



PERCEPTION OF MUNICIPAL MANAGERS IN THE FACE OF THE IMPLEMENTATION OF THE MENTAL HEALTH POLICY

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ABSTRACT

Objective: to understand the perception of health managers about the implementation of the Mental Health Policy in municipalities belonging to the 5th Health Regional Unit of the State of Paraná. **Methods:** study with a qualitative approach and an exploratory nature, conducted in the months of February and March 2015. Twenty health managers from the 5th Health Regional Unit were interviewed, through semi-structured interviews. Data analysis was developed according to Bardin's content analysis method, thematic modality. **Results:** two categories emerged: "The perception of managers about MH in the municipalities" and "Difficulties in implementing PNSM". Health managers highlight the need for better implementation of the Mental Health Policy in their municipalities and the adequacy of the Psychosocial Care Network. The difficulties faced are the lack of financial resources, professional training and prejudice. **Final considerations:** the lack of visibility among health managers about the role of the services that make up the Mental Health Care Network is noticeable, especially primary care, as it is primarily responsible for the actions of welcoming and promotion/prevention of mental disorders.

Keywords: Mental health. Mental health services. Health manager. Health policy.

INTRODUCTION

The National Mental Health Policy (PNSM, as per its Portuguese acronym), established by Law 10.216/01, consolidates a model of accessible and community-based mental health care, ensuring the free movement of people with mental disorders (MD) and the effectiveness of precepts that led to the Brazilian Psychiatric Reform⁽¹⁾.

In order to ensure access and quality of the care in the scope of mental health (MH), the Psychosocial Care Network (RAPS, as per its Portuguese acronym) was created through Ordinance n° 3.088, dated December 23, 2011. This network expands and articulates the points of care for MH, where care must occur in an integrated and territorial manner, with

welcoming, continuous monitoring and attention to urgencies⁽²⁾.

The components of the RAPS are Primary Health Care (PHC), specialized psychosocial care, urgent and emergency care, transitory residential care, hospital care, deinstitutionalization strategies and psychosocial rehabilitation⁽²⁾. In this sense, the network must be implemented at state and municipal level, in an equitable and inclusive way, focused on meeting the changes produced in the way of caring for in MH⁽³⁾.

In the period from 2008 to 2017, small-sized municipalities showed greater progress in the availability of MH outpatient services compared to large metropolises⁽⁴⁾. In the state of Paraná, it was necessary for the service network to organize itself to meet the changes that had

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occurred. To this end, PNSM was restructured between 2012 and 2014, with discussion of the reality of municipalities by the Health Regional Units and creation of the RAPS of the State of Paraná⁽⁵⁾.

Health managers are considered essential for the maintenance of a health service, as they are responsible for mediating and producing the minimum conditions necessary for the implementation and performance of multidisciplinary teams in the territories, since they are responsible for managing physical, economic and human resources⁽⁶⁾.

Accordingly, it is up to municipal health managers to articulate knowledge and strategies for the full implementation of PNSM, with the restructuring of the care model of the RAPS, professional qualification and compliance with legislation on MH, so that the care of people with mental disorders is adequate⁽⁷⁾.

In this perspective, the research justifies the need for greater knowledge about the work of municipal health managers, as they are essential to the articulation of services in a health region for PNSM to be effective. This study sought to understand the perception of municipal managers on the implementation of PNSM in the municipalities belonging to the 5th Health Regional of the State of Paraná.

METHODOLOGY

This is an exploratory research with a qualitative nature, inserted in the study "Components of the RAPS: reality of the 4th and 5th Regional Health Units", subsidized by the Research Program for the Brazilian Unified Health System: Shared Management in Health PPSUS – 2011 Edition conducted between the years 2013 and 2017.

The territory of Paraná is organized into six macro-regional units and 22 health regional units that make up the intermediary administrative instance of the State Department of Health of Paraná (SESA, as per its Portuguese acronym). Among these, there is the 5th Regional Health Unit, which is composed of 20 municipalities that are articulated to establish reference services and health consortia⁽⁵⁾.

The research participants were municipal health managers from the 20 municipalities of

the 5th Regional Health Unit of Paraná. This region has a population of 438,250 inhabitants, with 15 municipalities (75%) having a population of up to 15 thousand inhabitants, while four municipalities have between 15 and 50 thousand inhabitants and only one has a greater population (166,165 inhabitants).

During the research period, the region was in discussion about the reality of MH services, being stimulated by the reformulation of PNSM and the implementation of the RAPS in the State of Paraná. At that time, the municipalities needed to organize themselves to ensure mental health care to their citizens, redesigning flows, actions and services.

Data collection took place in 2015, between February and March, carried out by two trained and qualified interviewers, after the acceptance of 20 health managers from the municipalities. The criteria for selection of participants were: being a professional with a higher education, being in the position of municipal health manager for at least 1 year, not being on vacation, removed or on leave. There were no exclusion criteria for the participants, since none of them were removed during the collection period.

The presentation of the research and the invitation to participate occurred by means of telephone contact with the municipal health managers, who indicated the best day and time for data collection. This step took place through a semi-structured face-to-face interview, based on a script developed as part of the research, containing questions regarding the implementation of PNSM in the municipalities.

The interviews were conducted at the Municipal Health Department of each municipality, ensuring an adequate environment and privacy. Each one lasted approximately 30 minutes, were audio-recorded and fully transcribed by the main researcher.

Data analysis was guided by content analysis⁽⁸⁾, consisting of the following phases, pre-analysis: at this stage, the construction of the project took place, with the insertion of each interview as a primary document. Afterwards, a floating reading was performed, allowing the material to be approached and possible hypotheses to be elaborated, and the excerpts considered most important for further analysis

were cut. Material exploration: a reliable reading was performed with the coding of data and identification of the core meanings consistent with the objective, with a detailed analysis of the speeches being carried out, with the coding process. Treatment of results: at this stage, the data were processed in order to make them meaningful and make it possible to build the study categories.

All ethical precepts of resolutions 466/12 and 510/2016 of the National Health Council were followed. The study was approved by the Research Ethics Committee/State University of the Midwest of Paraná in August 2012, under Opinion n° 79531. All participants were informed about the study objectives, data collection procedures, risks and benefits and signed the Free and Informed Consent Form. In order to ensure privacy and anonymity about the collected information, the reports of the participants were identified by the letter G, followed by an Arabic number, according to the sequence of interviews.

RESULTS

The exploration and analysis of the speeches of the participants resulted in two thematic categories: **“The perception of managers about MH in the municipalities”** and **“Difficulties in implementing PNSM”**.

The perception of managers about MS in the municipalities

The interviewed managers pointed out the need to better develop PNSM in their municipalities, highlighting the implementation/maintenance of the Psychosocial Care Center (CAPS, as per its Portuguese acronym) and the reduction of hospitalizations in psychiatric hospitals as important points of care in MH.

Yep, in fact, the policy has been initiated, right? On the issue of the CAPS management and the work that is starting with the CAPS professionals, the issue of improvement, harm reduction, there is a policy, yes! In fact, a more effective work is starting [...]. (G3)

Therefore, since we took over our administration, we have been thinking about developing the

policy, we are now working to develop it. Yes, there is already something, but we have to improve it further. (G13)

Well, the municipality started with the implementation of the CAPS where the work started [...] where the high rates we had here of people hospitalized in psychiatric hospitals were worked on and with the new legislation so that we could adapt and meet the existing demand in our municipality [...]. (G2)

Participants proved that they try to enable actions recommended by PNSM, often needing to refer users to receive care in neighboring cities. Thus, given the lack of effective municipal services and the limited supply of specialist professionals, referral is understood as an important action for the care in MH.

[...] the municipality has a psychiatrist who helps a little, we have the APAE that we refer several people there, we also refer some actions to the CEDETEG (reference service) and we also refer them to the CAPS [...]. (G8)

Psychiatry appointments too. If there is no quota, we always find a way to refer patients. (G17)

[...] we forward them there, but we have the NASF here in the city (Family Health Support Center) that follows them up with the team we have: the nutritionist, the psychologist, we have social worker and also the physical therapist (G9)

Managers highlighted that it is necessary to invest in the medicalization of patients in order to halt outbreaks and hospitalizations. The use of controlled drugs and their distribution are seen as the main form of treatment for patients with MD. Nevertheless, other actions that contribute to an adequate treatment in MH were not mentioned, showing the low knowledge about the possible therapies that can, and must, be implemented in PNSM.

[...] mental health, it only works if the patient is taking the medication correctly, then he doesn't freak out, as you say in mental health [...]. (G3)

[...] we have the supply, that is, the acquisition and distribution of medications for mental health patients and meetings are held with them, with people called with mental health problems (G14)

Some participants highlighted the importance of the presence of a multidisciplinary team in the provision of care in MH. However, the most cited professionals are those who are routinely

responsible for the care in relation to mental illness, such as psychiatrists and psychologists.

[...] after the service was started to follow up with the psychiatrist the issue of hospitalizations has improved a lot, it has decreased a lot. (G6)

This is how it happens and we are at this moment facing a difficulty because, until last month, I had a psychologist here who was a civil servant, unfortunately for us, or fortunately for her. (G5)

[...] we have a social worker, we have a psychologist, nurses, doctors who provide care once a week. It is little, and we know that, we have an occupational therapist. (G10)

The work of the Family Health Strategy (FHS) team was cited as essential in monitoring individuals with mental disorders, with emphasis on the accomplishment of home visits by Community Health Workers (CHW) and other professionals. It is understood that this contributes to improving the quality of care, even when there is a shortage of professionals, as reported.

[...] The nurse and the CHW are following up during the home visits. We have itinerant nursing technician, he has a motorcycle and a backpack and he attends where there are families at risk. (G12)

[...] what we are trying to do is a differentiated monitoring with all these people. As much as we cannot embrace it, as small as the municipality is, as I said, there is a lack of employees. But we want to get treatment, following up all these people at home. Not only the people, but, mainly, the families! right?! (G17)

The family approach is pointed out as necessary for providing comprehensive and quality service to the user. The inclusion of the family in the treatment allows the needs and difficulties faced in the family environment to be known and can contribute to the stability of the condition of the patient.

[...] we also have to make the family participate in this service, there is no point in the health sector spending money, the person going home and then spending six months and going back again. (G6)

[...] he enters a situation of illness, depression, becomes aggressive and ends up becoming a MH patient, but because of the lack of family and housing conditions [...]. (G7)

Difficulties in implementing PNSM

Through the reports issued by managers, it is possible to note the barriers to be overcome for changes to occur in the care in MH in the municipalities. It was possible to observe, in certain speeches, that there is concern with the MH area, but difficulties such as the lack of professionals, training, financial resources and infrastructure, become difficult obstacles to overcome.

But, we have many difficulties, because the municipality is very small and I cannot have, for example, form a group, have a policy, in addition to being a small municipality, there are municipalities that have very low financial resources, and then it generates several problems [...]. (G1)

A difficulty that is not just mine is the question of resources. Currently, there is a lot of service to be offered and a lot is demanded of us, what is lacking is financial incentives, which is one of the difficulties. (G15)

Municipal managers recognize the need for actions to promote MH, including in spaces that go beyond health services. Nonetheless, they highlight that there are difficulties in implementing these actions, since curative actions demand more attention than those aimed at promoting MH and preventing mental illnesses.

I have a lot of plans about that. Not only with mental health, but with health in general. I like to work with prevention and health promotion, but we don't have the opportunity, we feel overwhelmed (by the demand). (G20)

I think what we could be helping (in promoting mental health), with an increase in the number of professionals to help, maybe larger spaces [...] some better spaces with swimming pools, psychological care, could be improving. It's not that we don't have problems, but this could be improving. (G11)

With the restriction of financial resources for investment in health in general, other difficulties to develop care in MH become evident in the reports. The limitation in hiring specialized personnel and in the availability of an adequate physical structure for services should be

highlighted, which affects the care of individuals with MD. With this, the actions of treatment, promotion, prevention and rehabilitation in MH become impossible to be carried out.

Lack of structure, physical and professional structure. You can see, these are resources (lacking) actually [...]. (G19)

[...] the patients that go to the hospital are the ones that are in outbreak. He arrived in an outbreak, the referral is hospital. We have no way to keep him here, we have no space, nor how to take him out of the crisis here. He goes with the ambulance from the municipality. (G8)

Coupled with financial difficulties, the lack of professional qualification is seen by managers as an aggravating factor for the care of users with MD, and the need for more training for PHC professionals is reported.

Employees, for me, the biggest problem is really the lack of committed employees, lack of training, as I said, recently, the policies are improving, but today let's say what I think (I can say that I've been sure for 8 years) here is really the lack of employees committed to mental health. (G15)

I believe that there is a lack of improvement in the structuring of the program, more training for professionals, not only professionals from primary units, but professionals who will assist in hospitals, in such a way as to have communication among all sectors. (G16)

In addition to the qualification of professionals, another highlighted point is the difficulty in assisting individuals with MD due to the stigma and fear that permeate the actions of health professionals. This is also intensified by the lack of knowledge about how to develop MH care outside the specialized service.

I think it's the prejudice that only some professionals are able to do. When you go to the primary care unit itself, you perceive that the professional has this resistance, you can't implement many things because we are often left aside [...]. (G20)

People's prejudice, right?! Lack of knowledge in dealing with it. Furthermore, we as managers, as professionals, have a certain difficulty [...]. (G17)

DISCUSSION

According to municipal health managers, the

CAPS and the hospital care for crisis containment were the two devices most mentioned during the interviews. It is known that the CAPS are strategic institutions for the organization and redirection of the service flow of the care network to MH⁽¹⁾.

In addition to the CAPS, the implementation of PNSM involves the humanization and centrality in the needs of people with MD and the development of strategies focused on continuing education and harm reduction in these services. Moreover, it must promote the rehabilitation and reintegration of users into society, through work, income and housing, and ensure access to all services available in the RAPS, with improvement in their quality⁽²⁾.

It is important to highlight that the deinstitutionalization process does not only portray the de-hospitalization of people, but refers to the construction of practices and knowledge that form ways of perceiving, understanding and relating to political and social issues carried out by psychiatric hospitals⁽⁹⁾.

In the quest to ensure access, comprehensiveness and resoluteness in health services, it is necessary to improve the flow of patients, from the reception to the exit from the service. In this sense, it is up to the health services, articulated at different levels of complexity, to ensure comprehensive care. For this purpose, it is necessary to recognize which care practices in MH are really necessary and which require organization and interaction with the network, thus avoiding unnecessary referrals that lead the patient to get lost within the network and generate fragmentation of care^(10, 11).

Regarding the use of medications in the MH area, numerous psychosocial practices can be implemented and articulated in conjunction with drug treatment, aiming at restoring autonomy and improving mental condition. One can mention integrative and complementary practices (ICP), such as homeopathy, acupuncture, hydrogymnastics, music therapy, community therapy, participation in art groups, in addition to the construction of an Unique Therapeutic Project, among other strategies⁽¹²⁾.

Recent studies have shown that, in addition to the focus of care in MH being on medicalization to the detriment of other therapeutic actions, it

has also been centered on the physician rather than on the multidisciplinary team⁽¹³⁾. Such practice goes against the principles of the RAPS, which proposes multidisciplinary and interdisciplinary action.

In order to achieve the comprehensiveness of care in MH, it is necessary to organize and make PHC co-responsible for the care and its articulation with other services in the network^(13,14). In this context, matrix support is essential, since it offers technical-pedagogical support to primary care, enabling greater knowledge about the RAPS and enhancing the interventions carried out. It also enables teamwork, qualified listening and co-responsibility⁽¹⁵⁾.

It is up to health professionals to monitor individuals with MD and their relatives, and the home visit (HV) is an important tool, as it allows understanding the situation experienced by families and directing actions, obtaining more effective results⁽¹⁶⁾. HV with the multidisciplinary team allows to expand the bond between the patient with MD, his/her family and PHC, becoming a means for qualified listening, understanding and development of joint actions. Accordingly, the greater the expansion of this bond, the better the implemented therapy will be, obtaining satisfactory results in the quality of life of the patient and his/her family⁽¹⁷⁾.

The family is a strong ally in the process of monitoring, building bonds and treating patients with MD. Due to its greater proximity and coexistence, it is better able to monitor the health-disease process and the treatment of its member⁽¹⁸⁾. Therefore, it is essential to carry out actions to support and strengthen the family network, integrating it into the process of care and construction of the Unique Therapeutic Project, clarifying doubts and providing tools for dealing with possible existing problems⁽¹⁶⁾.

The promotion of MH and prevention of mental disorders must be part of the daily routine of health services. Among the actions for the promotion of MH carried out by PHC, one can mention welcoming, guidance, family support, educational activities and construction of the family genogram. In the primary prevention in MH, actions are taken that seek to prevent new specific mental disorders from appearing in the community⁽¹⁾.

Studies show that a better structuring of PHC is necessary so that joint actions for the promotion and prevention of MH are put into practice. For this purpose, more training is needed for the multidisciplinary team and better communication with the other points of the RAPS^(4,12,19).

Funding is considered insufficient for the full implementation of the various components of the RAPS, being a problem of great impact, as well as the difficulty of integrating MH in primary care and the unsustainability of patients in the service⁽¹¹⁾.

Even with the advances observed in the structure of health services, problems still persist, with strong structural inequalities among municipalities due to characteristics of a certain region, their population size, the Human Development Index (HDI) and the coverage of FHS⁽²⁰⁾.

The absence of professional training in MH can make it difficult to develop the necessary changes so that the care offered is in accordance with what is recommended by PNSM. The number of PHC professionals with training in mental disorders is still small, due to the focus on other groups, the existing difficulties and the reduced interest of workers in the topic⁽¹⁹⁾.

Nurses from PHC point out that they feel unprepared to work with actions aimed at the promotion, prevention and treatment of people with mental disorders, as a result of the lack of support from managers; absence or deficiency of the topic during graduation; or lack of a reference flow in the RAPS⁽²¹⁾.

Many professionals still see the person with MD as aggressive, incapable, dangerous, which ends up interfering in their approach and in the care to be provided. This perception was built over the years and is still in the process of demystifying with the Psychiatric Reform, which proved that the patient with MD is able to be socially inserted, with treatment and adequate attention to his/her health needs⁽²²⁾.

However, it is perceived that the stigma and prejudice aimed at patients with MD result in the fragmentation of their treatment, as the care that should take place in an integrated manner, without professional or location distinction, becomes dichotomized in various areas of knowledge, leading to partiality of care in

MH⁽²²⁾.

Considering the countless difficulties that must be overcome, it is essential to define and implement PNSM as one of the priority health needs of municipalities, based on up-to-date scientific data in line with human rights. It is equally important to involve all people with expertise in MH for its construction, joining efforts to continue the progress already achieved in our country⁽¹¹⁾.

FINAL CONSIDERATIONS

The results allowed us to understand that the perception of health managers about PNSM is still fragmented, both in relation to the organization and structuring of the RAPS, as well as the knowledge about the possible actions to be carried out for the promotion, prevention, rehabilitation and treatment of MH.

It was possible to identify some barriers that need to be overcome for the care in MH to be effective in accordance with PNSM, some of which are possible to intervene, such as professional training, improvement of the physical structure and reduction of the stigma coming from the professionals who provide the care. Nonetheless, other difficulties require actions that go beyond the sphere of the municipal health manager, such as the availability of financial resources and specialized professionals.

Moreover, the lack of visibility among health managers about the role of the services that

make up the health care network in MH is noticeable, especially in the scope of PHC, as it is there that welcoming and promotion/prevention actions in relation to mental disorders should take place, requiring greater understanding of management for this care device.

In this scenario, the nursing professional needs to build, together with the multidisciplinary team, care strategies for the population with MD, overcoming obstacles to the development of the minimum actions established by PNSM at the three levels of health care, seeking to provide comprehensive and humanized care to the patient and his/her family.

The limitations of the study may be related to the option for individual interviews, as group strategies could provide a joint reflection on the RAPS in these municipalities. In addition, the data collection process was prior to the recent changes in PNSM, characterized by setbacks to the care model and the emphasis on hospitalization. In this sense, the opinion of managers must be understood based on the precepts prior to these changes.

The contributions of this research in the field of health management should be highlighted, as a way of expanding knowledge and discussion about the potentialities and difficulties in implementing PNSM, in order to encourage continuous and comprehensive care, with qualified professionals and an interconnected network for quality of care.

PERCEPÇÃO DE GESTORES MUNICIPAIS DIANTE DA IMPLEMENTAÇÃO DA POLÍTICA DE SAÚDE MENTAL

RESUMO

Objetivo: apreender a percepção dos gestores de saúde sobre a implementação da Política de Saúde Mental nos municípios pertencentes a 5ª Regional de Saúde do Estado do Paraná. **Métodos:** estudo de abordagem qualitativa e caráter exploratório, realizado nos meses de fevereiro e março de 2015. Foram entrevistados 20 gestores de saúde da 5ª Regional de Saúde, por meio de entrevistas semiestruturadas. A análise dos dados foi desenvolvida segundo o método de análise de conteúdo de Bardin, modalidade temática. **Resultados:** emergiram duas categorias: “A percepção dos gestores sobre a SM nos municípios” e “Dificuldades para a implementação da PNSM”. Os gestores de saúde destacam a necessidade da melhor implementação da Política de Saúde Mental em seus municípios e a adequação da Rede de Atenção Psicossocial. As dificuldades enfrentadas são a falta de recursos financeiros, capacitação profissional e preconceitos. **Considerações finais:** é perceptível a falta de visibilidade entre os gestores em saúde sobre o papel dos serviços que compõem a Rede de Atenção à Saúde Mental, especialmente a atenção primária, pois é a principal responsável pelas ações de acolhimento e de promoção e prevenção aos transtornos mentais.

Palavras-chave: Saúde mental. Serviços de saúde mental. Gestor de saúde. Política de saúde.

PERCEPCIÓN DE LOS GESTORES MUNICIPALES ANTE LA IMPLEMENTACIÓN DE LA

POLÍTICA DE SAÚDE MENTAL

RESUMEN

Objetivo: compreender la percepción de los gestores de salud sobre la implementación de la Política de Salud Mental en los municipios pertenecientes a la 5ª Regional de Salud del Estado de Paraná-Brasil. **Método:** estudio de enfoque cualitativo y carácter exploratorio, realizado en los meses de febrero y marzo de 2015. Se entrevistaron a 20 gestores de salud de la 5ª Regional de Salud, mediante entrevistas semiestructuradas. El análisis de datos se desarrolló según el método de análisis de contenido de Bardin, modalidad temática. **Resultados:** surgieron dos categorías: “La percepción de los gestores sobre la SM en los municipios” y “Dificultades para la implementación de la PNSM”. Los gestores de salud señalan la necesidad de una mejor aplicación de la Política de Salud Mental en sus municipios y la adecuación de la Red de Atención Psicosocial. Las dificultades a las que se enfrentan son la falta de recursos financieros, la formación profesional y los prejuicios. **Consideraciones finales:** es perceptible la falta de visibilidad entre los gestores de salud sobre el rol de los servicios que componen la Red de Atención a la Salud Mental, especialmente la atención primaria, por ser la principal responsable de las acciones de acogida y de promoción y prevención de los trastornos mentales.

Palabras clave: Salud mental. Servicios de salud mental. Gestor de salud. Política de salud.

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