Psychosocial Care Network: Analysis of Coverage in Rio Grande do Sul in 2023

Rede de Atenção Psicossocial: Analise da Cobertura no Rio Grande do Sul em 2023
Red de Atención Psicosocial: Análisis de la Cobertura en Rio Grande do Sul en 2023

RESUMO
Objetivo: analisar a distribuição dos serviços que compõem a Rede de Atenção Psicossocial (RAPS) no Rio Grande do Sul, em suas Regiões de Saúde, de acordo com a legislação vigente e sua correlação com os indicadores em saúde mental. **Método:** Trata-se de estudo transversal, exploratório, quantitativo com dados secundários de 2023. Foram analisados os componentes da RAPS e sua correlação com os indicadores de saúde mental. **Resultados:** o Estado apresenta uma distribuição heterogênea dos Serviços de Saúde Mental, gerando iniquidades na assistência. As análises de correlação realizadas sugerem impacto negativo nas taxas de internações e suicídio pela oferta de CAPS com equipes multiprofissionais. **Conclusão:** Desigualdades regionais, equipes incompletas e baixa integração entre APS e Atenção Especializada sugerem porque o Estado tenha a maior taxa de suicídio do país, apontando a necessidade de melhor integração na RAPS, com uma distribuição de serviços mais equânime entres suas Regiões de Saúde.
DESCRITORES: Saúde Mental; Assistência à Saúde Mental; Serviços de Saúde Mental; Atenção à Saúde; Política de Saúde**.**

ABSTRACT
Objective: to analyze the distribution of services that comprise the Psychosocial Care Network (RAPS) in Rio Grande do Sul, in its Health Regions, in accordance with current legislation and its correlation with mental health indicators. **Method:** This is a cross-sectional, exploratory, quantitative study with secondary data from 2023. The components of RAPS and their correlation with mental health indicators were analyzed. **Results:** The state has a heterogeneous distribution of Mental Health Services, generating inequalities in care. The correlation analyses performed suggest a negative impact on hospitalization and suicide rates due to the provision of CAPS with multidisciplinary teams. **Conclusion:** Regional inequalities, incomplete teams, and low integration between PHC and Specialized Care suggest why the state has the highest suicide rate in the country, pointing to the need for better integration in the RAPS, with a more equitable distribution of services among its Health Regions.
DESCRIPTORS: Mental Health; Mental Health Assistance; Mental Health Services; Delivery of Health Care; Health Policy.

RESUMEN
Objetivo: analizar la distribución de los servicios que componen la Red de Atención Psicosocial (RAPS) en Rio Grande do Sul, en sus Regiones Sanitarias, de acuerdo con la legislación vigente y su correlación con los indicadores de salud mental. **Método:** Se trata de un estudio transversal, exploratorio y cuantitativo con datos secundarios de 2023. Se analizaron los componentes de la RAPS y su correlación con los indicadores de salud mental. **Resultados:** el estado presenta una distribución heterogénea de los servicios de salud mental, lo que genera desigualdades en la asistencia. Los análisis de correlación realizados sugieren un impacto negativo en las tasas de hospitalización y suicidio por la oferta de CAPS con equipos multiprofesionales. **Conclusión:** Las desigualdades regionales, los equipos incompletos y la baja integración entre la APS y la Atención Especializada sugieren por qué el estado tiene la tasa de suicidio más altas del país, lo que apunta a la necesidad de una mejor integración en la RAPS, con una distribución más equitativa de los servicios entre sus Regiones de Salud.
DESCRIPTORES: Salud Mental; Atención a la Salud Mental; Servicios de Salud Mental; Atención a la Salud; Política de Salud.

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INTRODUCTION

The discussion about madness has been a constant throughout the history of society, although public policies on mental health are relatively recent and often marked by neglect and invisibility. The mobilization of civil society in the 1970s and 1980s enabled the Brazilian Psychiatric Reform, a significant milestone that proposed changes in the model of care for people with mental disorders [1].

Law 10.216/01, which established the National Mental Health Policy (PNSM) in 2001, represented a fundamental milestone in the approach to mental health treatment in Brazil. Breaking with the asylum paradigm, the PNSM proposes an open and community-based care model, whose essence lies in the deinstitutionalization and social reintegration of the individual [2].

However, the political context and constant ideological disputes have hindered the effective implementation of this reform. In response, in 2010 and 2011, the Federal Government published a series of ordinances and decrees aimed at reorganizing the Health Care Network (RAS) in the Unified Health System (SUS), including the creation of the Psychosocial Care Network (RAPS).

The RAPS encompasses a set of services from different levels of care within the SUS, ranging from primary care to hospital care, organized into a territorialized network, reinforcing its coordination as a way of ensuring the effectiveness of comprehensive care and the resocialization of users. If necessary, the RAPS may recommend hospitalization of the user, which should be of short duration until the user's clinical stability [3,4].

The provision of integrated mental health care, supported by multidisciplinary work and expanded clinical practice, as guided by RAPS, represented a major advance in mental health care. However, it requires a substantial effort due to its complexity. In this sense, it is important to note that previous studies have highlighted the existence of gaps between policy and care guidelines and everyday practice [1].

Changes in the profile of the target audience and their needs, as well as epidemiological variables, budgetary and financial constraints, coupled with public health emergencies, such as that caused by the Covid-19 pandemic, highlight the need for agile adjustments in health policies, aiming to adapt the services provided to the population. The dynamics of these factors require constant review of the strategies and actions of the National Mental Health Policy (PNSM), ensuring an effective and adequate response to emerging demands and unforeseen circumstances [5].

This reality raises questions about the effectiveness of the changes implemented. Therefore, it is necessary to apply appropriate analysis and evaluation tools in order to understand and address these challenges in the health system and mental health care [6].

Therefore, this study is timely and necessary, as it sought to evaluate the distribution of RAPS services to the population of Rio Grande do Sul in 2023. These evaluations were made based on information contained in the SUS Department of Informatics (DATASUS) database through the Tabnet platform and information released by the Rio Grande do Sul State Health Secretariat (SES RS) through the Portal BI platform.

METHOD

This is a cross-sectional, exploratory study with a quantitative approach, based on a specific case study focused on the analysis of RAPS in the 30 Health Regions of the state of RS, thus covering the 497 municipalities of the state in the year 2023.

Data collection was carried out exclusively through secondary data, by means of a documentary survey, on the official digital platforms available for this purpose, namely: a) Health Legislation System (SLEGIS), b) CIB RS Resolutions, c) Brazilian Institute of Geography and Statistics (IBGE), d) National Register of Health Establishments (CNES), e) DATASUS, f) e-Gestor Primary Health Care, g) BI RS Portal, and h) Rio Grande do Sul Indicator Panel.

Initially, an updated survey of the legal framework governing RAPS in our country in 2023 was conducted. The same was done for the peculiarities related to this standardization at the state level.

Considering that the population of each municipality is a crucial parameter for defining the quantities and types of services offered, information was collected on the population data of the municipalities in Rio Grande do Sul. The reference data used by the Ministry of Health was employed, which is based on the document Relação da População dos Municípios (List of Municipal Populations), sent by the Brazilian Institute of Geography and Statistics (IBGE) to the Federal Court of Accounts (TCU) in 2023[7].

Data collection continued with the census survey conducted by the CNES. Data were collected on the health establishments that comprised the RAPS in 2023 and the analysis of Human Resources (HR) offered at the CAPS in RS. Data on PHC coverage were extracted from the e-Gestor APS platform. Data on health indicators were collected from the BI RS Portal and the RS Indicator Panel, namely (A) Systematic matrix actions carried out by CAPS with Primary Care teams, (B) Index of hospitalizations for Mental and Behavioral Disorders (TMC), and (C) Suicide Index.

To analyze the number of CAPS, the formula proposed by Borges et al.[8] was used, adapted to include the CAPS IV modality, which is based on the CAPS coverage rate per 100,000 inhabitants, expressed in the following algorithm:

> CAPS coverage rate per 100,000 inhabitants = [(Number of CAPS I x 0.15) + (Number of CAPS II x 0.7) + (Number of CAPS III x 1.5) + (Number of CAPS IV x 5) + (Number of CAPS i x 0.7) + (Number of CAPS AD II x 0.7) + (Number of CAPS AD III x 1.5)] / population x 100,000

CAPS coverage rate per 100,000 inhabitants = [(CAPS I number x 0.15) + (CAPS II number x 0.7) + (CAPS III number x 1.5) + (CAPS IV number x 5) + (Number of CAPS i x 0.7) + (Number of CAPS AD II x 0.7) + (Number of CAPS AD III x 1.5)] / population x 100,000

The parameters of the Ministry of Health(9) were used, with the CAPS coverage rate per 100,000 inhabitants classified as: a) very good (above 0.71), b) good (0.51 to 0.70), c) fair (0.36 to 0.50), d) low (0.21 to 0.35), e) insufficient (0.01 to 0.20), and f) no care available.

Subsequently, an analysis of human resources in CAPS in each state was conducted, using as a reference the annual average number of professionals with higher education degrees and the number of these professionals in the services offered.

With regard to the Hospital Care component, information was collected on the total number of beds available in the state for the treatment of Mental and Behavioral Disorders (TMC), as well as data on hospitalization rates for TMC generated in 2023, based on the place of hospitalization and the user's place of residence, maintaining the proportion of the hospitalization rate per 100,000 (one hundred) thousand inhabitants, according to each Health Region.

For statistical analysis, Spearman correlations were performed in the 30 Health Regions of the State, with pre-established mental health indicators: (A) Systematic matrix actions performed by CAPS with Primary Care teams and (B) Index of hospitalizations for Disorders.

RESULTS

Rio Grande do Sul shows a clear imbalance in the structure of mental health services: in Health Regions with a higher concentration of small municipalities (up to 15,000 inhabitants), there is high coverage of Primary Health Care (PHC) concomitant with deficiencies in the provision of Psychosocial Care Centers (CAPS), while in regions with higher population density, the opposite situation is generally observed. (FIGURE 1).

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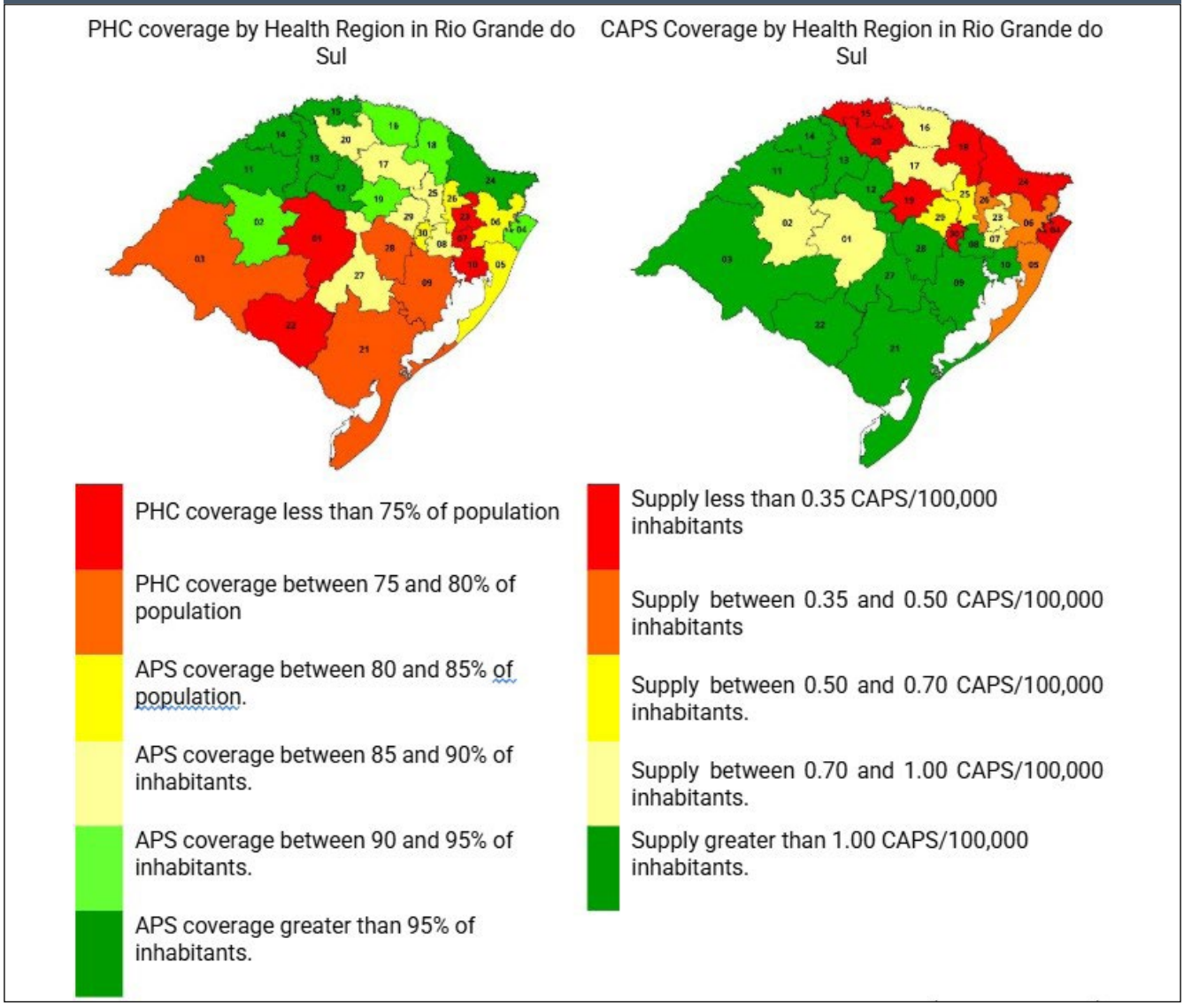
Figure 1 – Comparison between health maps of PHC coverage data for municipalities and CAPS coverage in Rio Grande do Sul



Source: DATASUS 2023 (Own production)

Rio Grande do Sul has a general coverage rate of 1.06 CAPS per 100,000 inhabitants, with 0.44 CAPS/100,000 inhabitants for the care of the adult population with Mental and Behavioral Disorders (TMC), 0.41 CAPS/100,000 inhabitants for the care of the adult population with Chemical Dependency (DQ), and 0.21 CAPS/100,000 inhabitants for the care of the child and adolescent population.

It is important to note that the Ministry of Health recommends the need for one Psychosocial Care Center per 100,000 inhabitants [10]. Thus, it indicates that the overall coverage of state CAPS is adequate according to current legislation and is considered by the Ministry of Health to be very good [9].

However, the distribution of CAPS is extremely heterogeneous, with a huge variation in coverage rates between health regions, ranging from 0.13 CAPS per 100,000 inhabitants in Botucaraí (Region 19), which indicates insufficient/critical coverage, to 1.97 CAPS per 100,000 inhabitants in the Sete Povos das Missões region (Region 11), which indicates very good coverage.

Although CAPS are also recognized as gateways to the SUS, they are an integral part of specialized care. Their classification is determined predominantly by the target audience and service capacity, taking into ac-

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count the population size of the municipality or region. The severity of the case is not used for classification.

However, the legislation does not require the presence of a psychiatrist. This allows for the continuity of treatment by a general practitioner with experience and/or training in mental health, even if the user has been referred for specialized care.

With regard to the hospital component, in 2023, the state of Rio Grande do Sul had 3,811 beds designated for TMC. Of these, 2,462 beds are linked to the Unified Health System (SUS). This amount represents, in absolute numbers, the second largest supply of beds for TMC in Brazil, both in relation to the total number of beds for TMC and in relation to beds for TMC linked to the SUS. In terms of proportionality, Rio Grande do Sul, with 0.21 beds per 1,000 inhabitants, has the largest supply of beds for TMC linked to the SUS, and this figure is double the national average [11].

With a rate of 357.18 hospitalizations per 100,000 inhabitants in 2023, Rio Grande do Sul stood out as the Brazilian state with the highest hospitalization rate. However, it had a state occupancy rate for TMC hospitalizations estimated at 77.36%. This figure is below the 80% (eighty percent) recommended by the Ministry of Health for TMC bed occupancy in Brazil [12].

In 2023, Rio Grande do Sul recorded 1,659 deaths by suicide, representing a mortality rate of approximately 14.47 per 100,000 inhabitants, which is double the national average and indicative of a 32.17% increase in the state rate since 2015. Most suicides occurred among men (80.04%), with the rate increasing progressively with age, especially among the elderly over 80 years of age [13].

When analyzing the correlation of variables (TABLE 1), PHC showed a strong positive correlation with suicide rates (+0.73) and a moderate to strong positive correlation with hospitalizations for TMC (+0.46). However, when considering other variables associated with this phenomenon, there is a strong negative relationship between PHC coverage and the availability of multidisciplinary teams in CAPS, where we have psychiatrists (-0.46), psychologists (-0.53), and nurses (-0.63), as well as a moderate negative correlation with occupational therapists (-0.29).

ting the suicide rate with the availability of human resources in CAPS, there is a strong negative correlation between the suicide rate and the presence of multidisciplinary teams, with nurses (-0.63), psychiatrists (-0.46), and psychologists (-0.53), a moderate negative correlation with occupational therapists (-0.29), and a weak correlation with social workers (-0.17).

Regional hospitalization rates for TMC showed a weak negative correlation with the availability of CAPS (-0.15). However, when we analyzed the correlation of this indicator with the availability of human resources at CAPS, the presence of psychiatrists at CAPS continued to show a strong negative correlation (-0.69), as did the associated presence of psychiatrists with other physicians (-0.61).

Regarding the overall supply of beds for TMC, this showed a weak negative correlation (-0.09) with the suicide rate, but a weak to moderate positive correlation when correlated only with the supply of beds for TMC SUS (+0.19). Regarding hospitalization rates, the overall supply of beds for TMC showed a moderate to strong positive correlation (+0.48) and a strong positive correlation when correlated only with the supply of beds for TMC SUS (+0.82).

TABLE 1 - Spearman Correlation Values[1] (Variables x Health Region)

	Suicide rate	Coverage APS	CAPS	CAPS Ad	CAPS i	CAPS Total	Beds TMC Total	Beds TMC SUS	Hospitalizations TMC	Matriciamento (CAPS)	Psychiatrist (CAPS)	Other Medical Professionals (CAPS)	Total physicians(CAPS)	Nurse (CAPS)	Psychologist (CAPS)	Social Worker(CAPS)	Occupational Therapist (CAPS)
Suicide Rate	1																
APS Coverage	0,73	1															

[1] As suggested by Cohen (10), the following cut-off points were used: (A) weak correlation (RS = ± 0.10), (B) moderate correlation (RS = ± 0.30), (C) strong correlation (RS = ± 0.50). Where positive values indicate that an increase in one variable is associated with an increase in the other, and negative values indicate that an increase in one variable is associated with a decrease in the other variable. The suggested cut-off points are not prescriptive, meaning that researchers should always interpret their values in light of the literature in their respective research areas [11]. The Statistical Package for the Social Sciences from International Business Machines (IBM SPSS Statistics) was used for statistical data analysis.

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CAPS	-0,20	-0,09	1														
CAPS Ad	-0,37	-0,30	0,50	1													
CAPS i	-0,30	-0,07	0,55	0,57	1												
CAPS Total	-0,27	-0,09	0,81	0,80	0,83	1											
Total TMC beds	-0,09	0,00	-0,08	0,14	0,00	0,00	1										
TMC SUS beds	0,19	0,14	0,04	0,07	-0,16	0,00	0,82	1									
TMC hospitalizations	0,33	0,46	-0,15	-0,20	-0,15	-0,12	0,48	0,68	1								
Matriciamento (CAPS)	-0,03	-0,22	-0,20	-0,17	0,13	-0,12	-0,07	-0,25	-0,26	1							
Psychiatrist (CAPS)	-0,46	-0,55	0,26	0,36	0,39	0,36	-0,19	-0,41	-0,69	0,32	1						
Other Med. (CAPS)	-0,21	-0,13	0,08	0,03	0,37	0,14	0,18	-0,09	-0,23	-0,02	0,25	1					
Total physicians (CAPS)	-0,47	-0,50	0,19	0,23	0,43	0,28	0,01	-0,31	-0,61	0,20	0,80	0,75	1				
Nurse (CAPS)	-0,63	-0,54	-0,02	0,29	0,07	0,07	0,26	-0,03	-0,34	-0,03	0,37	0,22	0,45	1			
Psychologist (CAPS)	-0,53	-0,48	0,26	0,10	0,19	0,15	-0,10	-0,32	-0,47	0,11	0,53	0,28	0,50	0,57	1		
Social Assistance (CAPS)	-0,17	-0,22	-0,24	-0,09	0,03	-0,18	0,25	-0,10	-0,26	0,36	0,32	0,20	0,40	0,47	0,29	1	
T. Ocupacional (CAPS)	-0,29	-0,30	0,29	0,15	0,15	0,24	-0,04	-0,27	-0,33	0,14	0,35	0,27	0,44	0,35	0,30	0,29	1

Source: Prepared by the author based on IBGE (2023), DATASUS (2023), and SES RS (2024)

DISCUSSION

The distribution of services that make up the RAPS in RS in 2023 reveals a complex and worrying reality, marked by a strong relationship of heterogeneity and inequalities in all its components. In large urban centers, there was insufficient coverage of Primary Health Care (PHC), in contrast to the excessive supply of Specialized Care services, especially hospital care. In regions with less dense populations, the opposite was true.

It can be observed that, over the years, the implementation of the PNSM has not been homogeneous in the state of Rio Grande do Sul, generating quite divergent conformations of policy standardization among its Health Regions. The 2012-2015 State Health Plan (PES), prepared by the State Health Secretariat, has pointed to this unequal reality since 2013 [14], showing that the current situation has not corrected the inequalities previously identified.

The total number of individuals without adequate access to Primary Health Care (PHC) in 2023 in Rio Grande do Sul is alarming, reaching an estimated 2,308,604 inhabitants. This number represents 20.13% of the population of Rio Grande do Sul, highlighting a significant gap in care in this important indicator [15], which requires the continuation of interventions that ensure the maintenance of the policy of expanding PHC coverage in the state.

It is important to note that the legislation regulating the RAPS does not provide for the accreditation of CAPS in municipalities with up to 15,000 inhabitants (16). This directs the care of TMC to the PHC of these localities. In the state context, there are 370 municipalities in this situation, which corresponds to 74.45% of the total number of municipalities in Rio Grande do Sul.

There is international consensus that National Health Systems should be based on strong and effective PHC (17). However, although the Ministry of Health directs part of the financing of PHC based on data correlated with PHC coverage, since 2019, with the establishment of the Previne Brasil Program[2] [18], there is no legal provision that defines a minimum value for PHC coverage in our country, thus hindering the analysis of this component of the RAPS.

According to the criteria established by the Ministry of Health [9], the overall coverage of CAPS in the state is considered very good. However, the geographic distribution of this provision reveals enormous disparities, characterized by significant heterogeneity. There is a significant variation of up to 15 times in the provision of CAPS between the state's Health Regions.

The absence of CAPS i in 11 regions and CAPS AD in 8 demonstrates a weakness in the mental health system, compromising access to specialized services for vulnerable populations, such as children, adolescents, and individuals with substance use disorders.

In 2023, Rio Grande do Sul stood out as the Brazilian state with the

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highest rate of hospitalizations. This rate is 37.54% higher than the second-ranked state, Santa Catarina, which records 259.69 hospitalizations per 100,000 inhabitants, and is an alarming 201.9% higher than the national average, which is 118.32 hospitalizations per 100,000 inhabitants. The state target for 2023 was 290.80 hospitalizations per 100,000 inhabitants [11].

Of the total number of hospitalizations for TMC by SUS, 14.13% were in psychiatric hospitals. However, when we look at the total number of daily stays generated by TMC, we see that 26.15% occurred in this same type of institution, reflecting, almost proportionally, the availability of SUS beds for TMC in psychiatric hospitals in the state, which reaches 27.78%. It is also noteworthy that 1.78% of daily hospitalizations for TMC were recorded in general hospitals not equipped for such treatment[11].

Although there is no legal definition or formal guideline from the Ministry of Health on reference values for the Hospital Occupancy Rate (HOR), the National Supplementary Health Agency (ANS) recommends keeping it between 75% and 85%. Monitoring this indicator is crucial for managing bed supply, as high HORs may signal an insufficient number of beds to meet demand [19]. Thus, it is noteworthy that 11 health regions had rates above 85%, indicating significant pressure on local healthcare capacity.

This excessive emphasis on hospital care, without the necessary support of policies that strengthen PHC, leads to a fragmented and conflicting network, with weaknesses in communication and centralization of mental health care in specialized services [20], resulting in a vicious cycle that perpetuates the population's vulnerability to inequality in access to mental health care, as has been occurring among the Health Regions of RS.

This disparity reflects a mismatch between the different levels of care, particularly affecting users who need closer and more accessible services[21]. Added to this, the difficulties of integrating primary care into the network make it difficult to ensure continuity and coordination of care in the Health Care Networks (RAS) [22].

It should be noted that the high incidence of suicides in RS, although complex and multifaceted in etiology, is related to this fragmentation observed in the RAPS in Rio Grande do Sul. The difficulty of access to the components of the RAPS, resulting from this disarticulation, aggravates the conditions of individuals with previous mental disorders and a history of alcohol and other drug abuse, which are intrinsically associated with suicidal ideation [23].

The areas of Rio Grande do Sul with the highest risk of suicide are mainly in the interior of the state, especially rural areas and small municipalities. The northern region of the state had the highest suicide mortality rates. The phenomenon in RS is multifactorial, involving social, economic, cultural, and environmental issues, reflecting the complexity of the public health problem facing the state.

The main causes associated with high suicide rates include a complex combination of psychological, social, and mental health factors. Most cases of suicide are linked to the presence of mental disorders, especially depression, bipolar disorder, schizophrenia, borderline personality disorder, and substance abuse such as alcohol and drugs [24].

The higher risk of suicide in these areas is associated with multiple factors, such as reduced access to mental health services, high prevalence of alcohol and other drug abuse, economic and social inequalities, social isolation, and specific cultural issues, such as exposure to agricultural and fishing work environments, which are also linked to higher suicide mortality rates. Acculturation and difficulties faced by indigenous and minority populations also aggravate this situation. The stigma surrounding seeking psychological help and environmental and social factors in these regions contribute to increasing the risk of suicide [13,25].

Therefore, it is necessary to highlight that the legal changes that occurred in 2017, with the publication of Ordinance GM/MS 3.588, despite not having generated significant changes in the already established care bases, generated an important change in the financing of RAPS, with the redirection of mental health resources, especially with the expansion of funding for hospital care to the detriment of community-based actions, reinforcing once again the logic of individualized, specialized, and hospital-centered care in Mental Health [6], further consolidating the current and worrying scenario of RAPS in RS.

Its revocation, with the publication of Ordinance GM/MS 757/2023, was not enough to restore the slow and gradual process of advances and achievements in the area of mental health. The simple reinstatement of some points from the previous legislation was not enough to reduce uncertainties regarding the future of the PNSM, due to the fact that numerous elements of this policy were omitted from the current legal provisions, as no new regulations have been issued to date, thus compromising the clarity and effectiveness of the established guidelines.

It is important to highlight the importance of qualified primary health care in this process, which should have broad coverage, easy access, and, not least, a qualified team for mental health care, thus allowing the coordination of care, in order to provide comprehensive continuity at

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its level of competence, as well as, if necessary, referring individuals to the most appropriate level of care, both in specialized outpatient care and in hospital care.

It is necessary to move forward in confronting the hospital-centered model, reversing the logic of hospitalization, consolidating the diversification of care strategy actions based on the Individualized Treatment Plan, thus favoring social inclusion through the promotion of autonomy and the exercise of citizenship.4

CONCLUSION

More than a decade after the implementation of the Psychosocial Care Network (RAPS), it is clear that the PNSM has made significant progress over the years. However, changes in its legislation during this same period have generated significant legal conflicts, as well as legal loopholes, which compromise the continuation of the PNSM as a strategy for consolidating changes in the mental health care model. Furthermore, the current RAPS legislation is unable to ensure the equitable distribution of legally mandated services among the Health Regions of Rio Grande do Sul.

Thus, the absence of new regulations that reflect contemporary social needs and use updated evidence perpetuates a scenario of uncertainty that hinders the implementation of effective mental health strategies in Brazil [1]. Therefore, the development of clear and comprehensive guidelines is urgently needed to ensure the continuity of the progress already achieved, as well as the continued consolidation of the Brazilian Psychiatric Reform.

It is important to highlight that the correlations presented suggest that strengthening specialized outpatient care, with the implementation of CAPS with multidisciplinary teams, in quantities adequate to local needs, and qualified, with the presence of professionals who are specialists in their fields, especially psychiatrists, nurses, psychologists, and occupational therapists, indicates a more appropriate process for consolidating RAPS in the state.

They indicate a reduction in high suicide and hospitalization rates, in addition to enhancing mental health actions in PHC. Similarly, the insufficient and fragmented provision of CAPS suggests that PHC will lead to a collapse of the entire RAPS, generating a backlog of referrals to specialized care, thus compromising mental health care as a whole and increasing regional suicide rates and hospitalizations for TMC.

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