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The production of care in psychosocial care services: home visits as an intervention technology to be used in the territory

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Abstract *Home visits are a technology used in mental health services to address individuals with mental distress and their families. The intent is to analyze different types of knowledge and professional practices related to home visits, grounded on the analytical framework provided by the Psychiatric Reform's dimensions, namely: theoretical-conceptual, technical assistance, legal-political, and sociocultural. This case study with a qualitative approach was conducted in a Psychosocial Care Center (CAPS) located in Fortaleza, Ceará, Brazil. Observation and semi-structured interviews were held with workers and later analyzed from a critical hermeneutic perspective. The results show the territory covered by the service is acknowledged as a social space in which individuals are allowed to express their experience/suffering and a place where care is produced. Home visits require the reorganization of work processes and the development of deinstitutionalization strategies, which in turn promote the patients' autonomy and contractual power. There are, however, challenges to be overcome, such as insufficient human resources and a lack of material resources. Additionally, workers have to deal with urban violence and impediments to cultural change in the way society deals with mental illness. Home visits are essential within CAPS as a strategy to dismantle the traditional asylum apparatus.*

Key words *Mental Health, House Calls, Mental Health Services*

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Introduction

The implementation of the territory-based psychosocial care model that resulted from the Brazilian Movement of Psychiatric Reform represents an innovation in the care provided to individuals with mental distress because of an ethical-political, aesthetic and technical break from the traditional type of treatment centered on the use of asylums as the dominant paradigm[1]. Such a rationale reduced individuals to a nosological category, disregarding the remaining dimensions of human existence – political, economic, psychosocial, cultural, spiritual, among others.

Therefore, the production of care in the psychosocial care model is based on therapeutic interventions implemented in the territory covered by the service, considering the application of the concept of health, the individuals' history, as well as integral and humanized care practices. Thus, the complexity of the health-disease continuum is recognized, as well as that the territory is an essential level at which healthcare practices are implemented[2]. That is, there is a new commitment to the production of knowledge and political, cultural, and legal interventions directed to individuals experiencing mental distress and in relation to insanity[3,4].

The production of care in the community area requires actions able to meet the multidimensional needs of people, taking into account the complex processes that are involved in care processes. The development of innovative intervention strategies and technology is necessary to improve the connection between mental health services and the various social and health devices existing in the territory in order to improve the access and participation of people with mental distress in social dynamics[4,5].

The concretization of this care model is made possible through the construction of a mental health care network with intersectoral cooperation. For that, the Ministry of Health has promoted the implementation of a Psychosocial Care Network (RAPS), in which Psychosocial Care Centers (CAPS) function as strategic devices intended to reorient practices and promote the deinstitutionalization of mental health care[5].

Indeed, the strategic nature of CAPS confers on it a key role in connecting care settings within RAPS, especially in relation to primary health care services through matrix support and sharing actions within the coverage territory with the Family Health Strategy (ESF), in connecting other sectors involved in healthcare delivery, by guiding mental health policies and programs, in implementing therapeutic interventions, while taking into account the individuals' social-contractual aspects, and in reflecting upon models of health care and mental health practice[2,4].

CAPS is supposed to transcend its institutional boundaries[5] when implementing territorialized care, as well as the idea that the territory in question is geographically bounded. That is, CAPS is supposed to incorporate the notion of a live territory, which is both a process and product of social relations, considering it is a social instance[6], a place of experiences and subjectivations. In this context, home visits emerge as a technology able to promote the establishment of bonds between the staff and their patients, families and territory. It is, therefore, an intervention that promotes greater interaction among the subjects, favoring workers coming to acknowledge the context in which this population lives, promoting the establishment of bonds and a better understanding of the families' structures and dynamics[7].

It is, therefore, important to problematize the role and scope of home visits in the reorientation of the care model, especially in taking deinstitutionalizing actions to materialize the obstacles hindering the proper delivery of psychosocial care. Such obstacles, widely addressed in the literature[2,4,8], include: the risk of reproducing asylum practices; the precarious nature of labor; poor infrastructure and insufficient material resources; and a lack of continuing education, among others.

Given the preceding discussion, this study's objective was to analyze the different types of knowledge and practices implemented by the CAPS team within the scope of home visits, based on the dimensions of Psychiatric Reform.

Theoretical-methodological framework

This study is based on the qualitative tradition of social research in the health field, the general design of which is a single case study[9], theoretically grounded on the dimensions of the Psychiatric Reform delimited by Amarante[10], namely the theoretical-conceptual, technical-assistance, legal-political, and sociocultural. These dimensions support the development of new mental healthcare practices, in addition to promoting critical reflection upon how work is organized and psychosocial care is produced.

The theoretical-conceptual dimension refers to the resignification of concepts underlying the

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know-how of Psychiatrics. It requires an epistemic attitude implicated with other forms in which knowledge is produced, based on the possibility of new empirical contact with the phenomenon – the experience of individuals. The technical-assistance dimension refers to the care model, the organization of the healthcare network, and interventions intended to meet the population's mental health needs. The legal-political dimension highlights a debate concerning citizenship and civil, social and human rights. Thus, it proposes that the legal framework be revised, as well as that specific legal standards be established to ensure patients exercise their citizenship. Finally, the sociocultural is a strategic dimension to reconfigure the relationship established between society and mental illness, mediated by new forms of sociability, which requires listening, respect, dialogue and an ethical-political commitment to provide opportunities for the coexistence of differences, at the same time in which the autonomy of individuals is acknowledged.

In accordance with the qualitative approach, we adopted a critical-reflective posture to observe the phenomenon in its uniqueness, interact with it and analyze how these individuals interpret their contexts within the scope of home visits. For that, an interpretative effort was made to connect the inter-subjective dimension to the material dimension within the scope of mental health practices.

The study setting was a CAPS located in Fortaleza-CE, Brazil, selected according to the following criteria: being among the three first CAPS implemented in the city; having permanent public employees composing the home-visits staff; and receiving students from the Mental Health Nursing Boarding School at the university with which the authors are affiliated.

The study's qualitative sample was composed of key informants, represented by four workers from CAPS: two nurses and two social workers. The participants' accumulated subjective experience with home visits was taken into account.

Data were collected during previously scheduled semi-structured interviews held in a private area. Interviews were audio-recorded and transcribed verbatim. Observation was also used and authorized by the staff and institution. In addition to nine home visits (three visits a week, on average), we also observed the service internally, totaling 40 hours of observation on different days and times.

The empirical material was analyzed based on the assumptions of critical hermeneutics[11,12], which is considered the art of understanding texts, especially human communication, including hidden meanings and contradictions emerging from individuals and their contexts. Communication, mediated by language, as a way to participate in the world, enables the composition of different and original meanings. Thus, the meaning of a text does not end with what was said, considering that understanding is always incomplete and an infinite process in which new sources of understanding emerge[11]. Hence, the organization of the *corpus* of information, coming from the transcription of the interviews, together with observations, enabled devising thematic categories that supported the development of the interpretative network (Figure 1).

In compliance with the ethical guidelines concerning research involving human subjects, this study was submitted to and approved by the Institutional Review Board at the State University of Ceará.

Results and discussion

The territory as a space to produce psychosocial care

An understanding that the territory is a space to implement psychosocial interventions permeates the discourse of the CAPS workers who make home visits, from multiple perspectives, which are analyzed here in light the Psychological Reform's dimensions.

The epistemological dimension, the essence of which is the reconstruction of knowledge underlying mental health practices, holds that the privileged space in which psychosocial care is delivered is transferred from the psychiatric hospital setting to the coverage territory, territory which, in addition to the physical dimension, encompasses a political and social dynamics:

The territory refers to the coverage area [...] the area in which we live (E1).

[...] not only is the geographical area delimited, but patients also have the right to be cared for. [...] Precisely, we have to work the issue of strengths existing in the territory (E4).

The territory, delimited in geographical terms, is under the health team's responsibility, whose duty is to connect policies and services, as well as connecting them to the care delivered to the population under the CAPS coverage[2,4]. Thus, the staff is supposed to encourage the participation of patients in the various spaces, facilitating

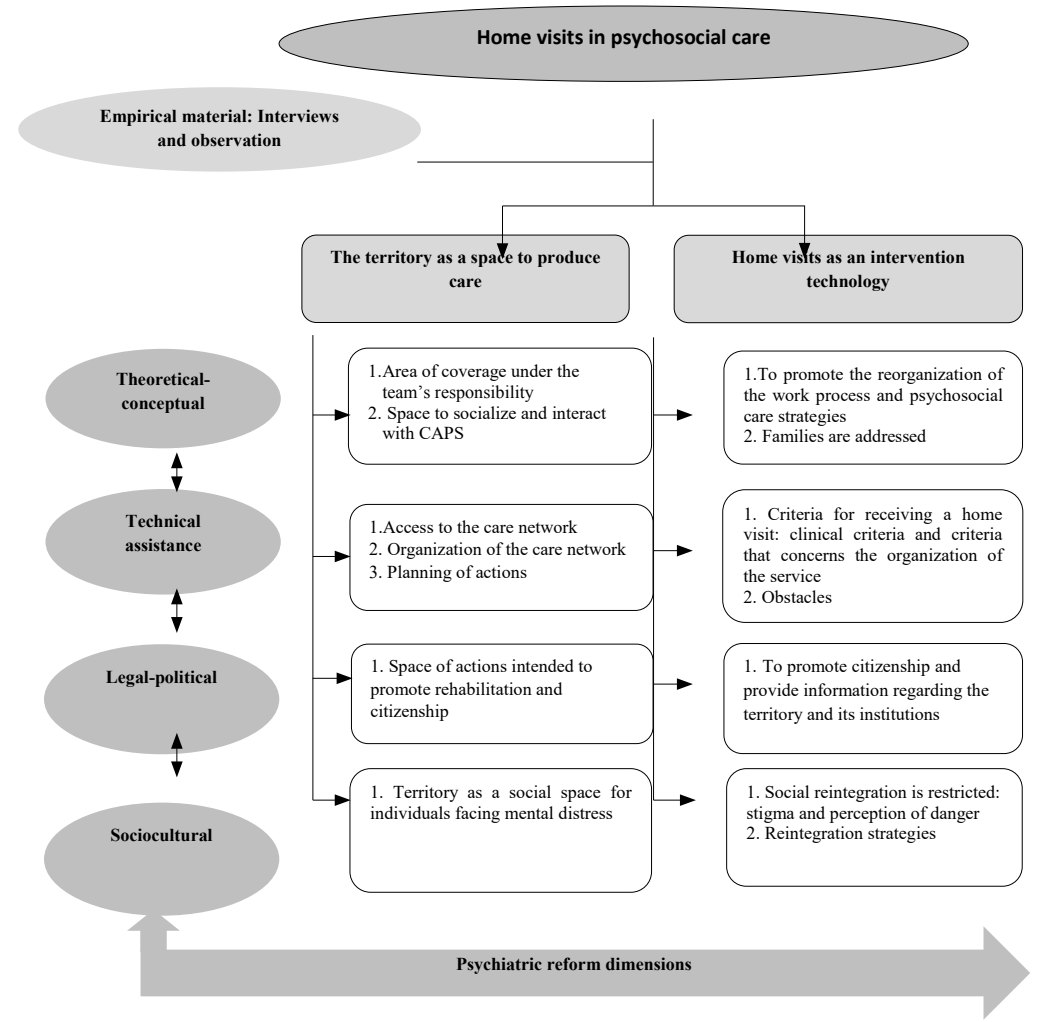

Figure 1. Interpretive network flowchart of home visits in psychosocial care according to the dimensions of Psychiatric Reform. Fortaleza (2019).

Source: Developed by the authors.

social reintegration and new ways to exercise their rights. Understanding the territory as a space where care is produced is relevant because it implies reconsidering the theoretical and practical grounds upon which therapeutic projects are developed, reorienting the mental healthcare model[1,13]. When workers recognize the resources existing in the territory, they are more likely to incorporate these resources in their care practices, subverting the logic of exclusion and furthering deinstitutionalizing practices.

The fact the work of CAPS is geographically delimited shows the political-administrative and legal division incorporated in the health system, in which the concept of territory is restricted to a geographical unit, which implies the need to expand such a notion and consider it from the perspective of Collective Health[14], particularly Mental Health; that is, the territory needs to be acknowledged as a space for the circulation of people, of socialization.

Even though the political-administrative and operational dimension seems to be centered on the territory's geographical extension, the workers report an understanding that this is a space where CAPS' patients can interact:

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I think it is easier for patients when they are familiar with this territory. Like, here at CAPS, I think it is important to receive the care they (patients) need, within the territory (E1).

The singularities of the population's social dynamics, translated into problems, conflicts, and needs that may become demands within the health services or require social protection should be accounted for when patients' access to goods and services within the territory itself is to be expanded. Additionally, each territory presents a demographic, epidemiological, administrative, technological, political, social and cultural profile, which characterizes it as a territory, a live space that is constantly changing[6]. As a consequence, the conception of territory shifts from an emphasis on the political-administrative to the sociocultural dimension, that is, from establishing boundaries between people, to the limits imposed by the body and affection among people[15].

In fact, the clinical practice within the CAPS is a way to provide care that results in a relationship among the service, the city and the patient's experience, in a complex cooperation that incorporates the notions of healthcare network and territory in its political, sociocultural and affective dimensions.

In regard to the technical-assistance dimension, the territory emerges in the workers' reports as being linked to access, organization of the healthcare network and the planning of care practices:

I believe access is facilitated. Everything patients need is available within the territory (E-2).

He can access all the institutions in the network, [...] from primary health care to specialized care (E-4).

Thus, there is recognition that the territory is a space in which to promote new interactions and care practices within the network, ensuring that patients have access to health services. The practice of territory confirms that law is complied with, that is, people experiencing psychological distress are supposed to have access to treatment that is appropriate to their needs, preferably in mental health community services[16].

Access is related to the availability of services, accessibility, organization of services, the warm reception of patients, meeting needs, and welcoming the population that seeks problem-solving capacity at all levels of complexity within the health service. All these aspects express the political-social dimension of access that should permeate the development and implementation of health policies[17], including the implementation of RAPS.

The organization of RAPS connects and integrates the services within the territory. CAPS is supposed to develop therapeutic projects based on integral care that is provided together with the ESF and the remaining social devices, according to the needs of each patient. One study, however, reports that access is hindered because of structural and organizational aspects of CAPS, in addition to poor intersectoral cooperation[18]. Managers and workers, in turn, indicate difficulties in the organization of RAPS, which are translated as disconnection among different services and an incapacity to assist all patients, which generates waiting lines and suppressed demand[4,8].

Nevertheless, Psychiatric Reform led to the reorientation of mental health services, requiring added care strategies and resources, in addition to the assumption that services are supposed to meet the territory's demand[19], aspects that are apparent in the reports of workers from CAPS:

[...] we must be familiar with the territory, its strengths and institutions, to use them as an ally in the therapeutic practices (E-4).

An appropriation of the territory with its various institutions, on the part of the CAPS staff, enables it to be used as an ally when implementing therapeutic projects. In this sense, the staff seems to ground the delivery of care on ethical-political guidelines that focus on the permanent reinvention of ways to organize and circulate in the city[4]. Thus, care shifts from the biological to the social body, from the institutional to the community space. As a consequence, new forms of receiving patients and intervening in their suffering-existence are needed, to incorporate the dimension of social relationships established in the time and urban space, through the development of therapeutic proposals within the network, which together compose territorial care[19].

Therefore, the planning of actions requires the use of tools to identify resources and strengths within the territory to incorporate them into the care processes. In fact, it is through "territorialization that we'll know the network as a whole. It is through knowing this network that we plan all our activities" (E-4).

The implementation of the CAPS role requires interventions that will advance its management and care delivery processes. Thus, it is necessary to identify both material and subjective resources that are available in the territory to include them in the development of the patients'

therapeutic projects[3]. In this context, territorialization is essential to characterizing the population under the staff's sanitary responsibility, considering the population's care problems and networks to support an analysis of the health situation, planning at a local level and implementing strategic actions that ensure the development and maintenance of problem-solving capacity. Hence, the territory should not be restricted to the construction of maps to identify risks, health problems and/or existing resources, much less as a mere organizational and managerial strategy of CAPS. Rather, it should be a tool to mobilize the population and promote social participation[15], a way to exercise citizenship and establish the individuals' contractual power, promoting co-responsibility and intersectoriality.

From the perspective of the legal-political dimension, the interviewees defined the territory as a space to implement rehabilitation actions, which have a social, political and legal nature[3], forged in the establishment of new ways to exercise citizenship and fight for rights, guiding care practices:

Often, he (patient) seeks an educational qualification so we put him in connection with CRAS (Social Assistance Referral Center) because they offer vocational courses there. If the individual needs social assistance, we refer him to Social Security. If they need documents, we put them into contact with the casa do cidadão [governmental agency]. When they have a legal issue, we refer them to the attorney general (E-4).

We also observed that the workers from CAPS, especially those from social assistance, create conditions under which patients and their families can circulate within the territory and seek their rights, providing them instructions, scheduling appointments with the agencies and designating one worker from the team to accompany them and ensure they have their needs met. In this way, the patients' desires and ways of life[20] are respected and taken into account, which shows that the asylum model is actually been replaced by the psychosocial model, respecting the individual and his/her subjectivations[2,4], mediating the patients' projects of life/happiness[20], and enabling them to resignify difficult experiences.

In fact, the proposal of territorial care, guided by integrality and intersectoriality[3] promotes and enhances psychosocial rehabilitation, taking responsibility, and establishing new social and institutional relationships. In this context, the territory is configured as a place of life, in which exchanges are established, where care delivery takes place in a process in which the individuals' contractual power is recovered in order to expand their autonomy[1,13] and to construct meaningful life projects[13].

According to the sociocultural dimension, the interviewees defined territory as a social place for those in mental distress, who are acknowledged as social subjects and integrate into the different spaces as a strategy to overcome stigma and traditional practices of institutionalization experienced during mental illness. In this sense, the territory can become a device to concretize social inclusion:

[...] a possibility to concretize social inclusion, a possibility to realize social being (E-3).

It's where he lives, attends leisure activities, goes to school and health units. All this is part of this territory where he interacts (E-2).

Note that the creation of possibilities for individuals with their experience-suffering to remain within the territory is determinant to dismantling the asylum apparatus[10] and a still persisting desire, on the part of society, to maintain asylums[21]. For that, it is necessary to advance with the discourse pro the development of policies and strategies of intersectoral action focused on overcoming stigma and concretizing social inclusion as a condition to develop new ways for society to deal with insanity, so that it does not focus on the illness, but on the social subject in his/her multiple dimensions and possibilities of social relationships.

Home visits as intervention technology in psychosocial care

As a care strategy used in psychosocial care, home visits have the potential to promote interactions among CAPS, territory and the homes of individuals facing mental distress.

From the perspective of the epistemological dimension of Psychiatric Reform, in the context in which knowledge and practices are reconstructed, home visits are considered a technology that promotes the reorganization of the work process and psychosocial care strategies, favoring interventions within the territory, and chiefly mediating social reintegration:

Home visits are an intervention strategy that expands the possibilities of CAPS working within the territory (E-3).

The team makes a visit, the interdisciplinary teams make visits (E-4).

These reports show the conception of home visits as being a strategy that connects the no-

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tion of territorial care, teamwork and interdisciplinary work, as guidelines for the organization of work, which requires that actions be shared within the multiprofessional team. Hence, home visits increase the possibilities of working with patients, considering the complexity of the mental health-disease continuum, as well as the complexity of the object of the intervention – an individual who is in distress and has been expropriated from his/her political-social relationships.

Home visits make it possible to address the family structure and dynamics – the team's object of intervention, and provides greater understanding of how these interfere in the lives of patients:

The patient's home is a territory, a space where many relations originate, where many limitations are imposed and many relationships need to be addressed. Sometimes the family is the first space where exclusion takes place. It is essential to address family dynamics, otherwise we provide psychosocial care, we'll go to CAPS work with an asylum type of care (E-3).

When you address the nuclear family, you make the family become co-responsible for follow-up (E-4).

The consolidation of the psychosocial care model stems not only from the implementation of new services, but mainly from the incorporation of care technologies that enable CAPS to interact with the patients' different living spaces, especially the family.

The inclusion of the family in care projects is a guideline that concerns the deinstitutionalization proposed by Psychiatric Reform. Hence, returning a patient to his/her family environment is essential to reintegrating him/her into society[22]. In this sense, there is consensus regarding the relevance of the family in the therapeutic process, both as a caregiver, as that role shares responsibilities with the staff, and also as a recipient of care.

Therefore, CAPS can develop actions directed to the families[23] according to the following objectives: promote patients' healthy coexistence with their families and social contexts; support and orient individuals experiencing mental distress and their families when facing difficulties in order to understand the health-disease continuum and ways in which care is provided, considering their needs and the supply of health care within the network; and strengthen family and community bonds, promoting acceptance of individuals' suffering-experience and their ways of living[21,22].

In the scope of the technical-assistance dimension, home visits are an activity performed by CAPS, the performance of which is determined by dimensions related to clinical practice and the organization of the service, based on criteria in which patients are selected to receive health workers at their homes:

Due to risk priorities, the need for a more urgent intervention, [...] when required by the professional who referred the patient, or asked by the patient or family (E-3).

[...] in other cases, is based on an active search of distant patients, who have been absent for a long time (E-2).

In these terms, home visits are performed when patients need assistance but are impeded from visiting CAPS due to behaviors that make social life difficult, or due to decreased mobility, clinical morbidity, or a crisis; these are clinical indications considered to be a priority. For this reason, the staff takes into account the health needs of patients, performing procedures (including nursing actions) based on clinical, psychosocial and family assessments:

We accompanied scheduled visits with specific objectives. One of the days, the approach was focused on a patient's behavior and family dynamics, in addition to listening to complaints. On other days, visits were exclusively meant to administer intramuscular medication because patients were not able to come to the service (Field diary).

In this context, home visits are characterized as a modality of care delivery that ensures access to health care from the perspective of integrality and humanization[1]. To this end, the CAPS staff establishes a monthly schedule based on local planning and considering the patients' demands:

[...] we work in a multidisciplinary team, so we have to plan the days these visits will happen (E-4).

We have a book where all patients' requests are recorded, or when the staff perceives the patient is in need (E-1).

Therefore, there is an effort on the part of the staff to organize the service and perform home visits based on the demands arising from therapeutic projects, according to availability within the service. Patients' crises, however, are not under control nor are they subject to CAPS planning, so it is not possible to adopt a model based on stages or structured instruments to address patients at home:

[...] there is no standardized script for home visits. There are situations in which we make the visit and later discuss the situation with the team (E-4).

In fact, the mental health clinical practice contributes to home visits to escape from previ-

ously established models. Thus, the staff always deals with the unpredictability that is inherent to processes of the subjective production of individuals experiencing mental distress. Therefore, the staff faces two possibilities: the first may be a situation in which there are disagreements or a situation that is difficult to manage and requires professional ability to handle them; the second may be a situation that requires an intervention, but an intervention is not possible at the time and a given action will take place later, after the visit. Hence, there is no manual for home visits, interventions or mental health care[24], which requires workers to exercise their creativity and welcome individuals in their uniqueness, respecting their differences.

From an operational point of view, the CAPS staff lists obstacles to home visits that are related to the service and dynamics of life within the territory, among which are the lack of availability of material or human resources, violence and a lack of acceptance on the part of the community:

[...] not being safe. Sometimes there is no car. And, even if there is a car, we go by ourselves and we are afraid. It's dangerous! Sometimes we are supposed to take a psychiatrist with us, but then there is not one available at the time (E-2).

The community has to accept the patient, for a visit to happen. Often, the community has a difficult time accepting the patient (E-4).

The organization of teamwork is affected by internal and external aspects, such as not having a vehicle available at all, or not having it at the right time, because the car is also used by other services. This is a situation similar to that reported by a study conducted in a city in Rio Grande do Sul, Brazil where there is also a lack of material resources, including not having a vehicle to drive workers to the patients' homes[25].

The work performed by the CAPS in the territory, especially in large urban centers, exposes workers to the risks of urban violence. Additionally, how patients and their families will receive the team is unpredictable, especially when the patient is in crisis, exposing workers to the risk of aggression. In this study, the staff indicates a need to have the company of a security professional, because workers acknowledge that it is dangerous to circulate in the territory. These results are consistent with studies conducted in Fortaleza and in other Brazilian states, reporting that CAPS workers are continually exposed to the risk of violence, which triggers feelings of fear, hopelessness, and that one's physical integrity is constantly under threat[4,25,26].

During home visits, workers may face situations in which their presence is not wanted, either at the patient's home or in the community. This may result from the patient having a crisis; the family considers visiting hours to be inappropriate; or a failure to acknowledge the intervention is necessary, among others. In these cases, home visits are seen as the health sector meddling in the lives of people and interfering in their freedom[27].

In terms of the legal-political dimension, the workers use home visits to encourage citizenship awareness, and attempt to explain the meaning of the territory and of the institutions it contains. In these terms, they contribute to sensitizing patients and families in regard to their rights:

Even with the visits we make, there are still patients who are not aware that CREAS or CRAS exist, and they are not aware there are other healthcare units available in the territory [...]. So, we work with these people and provide clarification regarding their rights and the services they can use (E-4).

The workers, therefore, promote political actions intended to empower patients and their families and allow them to appropriate of the social territory as a dimension of care. Thus, the actions performed during home visits are committed to overcoming a historical denial of the rights of people with mental distress, seeking to reconstruct their relationships with society and institutions. Workers seek to concretize one of the objectives of the psychosocial care model, which is the delivery of integral care, emphasizing political and biopsychosociocultural aspects as determinants of the mental health-disease continuum. They, therefore, emphasize a conception of territorialized care, by including families and the community and valuing the legal-political dimension[28].

Considering the sociocultural dimension, these workers face situations during home visits that restrict the possibility of social reintegration as consequence of stigma and a notion still persistent that an individual with mental illness is dangerous:

Patients, sometimes their families, do not want to go out with him, which makes it difficult [...] because of the harm he can cause to a worker, another patient, or society (E-3).

Therefore, we see the reproduction of a behavior that has historically hindered the circulation of individuals with mental distress in the territory due to difficulties dealing with differences. Note that the circulation of these people remains a concern in the social agenda and health services, seeking ways to ensure safety and

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prevent harm and disorder in society. Such safety is ensured through the role played by families and by using psychotropic drugs to control undesirable behaviors[19].

In order to meet an ethical imperative to establish a new social place for individuals with mental distress and new ways to deal with insanity, the workers seek social devices within the territory "when he needs to be inserted in leisure activities, we work together with SESC" (E-4). Actions with this purpose were observed on the part of the staff during one of the home visits:

On that day, we entered a house, after we got the resident's consent, who lived by herself. We were invited to take a seat. At the time, that lady was encouraged to take part in leisure activities that took place in a plaza near her home, in addition to interacting more with her neighbors (Field Diary).

In this context, the team implements guidelines from Mental Health Policies establishing that procedural and relational dimensions should be recovered to create new routes for people with mental distress to circulate in the territory, respecting political and sociocultural uniqueness[19].

Finally, despite challenges, CAPS workers actually promote actions intended to involve families and society in the development of inclusive actions that effectively increase the participation of these individuals in the city and in the construction of a new culture based on civilizatory values to enable respectful, welcoming and solidary coexistence with individuals experiencing mental distress.

Final considerations

When analyzing home visits by the CAPS workers from the perspective of the Psychiatric Reform dimensions, we realized that there is a process in play to recompose the know-how in mental health. In this sense, the participants of this study express an ethical-political and technical commitment to the development of care practices intended to socially transform the place of madness within society. These practices promote social reintegration, autonomy and greater contractual power among those experiencing mental distress.

In the context of psychosocial care, territory means more than a geographical area, it constitutes a space where care is produced, where greater circulation and participation of people with their experience-suffering is promoted, considering their unique ways of living. Thus, the practice of home visits works as a mediator between CAPS, territory and individuals regarding the construction of a practice oriented by integrality and intersectorality, intending to produce new ways to exercise citizenship through strategies that promote emancipation and empowerment of people to conduct their projects of life.

Hence, home visits contribute to the implementation of strategies for deinstitutionalization when planned to meet the needs of patients and the community and employ clinical and service management tools to reorganize the teamwork processes. In these terms, home visits are appropriate to address patients and families and enable them to interact with the life within the territory. Home visits, however, present limitations and face challenges imposed by the CAPS structure and functioning, given an insufficient availability of material and human resources, in addition to those challenges inherent to the psychosocial practice, translated into difficulties faced by the staff in expanding intersectoral cooperation and promoting greater circulation of people in the city.

In fact, it is essential that home visits become a permanent practice in the routine of CAPS as a technology to address patients and their experience of life, including the family context, and definitely to dismantle the asylum apparatus and all forms of exclusion and stigma that surround mental illness. Hence, it is an opportunity to reinvent professional knowledge and advance changes in the local culture to encourage society to establish a new relationship with madness, one that is grounded in tolerance and respect of differences.

Collaborations

All authors participated in the design and revisions that resulted in the publication of this article, and to make public its content.

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