MENTAL HEALTH CARE IN PRIMARY HEALTH CARE DURING THE PSYCHIATRIC PRE-REFORM PERIOD

ATENDIMENTO EM SAÚDE MENTAL NA ATENÇÃO PRIMÁRIA À SAÚDE NO PERÍODO PRÉ-REFORMA PSIQUIÁTRICA

LA ATENCIÓN EN SALUD MENTAL EN LA ATENCIÓN PRIMARIA DURANTE LA PRE-REFORMA PSIQUIÁTRICA

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ABSTRACT

Introduction: to analyze the mental health care in primary health care in a Minas Gerais municipality, in the 1980s. **Method:** a qualitative study, from the perspective of the history of the present time. Sources: Written and oral documents obtained by an interview with six professionals from a basic health unit (BHU). We used the inductive method that starts from the internal and external critical posture of the sources, establishing the relationships with the historical-social context in which they were inserted. **Results:** the data resulted in two categories: revealing the asylum reality in *Juiz de Fora* through the narrative of the professionals of the basic health unit and the professionals' reports about difficulties in understanding the reform proposal and consequences in the organization of services and care. **Discussion:** in the pre-psychiatric retirement period, the de-hospitalization process determined the demand for mental health care at the BHU, which was not properly received due to the unpreparedness of the health team. The asylum logic guided the care and did not sufficiently contemplate the care of people with mental disorders, being limited to the reproduction of medical prescriptions and referrals to specialized services. **Conclusion:** the team faced, as far as possible, the difficulties found, and the BHU studied was a pioneer in out-of-hospital mental health care, which would later be qualified by the Municipal Secretariat of Mental Health of *Juiz de Fora*.
Keywords: Psychiatric Nursing; Mental Health; History of Nursing; Primary Health Care.

RESUMO

Introdução: analisar a atenção em saúde mental na atenção primária à saúde em um município mineiro, na década de 1980. Método: estudo qualitativo, na perspectiva da história do tempo presente. Fontes: documentos escritos e orais obtidos por entrevista com seis profissionais de uma unidade básica de saúde (UBS). Utilizou-se o método indutivo que parte da postura crítica interna e externa das fontes, estabelecendo as relações com o contexto histórico-social em que estavam inseridas. Resultados: os dados resultaram em duas categorias: revelando a realidade manicomial em Juiz de Fora pela narrativa dos profissionais da unidade básica de saúde e relatos dos profissionais sobre dificuldades de compreensão da proposta da reforma e consequências na organização dos serviços e na assistência. Discussão: no período pré-reforma psiquiátrica, o processo de desospitalização determinou uma demanda de atendimento em saúde mental na UBS, a qual não foi devidamente acolhida devido ao despreparo da equipe de saúde. A lógica manicomial guiava o atendimento e não contemplou suficientemente o cuidado às pessoas com transtornos mentais, limitando-se à reprodução de prescrições médicas e encaminhamentos para serviços especializados. Conclusão: a equipe enfrentou, dentro do possível, as dificuldades encontradas e a UBS estudada foi pioneira em atendimento extra-hospitalar em saúde mental, o que mais tarde seria qualificado pela Secretaria Municipal de Saúde Mental de Juiz de Fora.
Palavras-chave: Enfermagem Psiquiátrica; Saúde Mental; História da Enfermagem; Atenção Primária à Saúde.

RESUMEN

Introducción: analizar la atención en salud mental en la atención primaria en un municipio de Minas Gerais, en la década de 1980. *Método:* estudio cualitativo, desde la perspectiva de la historia de la actualidad. Fuentes: documentos escritos y orales obtenidos por entrevista con seis profesionales de una unidad básica de salud (UBS). Se utilizó el método inductivo que parte de la postura crítica interna y externa de las fuentes, estableciendo las relaciones con el contexto histórico-social en el que se insertaron. *Resultados:* los datos dieron como resultado dos categorías: revelando la realidad del manicomio en Juiz de Fora a través de la narrativa de los profesionales de la unidad básica de salud y los informes de los profesionales sobre las dificultades para comprender la propuesta de reforma y las consecuencias en la organización de los servicios y en la atención. *Discusión:* en el período previo a la reforma psiquiátrica, el proceso de deshospitalización determinó una demanda de atención de salud mental en la UBS que, debido a la falta de preparación del personal de salud, no fue recibida adecuadamente. La atención de las UBS seguía la lógica del manicomio y no contempló suficientemente los cuidados de las personas con trastornos mentales, limitándose a la reproducción de recetas médicas y derivaciones a los servicios especializados. *Conclusión*: el equipo enfrentó, en la medida de lo posible, las dificultades encontradas y la UBS estudiada fue pionera en la atención de salud mental extrahospitalaria, después calificado por la Secretaría Municipal de Salud Mental de Juiz de Fora.

Palabras clave: Enfermería Psiquiátrica; Salud Mental; Historia de la Enfermería; Atención Primaria de Salud.

INTRODUCTION

This study is about the care offered to people with mental disorders by the multi-professional health team in a Basic Health Unit (BHU) of *Juiz de Fora*, *Minas Gerais*, Brazil, in the pre-psychiatric retirement period when the de-hospitalization process began to gain strength in the country.

The Brazilian psychiatric reform was legally approved in 2001, but the political and social movement began in the 1970s, 20 years after the experiences of the reforms in Europe, provoking reflections that led to changes in different regions of the country, following the release of blunt criticism of the asylum model.[1,2]

The psychiatric reform movement before 2001 legal reference proposed a change in mentalities, attitudes, and social relationships regarding the reintegration of individuals with mental disorders into their families and society. Due to the territorial extension of Brazil, different strategies were used to reduce psychiatric hospitalizations, considering socioeconomic, political, and cultural aspects of each region of the country and facing different interests that sustained the psychiatric hospital at the center of mental health care.

In 1987 the Unified Health System (*Sistema Único de Saúde* – SUS) emerged, and it was regulated by the Organic Health Law 8.080/90. Thus, the principles of health reform in the country were recognized and constitutionalized, which also invested in proposals for the reformulation of psychiatric care, adding movements for the de-hospitalization and deinstitutionalization of people with mental disorders[5,6] whose treatment strategies were exclusively centered in the psychiatric hospital and specific out-of-hospital treatment alternatives.[7,8]

Thus, in the last decades of the twentieth century, the Brazilian political and social-historical context was strongly marked by the democratization of health, accepting new public mental health policies that led to the beginning of the transition from the model of hospital-centered care to another community.[1] This changing paradigm in mental health care is still a complex political and social movement with conflicting interests, theoretical and ethical conceptions and worldviews, which began to be faced more openly in Brazil since the 1980s.[3,4]

In the mental health care model offered in *Juiz de Fora* in the 1980s, its historical and political process has the misfortune of being a city at the time belonging to the "corridor of madness" along with Barbacena and Belo Horizonte as the cities responsible for 80% of psychiatric beds in the country. Thus, as in other states, the logic of care was guided by isolation, long periods of hospitalization and medicine behaviors, hindering any initiative to ensure citizenship to people with mental disorders.[9,10]

Therefore, *Juiz de Fora* depended on initiatives to reverse the logic of asylum care and people willing to face the established powers. Thus, in the late 1980s and early 1990s, complaints by the mental health workers emerged from the model of asylum care instituted, which led to inspections by the Ministry of Health (*Ministério da Saúde*, BR) in the institutions, showing that the care provided to people with mental disorders was below the minimum level required for quality care.[9]

Due to this movement, some initiatives emerged to change the reality of psychiatric care in *Juiz de Fora*, starting with the de-hospitalization process, which challenged the asylum culture and the economic interests of private hospital owners. The slow but progressive exit of mentally ill people from psychiatric hospitals increased the demand for care in the territory, more precisely in the BHU, in the 1980s.[11]

Therefore, the objective of this study was to analyze mental health care in primary health care in a mining municipality in the 1980s, having the BHU of the western region of *Juiz de Fora* as a spatial cut, made a gateway to the mental health care when their hospitalization was not justified. In this sense, during the psychiatric reform movement in the country in 1980, new devices began to be thought and the basic care, as it was and should be, calling the care and management of cases of mental disorders including them in out-of-hospital health programs.

Studying and recording the performance of the multi-professional team in mental health care in the BHU scenario to favor the out-of-hospital care will contribute to overcoming

difficulties experienced by primary care health teams that in the psychiatric reform still have limitations to assist people with mental disorders. The experience of the municipality of *Juiz de Fora* is an example of places that have not yet been able to implement community-based mental health care.

One of the principles of psychiatric reform is deinstitutionalization, presupposing the maintenance of the person with mental disorders in their territory that is, in their daily social relationships, and in this perspective, health care is contemplated by the primary care. New knowledge acquired by the primary care was necessary with the knowledge in mental health, determining the deconstruction of the historical distancing of psychiatric practices from primary care.

METHOD

This is qualitative research developed from the perspective of the history of the present time.[12] The cutting time begins in 1980, when the de-hospitalization movement began in the city of *Juiz de Fora*, *Minas Gerais*, Brazil, and ends with the regulation of psychiatric reform in the country in 2001.

The data of this article came from oral and written sources. The written sources were speeches and articles published in newspapers of great circulation in the city of *Juiz de Fora*, in the journal of the university hospital of the city and the journal of the Historical and Geographic Institute of *Juiz de Fora* (*Revista do Instituto Histórico e Geográfico de Juiz de Fora*), and the reports of the Mental Health Conferences.

The oral sources were collected from May to July 2016, using the thematic oral history (TOH)[12] technique. It had 6 participants experiencing the care given by BHU in the studied period. The participants were one nurse, one Nursing assistant, one social worker, and three doctors. At TOH, the number of respondents does not determine the quality of the data, but their record from memories, the facts that occurred.[12]

After the interviews, the records were transcribed and sent to the study collaborators for validation. At this stage, none of them requested any changes in the document, reaching the final stage of collection and preparation of oral sources, according to the proposed methodology.

We identified the collaborations in the text by the initial letter of their profession, followed by the number corresponding to the sequence of the interview.

For data analysis, we used the inductive method, starting from the internal and external critical posture of the sources, establishing the relationships with the historical-social context in which they were inserted.[13,14] The classification and contextualization of the data enabled the discussion of the results, which were triangulated based on the concepts of de-hospitalization, deinstitutionalization, psychosocial rehabilitation, and citizenship.

De-hospitalization is the removal of the mentally ill person from the psychiatric hospital upon discharge, ending their hospitalization.[15] The deinstitutionalization in mental health is not an isolated act, it is faithfully associated with the recognition of the process and the user's acceptance by the society and health services, including primary care. The concept of deinstitutionalization emerges as a process concomitant with the democratization of the country and reformulation of its health system through health reform, questioning psychiatric knowledge and practices, verifying the negative effects of psychiatric hospitalizations on the individual.[16,17]

Deinstitutionalization is considered the essence of the psychiatric reform, which aims at deconstructing paradigms that support addicted relationships to go beyond contact with the hospitalized individual. It demands the strengthening of ties and the inclusion of professionals, family members and the community in the care planning, according to the needs of each person, for their psychosocial rehabilitation.[17]

According to Pitta[18], the process of psychosocial rehabilitation consists of the reconstruction of the individual regarding the full exercise of citizenship, which implies the contract between individual, social network, and environment, scenarios that allow the actions of all individuals. It is a set of actions aimed at increasing human skills, generating the minimization of the effects of disability and damage caused by the disease.

Deinstitutionalizing includes psychosocial rehabilitation and provides a citizen's life. The citizenship of people with mental disorders is associated with the process of developing their rights within capitalist societies and, as there is a difficulty in inserting these users in this environment, these people end up being victims of stigmatizing behaviors and excluded from social life.[15,16]

The Research Ethics Committee approved the research, accredited and conducted according to the legislation for research with human beings in Brazil.

RESULTS

Revealing the asylum reality in *Juiz de Fora* by the narrative of the professionals of the basic health unit

The research allowed identifying the model of care provided to people with mental disorders in *Juiz de Fora* based on the social isolation imposed by compulsory hospitalizations from institutionalizing actions:

> *The mental health care in Juiz de Fora was wrong, it was centered in the hospital. There were 1,600 psychiatric beds here. In Juiz de Fora, there was the so-called "madness*

corridor" at the time, because the number of people insane and collected in hospitals was frightening (D 05).

In this study, we approached the care provided to people with mental disorders in the hospital of *Barbacena*, State of *Minas Gerais* as one of the ways to clarify the influence of the institutionalizing care model that reflected in the "hall of madness" at the time of the studied scenario, because most people with a mental health complaint were sent there:

I have had experience with psychiatry. My mother, 30 years old, went into postpartum depression and was treated at the hospital in Barbacena [...] it was like this if the person was nervous, she was immediately hospitalized (NA 02).

Juiz de Fora was known nationwide as a city that concentrated a large number of psychiatric hospitals at the time. It was untenable to maintain that model of mental health care (D 04).

The unfounded mental health care in the dignified and humanized care made health professionals denounce the practices performed in psychiatric hospitals issues through a documentary that drove the de-hospitalization movement because they were bothered with the reality experienced by people with mental disorders, with loss of their autonomy and right to live in social spaces:

In 1980, a psychiatrist came to Juiz de Fora to do something different in the field of mental health. In 1981, he brought the proposal, and I promoted the viability of the documentary "In the Name of Reason," which was recognized in the de-hospitalization movement (D 05).

The release of this documentary was the first impact here when it was effectively said that it was unsustainable to maintain that model of mental health care (D 06).

The participants reported the experiences of the multi-professional health team in caring for people with mental disorders regarding the reception provided by the BHU team during the period of hospitalization. In this scenario, the health team professionals identified difficulties related to the insufficient qualification of human resources to meet people with mental disorders:

The reception was precarious, it was not directed to the mental health patient, it was the same as any

other pathology, any other demand that arrived at the BHU, there was not even the preparation of the BHU professionals (N 03).

There was no preparation from BHU professionals or even the appointment staff because it depended on spontaneous demand. The control of care was not something prepared and adequate for patients with mental health demands (D 05).

[...] There were cases of patients who were given priority care [to the Health Care Center], which were the cases of suicides and people who used drugs [...] when they decided to consult in Psychiatry, the care was faster (SW 01).

From these extractions, the health professional expressed his anxieties about meeting the demand for mental health due to the lack of knowledge about the management relevant to the care of these patients:

It was not difficult for me to deal with these patients, but we had no answer about what to do. Sometimes the person was in crisis, and we had nothing to do, we had to send to third parties and wait for vacancy [...] (AE 02).

Besides these aspects, two respondents reported that, in addition to the lack of human resources, there was a lack of interest from some professionals of the BHU team to assist people with mental disorders who sought care:

[...] the service was offered by the BHU, much more from the sympathy, or not, that the professionals had for the mentally ill, a better or unfamiliarity with this area (D 04).

[...] some professionals showed no interest in assisting this population because it was a stigmatized population (N 03).

[...] professionals did not realize that health problems more broadly are impacted by mental health problems, and vice versa (D 05).

In this first category, it is possible to notice that the process of de-hospitalization was going on, and the search for mental health care at the BHU took the health professionals by surprise, who acted as they could.

The following category reveals the care strategies for people with mental disorders at BHU.

Professionals' reports on difficulties in understanding the reform proposal and consequences on service organization and care

The participants' reports showed that the lack of organization and the lack of care flow between primary care and other mental health instances had focused medical interventions, in a space that should be conducive to the constitution of the bond between the multi-professional team and people with mental disorders seeking care:

> […] There was no flow of care and referral. What happened was that the BHU team did what they could. If the patient needed it, he called to specialized outpatient clinics through suggestions from the BHU professionals… There was no communication channel between the BHU with the specialist and the instances (D 04).

> […] the patients were sent to the medical center, and the appointments here at the BHU were normal, as in the case with hypertensive, diabetic patients, but there was no time and date stipulated to meet the mental health demand (N 03).

> There was no organization, simply if you recognized a need for specialized care, you sent them to Psychiatry, as the same form that it was used to refer to any other specialty, such as Cardiology, Pulmonology. We made a "summary" of what you found in that patient, and that justified the referral, delivered to the patient to make the appointment in secondary care, and that´s it (D 04).

> There was no counter-referral, you didn't hear from that patient anymore, if he were being treated, what was being done, he would eventually come back to you for other clinical problems. Sometimes he had hypertension, diabetes, and sometimes he said he was treating in psychiatry, but we had neither information nor participation in this work (D 06).

One professional stated that people with mental disorders felt unsupported when the hospitalization in *Juiz de Fora* occurred:

> […] I think they took the hospitalization but did not give people another option because they were lost (NA 02).

Primary care is the guide for health care in SUS and must meet the entire population in its area of coverage, without discrimination, developing health care with the highest degree of decentralization and capillarity, close to people's lives. It should be the preferred contact of patients as the main gateway and communication center of the health care network.[19]

Corroborating the reports above, two collaborators reported how service was centered on revenue renewal and compulsory referral:

> […] There was no reception, the assistance was unified, it was a normal consultation, the patient arrived, made the medical appointment and scheduled for Psychiatry [at the medical center], and waited. If it was to renew a prescription, this was done during the medical appointment (N 03).

> If it were the case of repeating a prescription, we would make a new appointment for the patient, to renew the prescription while waiting for the vacancy of Psychiatry [at the health center] (NA 02).

Despite the challenges faced by the health team to assist people with mental disorders who came from hospitalization, this study focused on the need to reformulate the mental health care model, expressed in the following professional's speech:

> When a psychiatric reform was conceived, the idea was not only to remove the patient from the hospital but to establish an adequate flow, which meant having a defined gateway and efficient referral and counter-referral mechanism (D 06).

The results obtained by the study show the thinking of the professionals of the BHU facing the challenge to assist people with mental disorders immersed in a society that was not yet in favor of the reform movement that was gradually instituted.

DISCUSSION

The multi-professional health team of this study recognized that initiatives were necessary to enable the reception process of people with de-hospitalized mental disorders, who, before entering the BHU were inserted in a space eminently characterized by biomedical practice.

In this sense, reinforcing the interviewees´ reports, the initiatives that reported the complaints of the traditional care model emerged in 1979, with the visit of physician Franco Basaglia to the Colônia de Barbacena Hospital, to know the reality of people that were isolated from society. Thus, the doctor had the opportunity to identify numerous practices of violation of the dignity and subjectivity of hospitalized people, which extended to the residents of *Juiz de Fora*.[9]

After visiting the *Colônia de Barbacena Hospital*, the Italian psychiatrist, a pioneer in the struggle to end the asylums, said

before a press conference: "I was in a Nazi concentration camp today. Nowhere in the world have I witnessed such a tragedy."[9]

By evidencing that the care provided in that Minas Gerais city was opposed to the care far from what would be desirable for people with mental disorders and their families, mental health workers interested in changing the reality of assistance in *Juiz de Fora* exhibited in the city, in the headquarters of the Society of Medicine and Surgery (*Sociedade de Medicina e Cirurgia*) created in 1981, the movie "In the Name of Reason", by filmmaker Helvécio Ratton, which came to denounce the asylum practices and became a symbol of the anti-asylum struggle in the city.[11]

In this way, strong questions related to the human resources and infrastructure of psychiatric hospitals emerged, leading to demands for changes based on political, ethical, legal, and legal movements that strongly boosted the de-hospitalization movement. In this context, people with mental disorders who left psychiatric hospitals sought shelter in their area of residence going to the BHU, because they were without reference to care.

Therefore, the results found in this study revealed that the difficulties in attending newly hospitalized people in the BHU studied were related to the scarcity of human resources and stigmatizing postures by some professionals, established in the biomedical model and in the absence of integration of the mental health care, which made the referral and counter-referral process unfeasible.

Also, studies showed that from 1999 to 2009, most BHU professionals presented "stereotypical views on the predominance of asylum logic, lack of records, flows, strategies, qualified family support, and networking."[19,20] The study conducted in 2009 in the city of *São Paulo* stated that "the effective inclusion of mental health care in primary care is still an infrequent reality".[20]

These studies reinforced the idea that the power of primary care is not harnessed in the reception and management of mental health cases, as we extracted the present from history in this research.

From the moment in which the psychiatric reform was implemented progressively in the country, we must think about forming a substitute network for hospitalization, de-hospitalization, care network, territorialization, reintegration, and psychosocial rehabilitation, and to access to the public health devices, in an egalitarian and citizen way.

Primary care for these patients is a gateway to the health service, referral (if necessary), and, above all, a link and permanence to the territory, where are the resources for care.

Four categories defined the experiences of health professionals in caring for people with mental disorders: tension, lack of job satisfaction, difficulty and discomfort, respectively, caused by constant vigilance of professionals,

discrediting interventions performed to patients, discontinuity of work performed professionals as to the therapeutic flow and, finally, unpreparedness to deal with these people.[21]

This statement was unveiled in this study in which, initially, the participants mentioned care based on social isolation as a result of theoretical and practical ignorance, stigmatization, and exclusionary practices of health care. They also highlighted difficulties related to the inadequacy of the qualification of human resources to assist people with mental disorders and, on the other hand, some disinterest of the BHU team in assisting this population.

This is the first confrontation of the psychiatric reform, not only for the de-hospitalization, but to ensure and replace the previous model of care, getting a model of psychosocial care inclusive in the bias of citizenship, in health care. This is a broad, full of tensions and crossings process that have highlighted different elements, inherent to their complexity.[17]

Insufficient health care shown in the interviews conducted in the study leads to the reflection that good relational treatment and the provision of technical and procedural care are patients' rights. Therefore, the absence of one or the other shows the non-respect for their citizenship.[16] The professionals of these BHU health team expressed that they recognized severity tables presented by the patients, but made it clear that there were no therapeutic resources that could be used to meet the patient.

Participants expressed anguish in meeting mental health demands due to a lack of knowledge about the management relevant to the care of this patient. They also revealed a lack of organization and lack of flow of care between primary care and other instances of mental health, which may result from the lack of knowledge of the care network at the time meaning or even a negative in managing the health care cases that used BHU, which may be feasible before early referrals.

According to the interviewees, the poor communication of primary care with other services cannot be considered as support to the BHU team. The psychosocial care network was starting and is still being formed, so this study shows that there was a positive impact of the demand generated at BHU with the decentralization in *Juiz de Fora*.

Corroborating the feelings of helplessness for being in breach of the assumptions of psychiatric reform due to the ethics related to care in mental health care, studies showed the complexity of situations involving mental health work in primary health care, presenting difficulties in this process permeated by interests and priorities of the professionals involved; the tension between quantity and quality of services provided in primary care; and the ability of the network to respond adequately to their therapeutic needs.[19]

When this situation is negative in health, it contributes to the establishment of intense obstacles to psychosocial rehabilitation,

in which the actual management of subject insertion and social permanence is deficient, hindering them from accessing health and contributing to the return to the crisis.[22]

The conception of the BHU as a provider of psychosocial rehabilitation and citizenship was not well defined for this health team, because there was no knowledge of some professionals that would allow them to act as social agents, actively participating in the promotion of the rescue of individual and collective autonomy. However, they were distant from this concept of patient autonomy, which determines the freedom of the individual to freely manage his life, rationally making his own choices.[23]

Psychosocial rehabilitation should be part of a therapeutic process that seeks to promote citizenship of the patients from their insertion in the community, developing strategies that encourage people with mental disorders to regain their autonomy in society, with the right to follow up in their living area, seeking to minimize the effects of social exclusion, which did not occur in *Juiz de Fora* at the beginning of the de-hospitalization process.[18]

However, understanding the procedural psychiatric reform, it is necessary to consider this socio-historical event, as predictable and demanding economic investment, political and continuing professional education that contemplates the perspective of care for deinstitutionalization and expanded care in mental health.

CONCLUSION

Because of its historical approach, this study allowed the recording of processes that occurred in the health field in response to an important policy established in the early phase of the Brazilian psychiatric reform movement, conceptualized as de-hospitalization.

As people with mental disorders are in the community after years of detachment from health services, they sought the nearest service in the community that was the BHU. This search was initially frustrated due to the unpreparedness of the BHU health team to assist patients with mental disorders. Also, without specialized support from other services, the multi-professional team had to review its organization and practices to meet this new demand.

The care actions of the BHU multi-professional health team studied were evidenced in this study, identifying that the conception of the BHU as a provider of psychosocial rehabilitation and citizenship promotion was not well defined for this health team, since the mental health care model offered at the BHU in the region met a priority drug treatment, as the professionals did not know other ways of handling cases, eventually encouraging practices that went against the movement of psychiatric reform in *Juiz de Fora*.

Thus, BHU professionals in the western region had difficulty recognizing that patients with mental disorders have the right to be assisted in their area of residence, due to factors that included lack of professional experience in mental health and the theoretical and practical unpreparedness for that.

The deficiency in the preparation of these professionals was related to the lack of human resources and the permanent health education actions to train them in the aspects of the mental health clinic. This was linked to stigmatizing postures, which reflected in the quality of care offered by primary health care.

However, the study proved that there was an important movement of de-hospitalization in *Juiz de Fora*, but the mental health care model at that time-restricted their access to primary care and maintained the centralization of care in psychiatric hospitals, in which the health team is unprepared to receive the demand generated by the institutional discharge of people with mental disorders.

Thus, *Juiz de Fora* will prepare for this, creating in the 1990s protocols of conduct to make BHU a gateway to mental health, making this BHU the first to implement them, which reaffirms that psychiatric reform is procedural, and it was already occurring even before its historic milestone in 2001, when Law 10,216 was passed. Much has been done for people with mental disorders, and the history of Nursing should keep this memory alight, ensuring the record of the events occurred.

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