Mental health care management in the Brazilian National Health System*

GESTÃO DA ATENÇÃO À SAÚDE MENTAL NO SISTEMA ÚNICO DE SAÚDE

GESTIÓN DE ATENCIÓN DE LA SALUD MENTAL EN EL SISTEMA ÚNICO DE SALUD

Sônia Barros[1], Mariana Salles[2]

ABSTRACT

This article puts in context and evaluates the historical and political process of the Brazilian Psychiatric Reform. The goal is to provide a brief retrospective and analysis of the management mechanisms that have permitted the Psychiatric Reform to advance. This historic process is divided into three periods: the implementation of deinstitutionalization, the expansion of the psychosocial support network, and the consolidation of the reformist hegemony. It is verified that the Brazilian Psychiatric Reform advances as management mechanisms are created to increase the service network. Nonetheless, consolidating the territorial support network and increasing the resources of the annual mental health care budget of the national health system remain a challenge.

DESCRIPTORS

Mental health
Health Services
Politics
Unified Health System

RESUMO

Neste artigo é realizada uma contextualização e avaliação crítica do processo histórico e político da Reforma Psiquiátrica Brasileira. O objetivo é fazer uma breve retrospectiva e análise dos mecanismos de gestão que têm possibilitado o avanço da Reforma Psiquiátrica. Este processo histórico é dividido em três períodos: a implementação de estratégias de desinstitucionalização; a expansão da rede de atenção psicossocial e a consolidação da hegemonia reformista. Verifica-se que a Reforma Psiquiátrica no Brasil avança na medida em que mecanismos de gestão são criados para ampliar a rede de serviços. Porém, permanecem desafios para consolidar a rede de atenção territorial e aumentar recursos do orçamento anual do Sistema Único de Saúde para a Saúde Mental.

DESCRITORES

Saúde mental
Serviços de Saúde
Política
Sistema Único de Saúde

RESUMEN

En este artículo se realiza una contextualización y evaluación crítica del proceso histórico y político de la Reforma Psiquiátrica Brasileña. El objetivo es hacer una breve retrospectiva y análisis de los mecanismos de gestión que han posibilitado el avance de la Reforma Psiquiátrica. Este proceso histórico está dividido en tres períodos: la implementación de estrategias de Desinstitucionalización; la expansión de la red de atención psicosocial y la consolidación de la hegemonía reformista. Se verifica que la Reforma Psiquiátrica Brasileña avanza en la medida en son creados mecanismos de gestión para ampliar la red de servicios. No obstante, existen aún desafíos para consolidar la red de atención territorial y aumentar recursos del presupuesto anual del Sistema Único de Salud para la Salud Mental.

DESCRIPTORES

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[1]RN. Full Professor of the Maternal-Child and Psychiatric Nursing Department, School of Nursing, University of São Paulo. São Paulo, SP, Brazil. sobarros@ups.br [2]Occupational Therapist. Ph.D. in Health Care by the School of Nursing, University of São Paulo. São Paulo, SP, Brazil. marianasalles@uol.com.br

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INTRODUCTION

According to the Ministry of Health, the Psychiatric Reform process is a set of practical changes, knowledge, cultural and social values regarding *mad* and *madness*, but mainly regarding the public policies of dealing with the issue. It is s complex political and social process, comprised by authors, institutions and powers of different origins that affect different domains, in the federal, state, and municipal governments, universities, in the market of health services, professional councils, associations of individuals with mental disorders and their relatives, in social movements, and in the domains of the social imaginary and public opinion[1].

In the context of the creation and implementation of the Brazilian health reform, through the National Health System (*Sistema Único de Saúde* - SUS), in the early 1990s, the Ministry of Health Mental Health Care Coordination (*Coordenação de Saúde Mental do Ministério de Saúde* - COSAM), recognizing the poor quality of the psychiatric care in Brazil, and that this was a result mainly due to the health model of the time – centered on psychiatric hospital beds – stated priorities and proposed strategies for a transforming action in the field of Mental Health[2].

In the SUS domain, which regulation was completed in 1990, with the passing of Law 8,080 and Law 8,142, the operationalization of the system and the relationships between administrators were, since then, dealt by means of the Ministry of Health Ordinances, the Basic Operational Norms of the SUS (BON-SUS) and, more recently, the Health Care Operational Norms (HCON-SUS) and the Administration Pact (*Pacto de Gestão*)[3].

From the perspective created by the BON-SUS, the Mental Health area, in the federal level, took an important step to permit the changes in the health care model, which was the diversification of the procedures remunerated by the SUS, at the outpatient and hospital levels, as well as the regulation of health service work and the implementation of a system for the inspection of psychiatric hospitals[2].

The Brazilian Psychiatric Reform, from the perspective of using management mechanisms for its implementation and improvement, can be understood in three periods: the first, from 1992 to 2001, in which there was the implementation of deinstitutionalization strategies, by means of the first norms that permitted to experience humanization and hospitalization control, an increase in the mental health outpatient care and the beginning of financial support and the implementation of new substitute services; the second, from 2000 to 2002, marked by the approval of Law 10,216 of 2001 and the expansion of the psychosocial care network, with funding for the implementation of deinstitutionalization devices and the beginning of the expansion of the political agenda for new problems to be dealt with, such as the children and adolescents issues and substance abuse; and the third, from 2003 until today, marked by the consolidation of the reformist hegemony, with specific projects for specific situations, such as the *Going Back Home Program* (*Programa de Volta para Casa*) and a better connection of intersectoral policies.

The National Mental Health Policy, based in law 10,216/01, aims at consolidating an open and community-based mental health care model, i.e., assuring the free movement of people with mental disorders in services and in the city, and offering care based on the resources offered in the community. The objectives were: to reduce, in an agreed and programmed way, the low quality psychiatric beds; qualify, expand and strengthen the extra-hospital network formed by the Psychosocial Care Centers (CAPS), Assisted Living Facilities (ALFs) and Psychiatric Units in General Hospitals (PUGH); include mental health actions in primary health care; implement a comprehensive care policy aimed at users of alcohol and other substances; implement the *Going Back Home Program*; maintaining a permanent training program for the psychiatric reform; assure adequate and quality treatment to the transgressors with mental disorders (overcome the mental health care model centered on Judiciary Mental Health Hospitals) and continuously evaluate all psychiatric hospitals through the National Program for Hospital Service Evaluation (*Programa Nacional de Avaliação dos Serviços Hospitalares* - PNASH)[1].

In the perspective of a new health care model, it was also necessary for the administrators to develop a new look in order to create new coverage and assessment instruments.

In the perspective of a new health care model, it was also necessary for the administrators to develop a new look in order to create new coverage and assessment instruments. The indicators that were limited to bed/person medical appointment/person now defined the coverage in the community, among other aspects. It was also necessary to implement funding mechanisms of a network that could truly meet the needs of the national policy.

Therefore, this article makes a brief retrospective and analysis of the administration mechanisms that have permitted the Psychiatric Reform to advance.

The many administration reports of the Ministry of Health show that much has been done to meet the propositions of the Psychiatric Reform, with real advancements in the consolidation of a regionalized and integrated network, with the purpose to assure equitable and comprehensive mental health care. On the other hand, there is still a lot to be done.

In this context, some data demonstrate the changes to the administration of mental health care:

The Restructuring of Hospital Psychiatric Care

In 1997, there were 410,003 admissions to psychiatric units in the SUS. In 2001, there were 357,538 admissions, with a mean 29,759 per month. There was a 12.8% reduction in the frequency of admissions in the referred period. This data is in agreement with the policy of the Ministry of Health for that sector: reduce full admissions and increase day-hospital admissions and outpatient treatment[4].

Some administration instruments were essential for this reduction. Initiated in 1993, they include the supervision of Psychiatric Hospitals and the resulting loss of accreditation of those that did not have the minimum respect for patient rights.

Early in the millennium, in the second important period mentioned above, the Ministry of Health implemented the Ordinance GM/MS number 251, of January 31st, 2002, which established guidelines and norms for psychiatric hospital services, assigns psychiatric hospitals a new classification and defines the structure and the entrance to the psychiatric admissions in the SUS network. The psychiatric hospitals are classified based on an evaluation by the National Program for Hospital Service Evaluation (PNASH) and the number of hospital beds[5].

In 2002, almost all psychiatric hospitals were evaluated, resulting in humanization measures within the facilities, a reduction in the number of beds, and, in some cases, units were closed or the hospital was withdrawn from the system.

However, although the mental health legislation recommends reducing the number of beds in psychiatric hospitals and to prioritize extra-hospital treatment, more advancement is needed in terms of the crisis and consolidation of the substitute mental health care network in the territory[6].

Another important instrument involved in changing psychiatric hospital care was the Annual Program for the Restructuring of Psychiatric Hospital Care in the SUS-PRH, implemented in 2004, by the Ordinance GM number 52/04, which aimed making a progressive reduction of the size of the hospitals (160 beds or less). Hospitals of smaller size are technically more appropriate for good clinical functioning and effective integration with the extra-hospital network, while the contrary is true for macro-hospitals. In addition, it is assured that the reduction of beds follows a plan and, thus, does not cause any lack of care in places where the psychiatric hospital still has a strong participation in the care to people with mental disorders[7].

Therapeutic Residence

Another important initiative was the regulation of Ordinance GM/MS number 106 of year 2000, which created the therapeutic residences. Ordinance GM/MS number 1,220 of year 2000 created and included the health care procedures of the residences in the Ambulatory Care Information System of the SUS (SIA/SUS), thus permiting cities to truly implement the initiatives for the deinstitutionalization of patients submitted to a long asylum stay [5].

The Therapeutic Residence Service consist of houses organized to meet the housing needs of people with serious mental disorders, discharged from psychiatric hospitals, custody hospitals or in a situation of vulnerability. This is one of the main instruments for an effective deinstitutionalization[4].

The third stage of the Reform, the expansion and consolidation was one of the main concerns in the deinstitutionalization process of long-stay psychiatric patients. The funding mechanisms assured a fund-to-fund transfer of an incentive of 10 thousand reais for each module of eight occupants and covered the costs of the Therapeutic Residences, through the transfer of Hospital Admission Authorization Forms of the long-stay psychiatric beds that lost accreditation of the SUS to the Mental Health Program, which permits to close the year of 2010 with 570 Residences. However, the coverage of Residences in Brazil is still low[8].

The Going Back Home Program

Created by the Federal Law 10,708, in 2003, the Going Back Home Program is the achievement of a historical claim of the Brazilian Psychiatric Reform. Since the 1990s, there were attempts to create mechanisms for financial transfer to users, who after a long length of stay, could be discharged with enough resources to survive.

The objective of the Program is to make an effective contribution for the process of social inclusion of individuals with a long history of psychiatric hospitalizations, through a monthly payment of a rehabilitation support of R$320.00 to the beneficiaries. In order to receive the support, the individuals must have been discharged from a Psychiatric Hospital or a Custody Hospital and be referred to be included in a municipal program for social reintegration[8].

Despite the achievements over the last year, the number of beneficiaries of the Going Back Home Program remains very low – only 1/3 of the estimated number of long-stay in-patients in Brazil receives the support. In 2010, there were 3,635 beneficiaries[8].

Therefore, there is still a great difficulty to deinstitutionalize psychiatric patients with the most severe chronicity[8]. For instance, the State of São Paulo Psychosocial Census of Psychiatric Hospital Residents, performed in every psychiatric hospital of the SUS network, identified about 6,300 institutionalized people for over a year, that is, over 50% of the in-patients[9]. Despite some state administration mechanisms to fund municipal services, in 2011, there are approximately 300 Therapeutic Residences and the CAPS, which in 2005 were about 150, today are only about 260[8].

Health Care in the Territory

Another Ordinance considered essential for the Psychiatric Reform is the GM/MS number 336, of 2002, which established CAPS service modalities and defines their remuneration through the Authorization System for High Complexity/Cost Procedures (*Sistema de Autorização de Procedimentos Ambulatoriais de Alta Complexidade/Custo* - APAC) and its funding with resources from the Strategic Action and Compensation Fund (*Fundo de Ações Estratégicas e Compensação* - FAEC)[10]. This mechanism, implemented in the second stage of this Reform process, was essential for the development and consolidation of the model.

The CAPS developed slowly in the country, because its implementation competed with other items of the city budget. The FAEC funding assured that the cities that wished to implement a territorial work network, the necessary financial resources to maintain the services. Therefore, the Ministry of Health, in 2002, by establishing a specific *extra budget* funding mechanism for the daily care services, increased the resources for the creation of new services. In 1996, Brazil counted with 154 CAPSs, in 2001 there were 295 and, by October 2002, there were 348, with the new FAEC funding[10].

Brazil closed the year 2010 with 1,620 CAPS and coverage of 0.66 per every 100,000 inhabitants. The number of implemented services demonstrates the slow, but definitive reversion of the health care model. The amount of funding used for the hospital care devices, that was 94% in the early 1990's, was reduced to 80% in 2002[8].

These new CAPS also include those directed for the service of individuals dependent and/or abusers of alcohol and other substances (CAPSad), a model that was implemented in the National Health System domain through the National Program for Integrated Community Care for Users of Alcohol and other Substances (Ordinance GM/MS number 816 of April 30th, 2002)[5]. This Program was a significant advancement of the policies in the Mental Health area, because, for the first time, guidelines, a health care model, specific funding, and human resource development were created specifically for an area recognized as important, but to this point not prioritized by the Ministry of Health. Several strategies have been used to meet the needs of this population and deal with the increase of consumption, as well as the consequences on these individuals' health and social situation.

Mental Health in Primary Care

Since what we have referred to the first stage of the Psychiatric Reform, the Ministry of Health has encouraged the inclusion of guidelines that refer to the subjective dimension of the users and the most serious mental health problems in the expansion, formulation, formation, and evaluation of Primary Health Care.

With the institutionalization of the Family Health Strategy in most of the country, the strategy to implement Reference Mental Health Teams was organized with the administrators, and the cities have been increasingly adhering to this proposal, up to the creation of the Family Health Support Centers (*Núcleos de Apoio à Saúde da Família* - NASF). These *matrix services* consist of supervision, shared care, and training performed by a mental health team for primary health care teams or professionals[8].

In 2008, the Ordinance GM 154/08 recommended the inclusion of mental health care professionals in the NASF teams. This was one of the main advancements in the third period to include mental health care actions in Primary Care. The NASF are devices with a high potential to assure the connection between Family Health teams and the city's mental health teams, improving the accessibility and care of individuals with mental disorders and problems related to the use of alcohol and other substances.

Data from December 2010 informed that 1,288 NASF are currently in operation in the country. Of the 7,634 workers in these Centers, 2,349 or about 31% are workers of the mental health care area[11].

Advances in the Construction and Implementation of Intersectoral Policies

The great landmark of establishing intersectorality occurred in the last period with the 4th National Conference on Mental Health that proposes that the mental health field should no longer be disregarded as cross-sectional to several social policies. The intersectoral agreements should work together to establish guidelines, pacts, planning, follow-up and evaluation of policies, with the participation of their administrators and leaderships[12].

Some actions in the Mental Health area have the characteristic of bringing the integration of other public policies to the center of the administration setting and the everyday service routine. We can state some projects that have, particularly, demanded this activity: the Mental Health policy for children and adolescents, the Social Inclusion Program for Work, the Mental Health and Human Rights project, the Policy for Mental Health and Culture Intervention and the Crack Plan.

FINAL CONSIDERATIONS

The Psychiatric Reform process in Brazil advances as administration mechanisms are created and implemented to increase the service network.

In the federal domain, in the last four years, the absolute expenses with extra-hospital services and programs have doubled. In 2002, 24.82% of the SUS resources for mental health care were used in extra-hospital services and programs. In 2005, this investment reached 44.53%

overall. In 2010, it was found there was an effective reorientation of mental health funds, in a way that, for the first time, the extra-hospital domain overcame the hospital component[8].

Nevertheless, in the federal domain, 2.3% of the annual SUS budget is devoted to Mental Health. Efforts must be made to increase the resources devoted to mental health to at least 3% of the health care budget in the next biennium, highlighting that the World Health Organization recommends that it should be *more than 5%* of the global health budget. Similarly, it is necessary to create resources in other Ministries for intersectoral projects[8].

In the current setting, we agree with the evaluation by the Ministry of Health Mental Health Coordination, that there is a tendency of reversion of the hospital model to a significant growth of the community-based extra-hospital network[8].

However, we experience a time when the pressure from corporations and professionals, legislators against the reform, university sectors and negative statements in the press, try to disqualify the reform process and eventually favor the strategies of the Federal Government and some State Governments that result in compulsory hospitalizations and imprisonment processes that aim at an eugenic cleansing of the cities, without any qualified debate about the existing problems.

On the other hand, some mechanisms must be reviewed and improved. For example, the monthly support mechanism (federal support) of the Therapeutic Residences was one of the largest obstacles for the expansion of SRT over the last years.

Another serious issue is the human resources for the service network. Despite the existence of resources and programs, they have proved insufficient for the needs of training the mental health network workers. Most of these workers eventually follow the Psychiatric Reform model and are educated in schools that (mostly) teach the medical-centered and biological care model. It becomes clear that there is a need to propose and implement projects for large-scale training/qualification.

Therefore, many challenges persist in terms of implementing and expanding a community-based and territorial health care network that promotes the social re-inclusion and citizenship. Some fundamental challenges are to increase the resources of the annual SUS budget for Mental Health, and, especially, to increase the Federal support for the CAPS so it becomes closer to the real cost demands of these services, thus permitting the expansion of the CAPS network, especially CAPS III.

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Correspondence addressed to: Sonia Barros
Av. Dr. Enéas de Carvalho Aguiar, 419 – Cerqueira Cesar
CEP 05403-000 – São Paulo, SP, Brazil