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Deinstitutionalization and network of mental health services: a new scene in health care

Desinstitucionalização e rede de serviços de saúde mental: uma nova cena na assistência à saúde

Desinstitucionalización y red de servicios de salud mental: una nueva escena en atención médica

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ABSTRACT

Objective: to analyze the process of deinstitutionalization resulting from a psychiatric hospital shut down, and know the fate of users after dehospitalization. **Method:** a descriptive, qualitative study based on the critical-analytical perspective, which had as its setting the *Hospital Colônia de Rio Bonito*. Institutional documents and narratives of five managers who participated in the deinstitutionalization process were analyzed. **Results:** *Hospital Colônia* deinstitutionalization lasted longer than expected. For this to happen, a tripartite intervention was necessary, and especially the mobilization of networks and implementation of Psychosocial Care Networks by the cities. Regarding destination of users, most were referred to therapeutic or transinstitutionalized residences. **Final considerations:** *Hospital Colônia* deinstitutionalization led to the establishment of connections between services and people. This was a powerful device for the implementation of Psychosocial Care Networks at municipal level.

Descriptors: Deinstitutionalization; Health Care; Mental Health Services; Public Policy; Nursing.

RESUMO

Objetivo: analisar o processo de desinstitucionalização resultante do fechamento de um hospital psiquiátrico, e conhecer o destino dos usuários após a desospitalização. **Método:** estudo descritivo, qualitativo, fundamentado na perspectiva crítico-analítica, que teve como cenário o Hospital Colônia de Rio Bonito. Foram analisados documentos institucionais e narrativas de cinco gestores que participaram do processo de desinstitucionalização. **Resultados:** o processo de desinstitucionalização do Hospital Colônia durou um tempo maior que o esperado. Para que se concretizasse, foi necessária uma intervenção tripartite e, especial, a mobilização das redes e implementação das Redes de Atenção Psicossocial pelos municípios internantes. Quanto ao destino dos usuários, a maior parte foi encaminhada para residências terapêuticas ou transinstitucionalizada. **Consideraç**ões **finais:** o processo de desinstitucionalização do Hospital Colônia provocou o estabelecimento de conexões entre serviços e pessoas, inferindo-se que este foi um dispositivo potente para a implementação das Redes de Atenção Psicossocial em âmbito municipal.

Descritores: Desinstitucionalização; Assistência à Saúde; Serviços de Saúde Mental; Políticas Públicas; Enfermagem.

RESUMEN

Objetivo: analizar el proceso de desinstitucionalización resultante del cierre de un hospital psiquiátrico, y conocer el destino de los usuarios después de salir del hospital. **Método:** Estudio descriptivo, cualitativo, que tuvo como escenario el *Hospital Colônia de Rio Bonito*. Se analizaron documentos institucionales y narrativas de cinco gestores que participaron del proceso de desinstitucionalización. **Resultados:** el proceso de desinstitucionalización del *Hospital Colônia* duró un tiempo mayor que lo esperado. Para que se concretizara, fue necesaria una intervención tripartita y, especialmente, la movilización e implementación de las Redes de Atención Psicosocial por los municipios que internaban. Cuanto al destino de los usuarios, la mayor parte fue encaminada para residencias terapéuticas o transinstitucionalizadas. **Consideracion finales:** el proceso de desinstitucionalización del *Hospital Colônia* provocó el estabelecimiento de conexiones entre los servicios y las personas, deduciéndose que este fue un dispositivo potente para implementar las Redes de Atención Psicosocial en el ámbito municipal.

Descriptores: Desinstitucionalización; Prestación de Atención de Salud; Servicios de Salud Mental; Po*líticas Públicas; Enfermerí*a.

INTRODUCTION

In the late 1970s, under the influence of social movements criticizing psychiatry around the world, the process of psychiatric reform began in Brazil. This reform aims to build an ethic of mental health care and ensure the rights and citizenship of people with mental disorders. Assuming it as a social and cultural process, one goes beyond the idea of operating changes only in the services that serve this population, breaking with the exclusivist biomedical logic of the pathological concept that involves madness[1].

The Brazilian Psychiatric Reform gained strength mainly from the late 1980s, along with the *Sistema Único de Saúde* (SUS - Brazilian Health System) and mobilizations for country redemocratization. From then on, mental health conferences and congresses gain visibility. The first Psychosocial Care Center (CAPS - *Centro de Atenção Psicossocial*) is created, nursing homes are shut down, and Therapeutic Residential Services (SRT - *Serviços Residenciais Terapêuticos*) are established. The feasibility of its implementation occurred with the sanction of several laws and ordinances, especially Law No. 10,216 of 2001, known as the Psychiatric Reform Law. This law aimed at protecting the citizenship rights of users and proposed redirection of the care model. Understanding that breaking with the segregating logic implies more than shutting down asylums and opening therapeutic residences[2-3], it is important to cite Ordinance No. 336 of 2002. This Ordinance established CAPS as priority care devices. Law No. 10.708 of July 31, 2003 created the Homecoming Program (*Programa de Volta para Casa*), enhancing deinstitutionalization through financial aid for long-term graduates, making life outside the walls of psychiatric hospitals more viable.

Another important milestone in shaping the Brazilian National Mental Health Policy (*Política Nacional de Saúde Mental*) was the implementation of the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*), established by Ordinance No. 3088 of 2011[4]. This Ordinance articulates the fundamental devices for the advancement of Psychiatric Reform such as Street Outreach Offices and SRT that should offer differentiated care to people with mental disorders. Within its scope, the Deinstitutionalization Program[5] was created, which aims to remove psychiatric hospitals from the scene, significantly reducing their hospital beds[6].

In Brazil, even in the face of difficulties in consolidating SUS, its basic principles permeate the perspective of mental health care, seeking a subject-centered practice that goes beyond the health sector. However, it is necessary to overcome the fragmentation of services, based on Health Care Networks (RAS - *Redes de Atenção à Saúde*), understood as a tripartite construction process, of horizontal and dynamic organization of services. Notwithstanding the many challenges for their real articulation and alignment, RAS are an innovative arrangement that is coherent with the principles and guidelines of the SUS through which the integrality is achieved[7-8].

While many advances can be seen, such as increasing CAPS coverage and its place as a network and care organizer, there are still many challenges in consolidating mental health care practices consistent with Psychiatric Reform principles[9]. Psychiatric hospitals, for example, still play an important role in many situations in which, for CAPS, the possibilities of crisis contour are exhausted, or in which the user is or exposes third parties to risk situations, thus justifying an internment for social reasons. In this connotation, walls often gain a protective character and are seen as a unique resource in a given context, by professionals, family members and even users who are in vulnerability[10].

Despite the recognition of psychiatric hospitals bankruptcy as care institutions, Ordinance No. 3588 of 2017 was implemented. The daily psychiatric hospitalization value increased and proposed the increase of psychiatric beds, potential incentives for hospitalization. This denotes a marked loss for the advance of the deinstitutionalization proposal in the country. In addition, it therefore points to a setback in the Psychiatric Reform movement as it establishes a new direction of mental health policy.

In this setting, deinstitutionalization guideline adoption requires the implementation of new ways of dealing with madness, developing services and user-centered actions that work with the logic of the expanded clinic and that have the territory as a locus of action[3,9,11].

However, after some years of RAPS implementation in the country, and facing setbacks in the direction of public policies on mental health, there are some gaps and dissonances about the possibility of adding essential attributes of Psychiatric Reform, as well as its innovative power in care. Despite many advances in mental health care such as the expansion of community-based territorial services and the significant shut down of beds and psychiatric hospitals, it is necessary to know how networks have been organized to care for users outside segregation spaces, if they are and how they are working to get users into life and the city.

OBJECTIVE

To analyze the process of deinstitutionalization resulting from a psychiatric hospital shut down, and know the fate of users after dehospitalization.

METHODS

Ethical aspects

This is a research involving human beings, being submitted to the Research Ethics Committee of *Hospital Universitário Antônio Pedro* of *Universidade Federal Fluminense*, with approval in July 2017. All recommendations of the Brazilian National Health Board (*Conselho Nacional de Saúde*) Resolution No. 466/12 were followed. Signing of the two-way Free and Informed Consent Form was included, as well as clarification of the risks and participation in the research through recorded interviews.

Type of study

It is a descriptive, qualitative research, based on the critical-analytical perspective, understood as a possibility to understand the social phenomenon investigated. This study endowed hermeneutics as a methodological way to ground qualitative research, allowing to value the relationships and practices of the studied phenomenon. For this method, there is no impartial observer - values subjectivity, allowing a critical understanding and allows closer approximation with the real. It is a method that allows greater understanding of the phenomenon of madness and

shutting down processes of psychiatric hospitals, as it enables the identification of differences and similarities, seeking to understand the reports and relate them to the historical social context.

Study setting

The research had as setting the *Hospital Colônia de Rio Bonito* (HCRB). This is a large private psychiatric institution located in Rio Bonito, Metropolitan Region II of the state of Rio de Janeiro.

Data source and study participants

Institutional documents pertinent to deinstitutionalization were constituted as data source, especially records related to discharge and destination of HCRB patients, and narratives[12-14] produced by participants.

Seven health managers were invited to join the study. It was considered as inclusion criteria to have effectively acted in shutting down the HCRB, at the municipal and/or state level. Of these, five became available, thus conforming the sample of this research.

Collection and organization of data

Data were collected through documentary research and five open interviews conducted at the participants' place of operation, in August and September 2017.

The documents analyzed in the scope of this study were previously made available by the interviewed managers. In possession of this material, a primary evaluation was carried out to select and organize the relevant documents to the research proposal, followed by reading and highlighting the information of interest.

Narratives produced by interviewees were recorded and then fully transcribed and identified by the letter N (narrator), followed by a number corresponding to the chronological order of the meetings.

Data analysis

Document appreciation happened through exhaustive reading, guided by a script prepared from the objectives of the study. It was composed of topics of interest, such as hospital history, shutting down and deinstitutionalization process and data related to discharge and destination of hospitalized patients.

Narratives, in turn, were analyzed according to the method of hermeneutics[15]. This method was chosen because it is useful to understand the social dynamics, choices and perceptions of individuals in dynamic and non-neutral fields, such as mental health services. Therefore, after interview transcription, a first general reading of the set of statements was carried out, identifying the main themes on which they addressed. Then, exhaustive reading of each narrative was conducted to apprehend the individual experience of the deinstitutionalization process, based on information and experiences impregnated by the encounter that each one could establish with that action.

From this process of critical analysis, two categories were elaborated: "Deinstitutionalization Process: The Beginning of a New Scene" and "What Destination Did HCRB Patients Have?" The first category addresses hospital shut down and RAPS broadening based on the narratives of the subjects involved in the process under analysis. They were grouped into scenes that synthesize HCRB's deinstitutionalization path. The second category, in turn, deals with the fate of users after their hospitalization.

RESULTS

Inaugurated in 1967 and affiliated to SUS, the HCRB treated about 15,000 patients by 2016. As a result, it closed its doors, following a public intervention by the three federated entities, mainly motivated by complaints about poor care conditions, structural precariousness and significant numbers. of patient deaths, later confirmed by the State Prosecutor.

The four-year HCRB deinstitutionalization process (2012-2016) was conducted by the Mental Health Management of the state of Rio de Janeiro. The management supported and advised the interning cities to know and receive patients in their place of origin. It is about this process that the categories of analysis address.

Deinstitutionalization Process: The Beginning of a New Scene

To present the results, deinstitutionalization that took place at HCRB was taken as a movie, a kind of drama. For this reason, it was decided to describe his shut down in shots, in real life scenes of who led this process: managers, understood here as narrators of this story.

Scene 1: The Beginning

> *The first thing was to propose a clinical census of patients. The city of Paracambi started with a psychosocial clinical census. Hospital do Carmo, which was the first one we closed, was census. Because this census was almost an intervention in itself, because in addition to mapping cases and patients, you had a general clinical and psychiatric assessment of each. We also had a social assessment, in the sense of knowing who had or had not family; who received or did not visit; who counted or not with benefit, who did not count, but could tell because he was entitled, who counted, but did not enjoy the benefit, anyway. Today, if I'm not mistaken, census has been taken in most hospitals in the interior of the state. As it was built, the census was adapted to various situations, opening up a range of possibilities for those who were hospitalized and for working with them. So that's why we understood that this census was already an intervention, because this guy was going to be looked at as maybe never by a team.* (N1)

Scene 2: Setting Up to Close Doors

> *It was not about closing the hospital doors and getting everyone out, it was really about doing a deinstitutionalization process from within. We knew we had a process that was going to continue outside, but we knew we had a process that started inside the hospital, that we could minimally guarantee that these people would be cared for in their cities, after responsible departure and careful of them from the hospital.* (N4)

Scene 3: Organization for Change

> *Because this was a very careful action indeed, and we wanted to be able to guarantee, when I say guarantee, of course something escapes, but, in the main, is that the people were actually welcomed in the cities, that they did well, they were well, could be assured*

that they would be followed up. The cities sometimes had no resources, so this extended time, for me, has no justification other than the difficulty we had to make managers responsible for this, to understand that it was with themselves. Take it as a cause for you and not just as an obligation. (N1)

Scene 4: Reports

We had already received a complaint from the employees themselves about what was happening inside, in terms of lack of food, care, in short, this precariousness that we always hear about in hospitals. This led to a visit from the regional councils, a caravan of councils went to visit the hospitals, including Rio Bonito, and that was when it began somehow. These complaints accelerated the process that we had been trying very hard to do. (N1)

Scene 5: Interfederative Articulation

This plan involved the three entities, then there was the Tripartite Commission, which was set up since the census time, since the TAC [*Termo de Ajustamento de Conduta* - Conduct Adjustment Term]. *And that commission included the state, the county, and the federal government. The federal government was already monitoring and financing the action, because it was the one who passed the AIH and he put an extra resource; The state joined the census team and was committed to transfer 50,000 reais* [*reais* is Brazil's currency, which is about 12,500 US Dollars]/*month to the city by the end of the action, so it was a state co-financed action; and the city was the executor of the actions. The plan basically had funding, a fairly reasonable amount of money, the city's request for services, the partial request for services, so that the city would not have to bear any labor costs and the tripartite management of the process.* (N5)

Scene 6: Work Intensification

In the plan, there was prosecution of cities that had patients hospitalized there. Then, according to the diagnosis that had already been made by the mental health team, but was later supported by this technical team that assumed, according to the therapeutic plan of that set of patients that each city had, the city would have to implement those devices and remove their patients from there. And then, in the plan, the federal government forced to contribute resources in the cities according to the network that was defined for that set of cities, if I'm not mistaken were 18 or 20 cities that had patients in there, had cities out of state from Rio de Janeiro, I think it was Vitória and some from Minas Gerais and Bahia. This resource was passed on to the municipal health funds according to the design that was made by this team, so it was the city that had to establish therapeutic residences, to expand its CAPS. The state assumed the responsibility for the transinstitutionalization of patients who could not be followed in substitute services. This process, I think it started in 2010, I left there in 2012, I think we managed to reduce from 410 patients to 268, I don't have the exact numbers, but I think it was almost half in this whole process. Patients from Rio Bonito, right away, we already removed all of them, we implemented three therapeutic residences and turned the CAPS that was type 1 into CAPS III. (N4)

Scene 7: Action Strategies

We encouraged the cities involved with Rio Bonito to set up deinstitutionalization teams, so we had meetings inside the hospital, we forced the bar and they went to the hospital to attend. It was not to visit, but to effectively meet the people of their cities that were interned. Then, the projects were also discussed with the teams they were following from inside the hospital, the goal was to have a harmony in the work, in a perspective that the work inside and outside corresponded. (N1)

Scene 8: Complexity, Setbacks, Problems

The greatest problem we detected was really the lack of the network, the insufficiency of the network. Lack of therapeutic residences, sometimes very small teams and these teams needed to go to the hospital, needed to go to families, in short, a very complex job. (N3)

Scene 9: To Shut Down and Build RAPS

The network itself begins to have to structure itself. The interning cities are beginning to have to organize themselves in order to care for these patients, not only those who are leaving, but those that are emerging in their city. So you have to have a gateway, a minimally assembled service to be able to handle the clientele. (N2)

Our network is configured as follows, our gateway is the ECU [Emergency Care Unit], *it is the gateway of urgencies and emergencies. ECU makes contact with CAPS, and this is already well tied, because we have a protocol with ECU. ECU makes this contact informing that there is a patient who has been admitted to the emergency room, a psychiatric patient, and then the CAPS enters the evaluation of the technical team. And we evaluate the patient, who can stay in the ECU for up to 72 hours. If you do not have the remission of symptoms, we have the possibility of extending this hospitalization in the general hospital. There are three beds, including one bed is for childhood and youth. So we can use these beds to extend this hospitalization and it is a hospitalization along the lines of the Ministry of Health, because it is an internment in the territory, an internment assisted by the CAPS team and the general hospital team.* (N5)

From the narratives and documentary analysis, it was found that HCRB deinstitutionalization lasted longer than expected. The main reasons given were: slow bureaucratic and bidding processes; absence or precariousness of the network established in the interning cities, making it impossible to receive patients outside the asylum; untrained professionals in the field of mental health; resistance to deinstitutionalization; lack of patient documentation; fragile or absent family support; no financial income; and high turnover of professionals throughout the process.

If, on the one hand, the delay was longer than expected, on the other hand, it was possible to take a closer look at this process. Patients with more delicate clinical and social issues remained in the HCRB, so the deinstitutionalization team needed to take care of the hospital's physical space and food and hygiene issues to ensure a process of deinstitutionalization from the inside out. This situation did not happen without conflict. At first it was difficult to consider the organization of the asylum and then shut it down. Many regarded this act as a strategy for maintaining the institution, which proved false after the hospital's shut down in February 2016: forwarding an end to a new beginning.

What happened to Hospital Colônia de Rio Bonito users?

Following the Public Civil Action prosecution for HCRB deinstitutionalization by the Federal Prosecutor and State Prosecutor, the

main objective was to remove patients admitted to the hospital for a RAPS territorial assistance device, as directed by Law No. 10.216 of 6 April, 2001[16]. Each federated entity had its role determined in this action, and it took a shared movement to finalize the process. After agreement between the three spheres, managers made a commitment to receive users. In this sense, there was intense conversation in the various spaces of inter-federative articulation such as the Regional Management Commission (*Comissão Intergestores Regional*), Bipartite Management Commission (*Comissão Intergestores Bipartite*) and State Health Council.

Some cities found many impasses to receive these patients, because they do not count as a substitute network, with the necessary devices to absorb the demand. As a result of the Public Civil Action, hospital's doors were closed and, consequently, deinstitutionalization.

Table 1 shows that 255 discharges were computed in the period 2012-2016, of which 68 were given in 2012, the year in which the deinstitutionalization of hospitalized patients began.

Most patients were referred to therapeutic residences in their respective cities of origin (51%). It is noted that municipal networks were organized to receive these users and implying the strengthening of the deinstitutionalization policy. On the other hand, among those who were transferred to other institutions (19%), most were sent to other psychiatric hospitals, suggesting that the asylum-replacement device network is still deficient. Moreover, the fact that only 24% of patients are able to return to their families shows that there is still fragility or lack of affective ties with family members after a long period of hospital asylum.

Table 1 – Annual number of discharges from the Hospital Colônia de Rio Bonito after the start of the public deinstitutionalization civil action (N = 255), Rio Bonito, Rio de Janeiro, Brazil, 2017

Year	Discharges
2012	68
2013	35
2014	50
2015	43
2016	59

Table 2 - Destination of users after discharge from the Hospital Colônia de Rio Bonito due to public civil action (N = 255), Rio Bonito, Rio de Janeiro, Brazil, 2017

Destination	n	%
Therapeutic Residences	130	51
Family Return	61	24
Transinstitutionalization	48	19
Deaths	13	5
Housings	3	1

DISCUSSION

Deinstitutionalization represents a complex process that guides the actions of services and professionals, implies a work to rescue the subjectivity of people in psychological distress and proposes possibilities for life trajectories outside the hospital. However, it cannot in any way be reduced to the mere idea of dehospitalization. Care must be taken in freedom, but it is clear that hospital psychiatric institutions shut down per se does not guarantee the adoption of non-asylum practices. Deinstitutionalization alludes to full exercise of citizenship[1,16-20].

The institutionalization of psychiatric patients, not only in the HCRB, has had an effect of exile in their lives, resulting in loss of citizenship, values, obligations and social rights. In this sense, the deinstitutionalization process was configured as a rescue to life, inserting users into the life of cities. And this was possible, among other strategies, by the adoption of Singular Therapeutic Projects (PTS - *Projetos Terapêuticos Singulares*)[21], which need to consider the subject's lifestyle and must be built from the real needs of users.

Agreement between the three federative entities provided for the financial transfer for the expansion of outpatient care devices that would enable the cities to receive patients from the HCRB. However, there was a slowness in the organization of this action. There was a delay in the shutting down, lack of structural resources in the cities to receive patients, absence of establishing care networks, in addition to issues related to social stigma and fragile bonds between family and patients, making it difficult to return to their respective homes.

Since the beginning of HCRB shut down, the number of discharges has been progressive, culminating in shutting down hospital activities in 2016. Many patients had already lost ties with their families, mobilizing managers and professionals so that more patients were referred for SRTs.

Although many patients did not return home due to their families' structural needs, they were referred to the SRT. HCRB deinstitutionalization constituted an ethical need and concretely meant the possibility of rescuing patients' lives, restoring their citizenship and their right to live in freedom. In this understanding, SRTs cannot replace the asylum space, occupying the segregation function assigned to the hospital. They must enable the transit of people in the city, work on the autonomy of the residents and constitute themselves in houses inserted in the community[22-23].

Reflecting on the substitute network and the adoption of innovative care practices to counter the insane asylum ideas is necessary for the advancement of psychosocial care[11]. Therefore, it must be considered that the asylum goes beyond the physical space of the institutions, it represents the repression and violence used as sources of segregation and social isolation of the mentally ill subject[24]. Network replacement needs to be configured beyond physical space. To build a network that actually replaces the asylum, it is necessary to deal with anguish, contradictions and difficulties that surround the occupation of services and, above all, of the territory[10].

It is essential to take territory as a possible social place for mental health users, reducing the stigma attached to the mad subject and transforming the social relationships established with madness[25]. Shutting down a psychiatric hospital and the consequent deinstitutionalization demand new and different ways of thinking about mental health care, based on the person-centered care in its territory[26-27].

This reinforces the importance of expanding the number of CAPS III in a stronger and more articulated network to receive and not collect, and in a process of individual deinstitutionalization that moves away from asylum practices[10]. Moreover, health professionals prepared to intervene with strategies that ensure continuity of care outside the hospital.

It is necessary to adopt a care ethic[28] based on users and the territory and, for this, it is necessary to invest in professional qualification, seeking to develop care strategies that ensure integrated and networked psychosocial care.

In addition, managers need to be involved in deinstitutionalization in order to enhance the adoption of new possibilities for dealing with madness in society. Amid the scarcity of resources, it is imperative that policies and planning of actions and services have the network as their working direction[29-30].

Study limitations

This study has limitations regarding the inclusion of only one actor in the deinstitutionalization process. This is because the manager, as spokesperson for his institution, may have focused more on the positive points of shutting down the HCRB. Another limitation lies in the fact that the research has as its setting only one large psychiatric hospital, which does not mean that the reality found is the same in other Brazilian cities.

Contributions to nursing, health or public policy

The results of this study contribute to the development of deinstitutionalization strategies, understanding that asylum in a psychiatric hospital affects people's health and citizenship in various ways. Policymakers, managers and health staff should act to mitigate the harmful effects of this practice.

Deinstitutionalization is pointed out here as a potent and indispensable strategy for the consolidation of the Brazilian Psychiatric Reform and for the importance of strengthening RAPS in this process.

FINAL CONSIDERATIONS

Narrative analysis indicated that the process of deinstitutionalization of the HCRB lasted longer than initially estimated. For the action to take place, a tripartite intervention was necessary, and especially the mobilization of the networks and RAPS implementation by the cities of origin of institutionalized patients. From the documentary appreciation, it was found that most patients were referred to therapeutic or transinstitutionalized residences. A smaller portion returned to live with their families, given the socioeconomic conditions of the family context of most users.

The qualitative approach adopted by this study made it possible to unveil issues inherent to the deinstitutionalization process whose implementation is paramount and which corroborates the progress of Psychiatric Reform underway in the country. Managers', professionals' and users' perception involved in the process suggests that actions with this dimension enable the demystification of madness and enable the inclusion, in the city life, of people previously deprived of citizenship.

Considering that HCRB deinstitutionalization led to the establishment of connections between services and people, this was a powerful device for RAPS implementation at municipal level. However, it must be borne in mind that, in public health, something always escapes during the course of change. They are hampered by numerous financial, structural and political factors, demanding a daily struggle to maintain and improve the redirection of health practices.

In this case, after RAPS implementation, it must be made effective in the daily practice of services. Therefore, it is not enough to list and add the points of attention. It is necessary that a network of people, health services and territorial devices be formed, aiming at care from the perspective of psychosocial care.

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