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EDITORIAL

Bridging local realities and global science: psychiatric education 35 years after the establishment of Brazil's Unified Health System

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The Unified Health System (Sistema Único de Saúde, SUS) is celebrating 35 years of striving to provide, in a universal, comprehensive, and equitable way, the right to health, even in the most remote corners of Brazil. One of the world's most ambitious universal health systems (serving over 210 million people across a territory slightly larger than the continental U.S. with profound regional inequalities), it was mandated by the Federal Constitution of 1988[1] and established by Organic Health Laws 8.080/90[2] and 8.142/90.[3]

A cornerstone of this commitment was the Psychiatric Reform, inspired by the experience of Franco Basaglia in Italy and driven by the Anti-Asylum Movement (Luta Antimanicomial), which initiated a paradigm shift from a hospital-centric model of care to a community-based, interdisciplinary approach. Law 10.216/2001[4] marks the legal framework for this transition, redirecting the model of care by prioritizing treatment in community-based services. However, the success of this ambitious reform is contingent not just on policy, but on the training of a psychiatric workforce equipped with the skills and values to thrive within this new paradigm.

In this editorial, we argue that to truly fulfill the promise of Psychiatric Reform and SUS, Brazil must bridge the gap between its excellent but often siloed graduate research programs and the on-the-ground context of community-based mental health care. We will first outline the unique context of the SUS, then examine the current state of psychiatric training, and finally propose a series of reforms to better integrate the two, ensuring that academic excellence serves the goal of health equity.

The unique context of the Sistema Único de Saúde: the promise and reality of community-based mental health care

For an international audience to appreciate the challenges of psychiatric education in Brazil, one must first understand the unique context of the SUS. In the pre-SUS era, mental health care in Brazil was centered on large psychiatric hospitals, often isolated from communities and families. The Psychiatric Reform sought to reverse this logic: rather than removing patients from their context, care was to be centered on individuals situated within their families and communities.

This person-centered, community-based, and territorially-oriented approach requires a reorganization of services. The Psychosocial Care Network (Rede de Atenção Psicossocial, RAPS), formalized by Ordinance GM/MS No. 3,088/2011,[5] organizes mental health care not as a hierarchy but as an integrated network. Primary health care, implemented through the Family Health Strategy, serves as the preferred entry point and coordinator of care, responsible for managing most mental health needs at the community level. For more complex cases, Psychosocial Care Centers (Centro de Atenção Psicossocial, CAPS) serve as strategic points of specialized care for individuals with severe and persistent mental disorders. Connecting these levels, collaborative care arrangements (*apoio matricial*) enable mental health specialists, including psychiatrists, to support primary care teams, thus enhancing their capacity to manage mental health problems without necessarily referring patients to specialized services. The network also includes therapeutic residential services, transitional residential units (Unidades de Acolhimento), psychiatric beds in general hospitals, and street outreach teams (Consultório na Rua). All of these services operate through multiprofessional teams committed to deinstitutionalization and interdisciplinarity, providing care according to the intensity of need rather than a fixed hierarchy of complexity – an approach that has been associated with significant reductions in psychiatric hospitalizations.[6]

In a trajectory filled with obstacles, the daily consolidation of SUS and mental health policies in Brazil faces chronic underfunding, network coordination weaknesses, resistance from the hospital-centric model that preceded

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the Reform, and the risk of setbacks. This creates a precarious system where Psychiatric Reform is often undermined by scarce resources.

The two tiers of psychiatric training: clinical training (*lato sensu*) and graduate research (*stricto sensu*)

Psychiatric training in Brazil is formally divided into two tracks. The first is clinical training (*lato sensu*), which encompasses two distinct pathways: 1) medical residency – a three-year program of intensive, supervised in-service training accredited by the National Medical Residency Commission (Comissão Nacional de Residência Médica) and 2) specialization courses, which offer training without the requirement of full-time dedication. Unlike residency graduates, who are legally entitled to the specialist title upon completion, specialization course graduates require additional certification through medical specialty societies. The second track is *stricto sensu* graduate training, which comprises master's and doctoral degrees focused on developing research skills.

Brazilian *stricto sensu* programs in psychiatry contribute to global science, producing research on the pathophysiology of mental disorders, clinical trials of pharmacological and psychosocial interventions, neuroimaging, genetics, and the development of novel therapeutic approaches. Beyond this international contribution, these programs also have a critical role in generating evidence that is directly relevant to Brazil: epidemiological data on the mental health of the population, effectiveness studies of interventions adapted to the local culture, and evaluations of RAPS service models, i.e., research that can guide the planning and continuous improvement of public mental health policies.

The Universidade Federal do Rio de Janeiro established Brazil's first graduate program in Psychiatry and Mental Health, a pioneering initiative that paved the way for subsequent programs. Today, several of these programs have achieved the highest rating from Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES), the federal agency responsible for evaluating graduate education, including the Psychiatry program at the Faculdade de Medicina da Universidade de São Paulo, the Mental Health program at the Faculdade de Medicina de Ribeirão Preto, and the Psychiatry and Behavioral Sciences program at the Universidade Federal do Rio Grande do Sul. Here, students are mentored by leading researchers who are recognized both nationally and internationally, benefiting from the free education at these public universities and an interdisciplinary approach that brings together physicians, psychologists, nurses, physical educators, pharmacologists, etc., forming networks and partnerships within a scientific community with common goals aimed at comprehensive care. Although these centers of excellence are a testament to the strength of Brazilian academia, they also raise a critical question: is this academic excellence being effectively leveraged to strengthen the public health system?

Bridging the gaps: from academic excellence to public health impact

Despite the strengths of Brazilian psychiatric training, a significant disconnect persists between academic culture and the needs of the public health system, manifesting in three key areas.

First, clinical training remains largely hospital-centric. Although community-based rotations exist in most programs, they are often marginalized – disconnected from the academic core, rarely integrated into research activities, and frequently perceived by residents as lower-prestige experiences. Bridging this gap requires not only curricular adjustments, but a cultural shift that values community mental health as a legitimate field of academic inquiry and clinical excellence.

Second, research often fails to address pressing local needs. Although Brazilian programs produce internationally recognized science, the development of care protocols and intervention methodologies adapted to the local context is limited by chronic underfunding. Brazil's research funding integrates federal agencies, i.e., CAPES (Ministry of Education) and Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq; Ministry of Science and Technology), with state-level research foundations,[7] yet this multi-layered structure remains insufficiently resourced. The resulting inadequate salaries and precarious working conditions drive psychiatrists toward the private sector. Brain drain to the Global North (an estimated 6,700 scientists have emigrated in recent years)[8] compounds this challenge, making the integration of Latin America into a multipolar scientific system all the more urgent.

Third, training opportunities are geographically concentrated in the southern and southeastern regions of the country, which concentrate 74.6% of all psychiatrists,[9] creating a vicious cycle where regions with the greatest mental health needs have the fewest professionals. A national strategy to create high-quality programs in the northern and northeastern regions is essential for equitable distribution of psychiatric expertise.

Addressing these gaps requires concerted action from universities, government, and funding agencies – preparing not only skilled clinicians and researchers, but future leaders equipped to develop, implement, and evaluate evidence-based mental health policies in SUS. A concrete policy lever would be for CAPES to incorporate local health impact (such as SUS-relevant research, service implementation projects, and community partnerships) as a weighted criterion in program evaluations, alongside international publication metrics. To ensure that academic excellence translates into better care, residency and graduate programs should also track outcomes, such as service use, CAPS/RAPS performance indicators, and follow-up of alumni career paths, to evaluate whether training models improve access, continuity, and quality of mental health care in SUS.

A call for action toward a more integrated and equitable future

Graduate education in psychiatry, which is indispensable for excellent mental health care in SUS, acts as a bridge

between academia and the service network. It requires ever-greater integration into the system, representing a persistent effort to reduce the discrepancy between academic output and daily health care demands in Brazil.

The promise of Psychiatric Reform and SUS can only be fully realized with a psychiatric workforce that is trained to meet their goals. Brazil has a strong foundation of clinical and academic excellence in psychiatry, but the current training system is not yet fully aligned with the principles of community-based, equitable, and interdisciplinary care. Bridging the gap between the worlds of academic psychiatry and public service is the central challenge for the next generation of psychiatric educators.

The future of mental health care in Brazil will depend not just on new treatments or technologies, but on our ability to train a new generation of psychiatrists who are not just skilled clinicians and researchers, but also committed and effective leaders in the public health system. It is a challenge that we must meet with creativity, courage, and a renewed commitment to the constitutional principle of health as a right for all – the same principle that, 35 years ago, gave birth to one of the world's most ambitious experiments in universal health care.

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Author contributions

LJ: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – original draft.
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