked by the history of human relations. In this perspective, no choice of health management and financing that excludes this perception will be able, in fact, to face the reduction of care gaps in mental health in Brazil.

Conclusions

This study consisted of an evaluation, from the historical and political viewpoints, of mental health financing in the ambit of SUS, drawing on the experience of state co-financing, in a

period of hindrances in the dialogue with the Ministry of Health, marked by the conceptual differences on the model of mental health care in Brazil. The revision of regulations and the experience of COFI-RAPS raises the alert for the challenges of mental health financing, indicating that the dispute of the financing and the care model is increasingly present in the spaces of management³³⁻³⁵. This makes urgent the need of managers' qualification for the agenda of mental health financing, recognizing the paradoxes currently faced by SUS when acknowledging that there is, in fact, a gap, but that it relates not only to providing individual and medical care. Furthermore, from the study of COFI-RAPS, it is observed that its existence involved different sectors of the state governance and that the intersectionality and the relation with the municipal managers were crucial for its construction. Thus, SUS considers macro-political issues and, at the same time, it has capillarity, reaching all municipalities of ERJ.

The development of this study is an opportunity to reflect on good practices of RAPS financing, but it is necessary to name more clearly the population's needs in the ERJ today. The research demonstrated that COFI-RAPS is a marker of resistance to the dismantling of psychosocial care and the de-financing by the federal level, but that can occur in the state and municipal ambits according to the

chosen model of care. Moreover, the data observed are an important warning to the need of debating mental health in practice, considering the experience and the needs of the population regarding the current issues that affect society daily. For example: life post-COVID-19³⁹; childhood and adolescence⁴¹; populations in situation of vulnerability²¹ and natural or sanitary catastrophes, or with chronic violence situations³⁸; and the traumas increasingly more commonly experienced in different territories²².

As a limitation, this study does not comment on the utilization of health resources in the package of Agreed Integrated Programs (PPI) of the MAC ceiling of SUS. Therefore, this study points to future studies aiming at the development of a methodology to support managers for the budgetary composition, according to the norms of SUS and involving the three levels of care, so that they can make more transparent, integrated, and aware decisions on the utilization of resources for mental health care.

Collaborators

Athié K (0000-0003-3936-7881)* contributed with the writing, data collection and manuscript analysis. Amarante P (0000-0001-6778-2834)* contributed with the analysis and manuscript proofreading. ■

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