

REFLECTIVE ANALYSIS ARTICLE

POST-DISCHARGE MENTAL HEALTH POLICIES AND CARE IN PSYCHIATRIC HOSPITALIZATION

POLÍTICAS E CUIDADOS DE SAÚDE MENTAL PÓS-ALTA DA HOSPITALIZAÇÃO PSIQUIÁTRICA
POLÍTICAS DE SALUD MENTAL POST-ALTA DE LA HOSPITALIZACIÓN PSIQUIÁTRICA

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ABSTRACT

Objective: to analyze current Mental Health policies, discriminating health care defined for the post-discharge period of psychiatric hospitalization, with a focus on Nursing care. **Method:** this is a quantitative, reflective study, based on research in 27 institutional, legislative or officially recognized documents that regulate the area of Mental Health regarding the return of the person to the home after psychiatric discharge. **Results:** 15 documents were identified that reveal Mental Health care focused on hospital productivity, with difficulty in establishing community structures and interventions. There is a insufficiency and variability in the distribution of human resources and interventions, with lack of uniformity among the various caregivers. In a multidisciplinary logic, nursing intervention is essential to ensure continuity of care. However, it is verified that the intervention of the specialist nurse is insufficiently integrated in the Mental Health policies. **Conclusion:** Portuguese Mental Health policies are still falling short in the definition and provision of transitional health care specific to the psychiatric post-discharge home. **Descriptors:** Patient Discharge; Psychiatric Department, Hospital; Health Policy; Psychiatric Nursing; Continuity of Patient Care; Nursing.

RESUMO

Objetivo: analisar as políticas de Saúde Mental atuais, discriminando os cuidados de saúde definidos para o período pós-alta da hospitalização psiquiátrica, com um enfoque sobre os cuidados de Enfermagem. **Método:** trata-se de um estudo quantitativo, tipo reflexivo, a partir da pesquisa em 27 documentos de caráter institucional, legislativo ou oficialmente reconhecidos que regulam a área de Saúde Mental no que concerne ao regresso da pessoa à casa pós-alta hospitalar psiquiátrica. **Resultados:** identificaram-se 15 documentos que revelam cuidados de Saúde Mental centrados ainda na produtividade hospitalar, com dificuldade em estabelecer estruturas e intervenções comunitárias. Verificam-se uma insuficiência e a variabilidade na distribuição de recursos humanos e de intervenções, com falta de uniformidade entre os diversos prestadores de cuidados. Constitui-se, em uma lógica multidisciplinar, a intervenção de Enfermagem como essencial para assegurar a continuidade de cuidados. Verifica-se, porém, que a intervenção do enfermeiro especialista está insuficientemente integrada nas políticas de Saúde Mental. **Conclusão:** mantêm-se as políticas de Saúde Mental portuguesas aquém na definição e prestação de cuidados de saúde transitórios específicos ao pós-alta hospitalar psiquiátrico para a casa. **Descritores:** Alta do Paciente; Unidade Hospitalar de Psiquiatria; Política de Saúde; Enfermagem Psiquiátrica; Continuidade da Assistência ao Paciente, Enfermagem.

RESUMEN

Objetivo: analizar las políticas actuales de Salud Mental, discriminando la atención de salud definida para el período posterior al alta de hospitalización psiquiátrica, con un enfoque en la atención de Enfermería. **Método:** este es un estudio cuantitativo, reflexivo, basado en la investigación en 27 documentos institucionales, legislativos u oficialmente reconocidos que regulan el área de Salud Mental con respecto al regreso de la persona al hogar después del alta psiquiátrica. **Resultados:** se identificaron 15 documentos que revelan la atención de Salud Mental centrada en la productividad hospitalaria, con dificultad para establecer estructuras e intervenciones comunitarias. Existe una insuficiencia y variabilidad en la distribución de recursos humanos e intervenciones, con falta de uniformidad entre los distintos cuidadores. En una lógica multidisciplinaria, la intervención de Enfermería es esencial para garantizar la continuidad de la atención. Sin embargo, se verifica que la intervención del enfermero especializado está insuficientemente integrada en las políticas de Salud Mental. **Conclusión:** las políticas portuguesas de Salud Mental siguen sin cumplir con la definición y la provisión de atención de salud de transición específica para el hogar psiquiátrico posterior al alta. **Descriptor:** Alta del Paciente; Servicio de Psiquiatria en Hospital; Política de Salud; Enfermería Psiquiátrica; Continuidad de la Atención al Paciente; Enfermería.

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INTRODUCTION

The post-discharge period of psychiatric hospitalization is clearly a complex and challenging transition process for the person. There is the need to deal with the transition from a context of permanent and global professional health care - the hospital - to a context of poorer non-professional care - the home - whose numerous contingencies, such as reduced insight into the disease, poor therapeutic adherence, deleterious drug iatrogeny for functionality and well-being perception, ineffective family or social support, weak financial resources, poor cognitive or emotional resources, among others, jeopardize their adaptation, evolution and achievement as a whole human being, integrated and prolific of the society in which it operates.

In the scientific literature, the immediate post-discharge period is highlighted as particularly arduous, with evidence of a higher incidence of mortality, self-harm, suicide, violent crime, or hospitalization for interpersonal violence at this stage.¹⁻³

The risk of psychiatric post-discharge suicide is found to be approximately one hundred times higher during the first three months, and for several years after discharge this risk remains approximately 30 times higher.⁴

In a scoping review, we highlight the experiences of adult patients returning home after psychiatric hospitalization, as the discharge process is peculiar to each and influences the transition process as more or less healthy.⁵ It is noted that often, it is in the convergence of a scenario of difficult contingencies that there is a need for the patient to readjust daily, resume responsibilities and domestic and work activities, adhere to and manage medicines and their iatrogenesis, manage the psychiatric hospitalization event about identity and adapt to the stigma and discrimination still perceived.⁵ In addition, it faces the same daily stressors previously present at hospitalization¹ and with the consequences inherent in a mental illness crisis that forced an internment - that is, an interruption of daily life - and whose manifestations can lead to personal, relational, financial, etc.

It is known that Mental Health Nursing, as an area of knowledge and care, plays a major role in the commitment to understanding and responding to the needs, difficulties and expectations of patients and their families. This is reinforced by the transition from hospital to community, a stage clearly recognized as fragile in ensuring continuity of health care.⁶ It is noteworthy that, in psychiatric hospitalization, the person has nursing

care 24 hours a day and, in their transition home, they can be completely remitted.

In addition, this specific transition from post-discharge psychiatric-community has already been the object of study published in several scientific articles from various areas of health.⁷⁻¹¹ Evidence of the need for specific care for this transitional context has been established, and here there is a double confluence regarding the term transition.

In this discharge movement from hospital to home, a transition can be established relative to the continuity of health care for patients who are transferred between different settings or levels of care; and it is possible to identify, as a focus of nursing care, the transition experienced by the patient, which can be established as a situational transition (involving the sum or subtraction of the person regarding the performance of pre-existing roles) and health-disease transition (that results from the person's passage from a health-disease situation or vice versa).^{12,13}

Therefore, it is clear that this transitional focus has long been a focus of attention by nurses. It is based on Meleis's theory that this health/illness transition is marked by identity and role-playing doubt¹¹ which, more or less consciously or insidiously, undermines one's ability to achieve this transition with mastery and reintegration. identity in the face of implicit changes.¹²

Nurses, particularly Mental Health specialists, are trusted to establish interventions to address these critical events and expedite patients' identity reintegration and role supplementation in order to realize the transition from psychiatric hospitalization - home to the fullest and healthiest way possible.

The horizon of action in Nursing is highly determined by health policies that stipulate what, how, when, how much, where the health care of a population will be invested. It is emphasized that health is a particularly important good that must be instituted as a fundamental right of every human being.¹⁴ To this end, it is essential to understand the political dimension and its real impact on health care.¹⁴

It is therefore believed that it is important to establish very well what is said when talking about mental health policies. These are defined as the decisions, strategies, plans and actions that each country establishes to achieve the health objectives of its constituents,¹⁵ shaping the plan of the future by projecting the goals to be achieved in the short to medium-long term, setting the investment and action priorities that shape and inform the expected roles of the different stakeholders, which in this case undoubtedly include health professionals.¹⁵

Thus, this paper emerges from the questions: "What health care is defined and operationalized

for the post-discharge period of a psychiatric hospitalization?"; "What roles, what interventions, what implications do nursing have for current health policies regarding the context of post-discharge care in psychiatric hospitalization in Portugal?"

Therefore, it is considered that several reasons have been gathered that make this reflective analysis of national health policies very pertinent, since:

(1) A paradigmatic change is underway with regard to mental health care, which is intended primarily for community rather than hospital-centered care;

(2) there is a need for specific health care for the transition here in focus;

(3) the literature strikingly highlights this need, but also the responsibility, for health professionals to establish specific responses to this transition;^{1,7,11}

(4) Nursing as a discipline and profession has the knowledge, but also the positioning in health care, to be able to respond to this demand and, finally,

(5) It is noteworthy that the National Mental Health Plan (NMHP) was extended until 2020, and is close to its re-evaluation and reformulation with regard to mental health policies. This is a milestone that Mental Health Nursing and Psychiatry cannot be unaware of.

OBJECTIVE

- To analyze current Mental Health policies, discriminating health care defined for the post-discharge period of psychiatric hospitalization, with a focus on nursing care.

METHOD

This is a reflective analysis article prepared from a bibliographic research that focuses on documents that focus on the adult population of 18-65 years and address the public sector health care in the post-discharge of the Psychiatry services. acute when it comes to the patient's return home. It is explained that the specialized responses addressed to the areas of addictive behaviors and addictions, neurodevelopmental disorders or dementias were not included.

Although they belong unequivocally in the area of Mental Health, they include a monitoring and organization of specific services that deserve particular attention and would complicate the achievement of the objectives proposed here.

All institutional, legislative or officially recognized documents regulating the area of Mental Health were considered, and for this, the following websites were consulted: Directorate-General for Health; Order of Nurses; Portuguese

Society of Mental Health Nursing; Portuguese Society of Psychiatry and Mental Health; Portuguese Society for the Study of Mental Health. It was previously considered pertinent to conduct a preliminary survey to determine if any analysis or reflection article had been conducted in this area at CINHALL Complete and MEDLINE Complete, which turned out to be unsuccessful.

It is based on the research formula: (health or health) AND politic * AND mental AND Portugal, obtaining a total of 27 articles. After reading the title and summary, only two articles were considered relevant for full reading and only one²⁷ was integrated as a document of interest to substantiate the results. This whole research process was based on an iterative logic, having been consulted the references present in the documents identified as pertinent to consolidate the obtained results. This survey was conducted from August 27, 2019 to September 15, 2019.

RESULTS

There are 15 documents¹⁶⁻³⁰ that allow the definition of health care after discharge from psychiatric hospitalization in relation to what is foreseen in official documents, but also evidenced in practice.

Generally, the various documents and references clearly pointed out the assistance activities that can ensure and intervene in the continuation of care after discharge from a hospital psychiatry service, including: external consultation - Psychiatry; external consultation - Psychology; consultation / complementary nursing care; consultation / complementary service of Social Work; day hospital or day area; home visit; Integrated Continuing Mental Health Care (ICMHC) - home support teams and socio-occupational units.

With regard to the provision of care, the following procedures provided by the Mental Health services include: individual psychotherapy; family psychotherapy; multifamily group sessions; group psychotherapy; psychodrama; electroconvulsive therapy; neuropsychological intervention; body mediation therapy and occupational therapy.¹⁶ In addition to the main available therapeutic programs: link to primary health care provided at health centers; home support; assertive treatment in the community; case management; employment support; residential support; psychoeducational programs; programs for individuals with first psychotic episode; rehabilitation programs and intersectoral programs (eg schools, justice).¹⁶

These types of care activities, procedures and programs are promoted by the Local Mental Health Services (LMHS), which define the matrix that best responds to the needs of the population.¹⁷ They

are responsible for providing global Mental Health care to a geodemographic area, usually consisting of psychiatric services/departments in general hospitals that coordinate both outpatient and inpatient care.¹⁷ Not all LMHS assure the above activities, and there is a disparate application that lacks uniformity and translates into interinstitutional variability.¹⁶

It is explained that the context of its realization can be at the hospital level, as in the context of Teams or Community Mental Health Units (T / CMHU). The latest emerged from the 2007-2016 NMHP in order to spread the decentralization of mental health services, establish proximity care and greater involvement and participation of people with mental illness, families and communities, promoting the rehabilitation and integration of people in the community, supported by the concept of recovery in mental health.^{18,19} They consider them, moreover, as the core of mental health care and as essential for ensuring the continuity of this care for the person who was discharged from the hospital and is now receiving outpatient and rehabilitation care.^{16,20} Included in the care programs that were highlighted by these T / CMHU: Integrated Program for Serious Mental Patients, with case management by referral therapists; Family Health Liaison Program and support for common mental disorders; Support program for elderly patients; Depression and suicide prevention program.^{18:20}

This ensures mental health care for people with severe mental illness, sharing with other institutions care for people with a common mental illness.¹⁹ In the latest PNSN assessment report, it warns of its insufficient development in many LMHS, the worrying decline in nurses and social workers, and the increase in outpatient consultation (accompanied by an increase in the number of psychiatrists and psychologists).¹⁶ From this, the limitations imposed by the hospital contracting model are perceived, pejoratively affecting multidisciplinary teamwork and the creation of community responses.¹⁶

In addition, there is a model of care still centered on medical care, with a hospital-centered focus, whose lines of productivity and hospital financing are primarily oriented towards hospitalization, medical appointments, hospital / day sessions and emergency room.^{16,18,20-22} It is noted that the productivity of mental health departments / services exclusively explains the number of hospitalizations, psychiatry consultations, hospital / day care and home visits.¹⁶ Consultations conducted by other health professionals are not discriminated, nor are interventions or procedures performed by health professionals.

In 2012, one of the proposed changes to the model of management of mental health services was precisely the establishment and quantification of home intervention programs that ensure an adequate response to the different care needs of the population, essential for the monitoring of health care and prevention of relapse and subsequent readmissions.^{21:8}

The question is: if it is assumed that the T / CMHU are fundamental to ensure continuity of care after discharge, it would not be pertinent to include a program dedicated precisely to this transition?

It is stressed in all NMHP documents and current Mental Health legislation that mental health care should be provided by multiprofessional teams.^{16-18,23,24} Incidentally, T / CMHU are defined as “multidisciplinary teams, with strong participation of nurses and other non-medical technicians”.^{18:20}

It is shown that this emphasis on Nursing participation does not stop here and is subsequently reiterated by another report that states precisely the same,²⁰ however, it is not just about the scarcity of human resources, namely non-medical technicians, and nursing interventions. but on the basis of an insidious and perennial asymmetry covering different levels of mental health care: (1) human resources, which are concentrated in central hospitals, mainly in Lisbon, Porto and Coimbra, and have disparate numbers and qualifications across regions and institutions; (2) the development and realization of outpatient responses (centered on consultations or hospital / day care sessions) arising from human resource allocation deficits and resistance to NMHP implementation; and (3) the type of offer and clinical practice of the various instituted responses, verifying a variability whose rationale is not clear.^{16,25}

It is therefore proposed, in the extension of the NMHP to 2020, to create a portfolio of SLSM minimum services that will ensure that credible interventions, programs, activities are duly credible and based on scientific evidence and good practice to ensure democratization and equity in the access to mental health care.^{16,22}

As far as the ICMHC network is concerned, there is a system that is clearly geared to the person with severe mental illness resulting in psychosocial disability that confers a degree of dependence.²⁴ The triggering of these mechanisms is believed to be effected by SLSM or psychiatric institutions in the social sector²⁴ whose assessment is based on a unique multidisciplinary assessment tool for psychosocial disability and dependence.²⁶ In this case, the person who returns home after discharge is exposed, that there are two structures that can be activated if all the

admission criteria are fulfilled and vacancy is available - home support teams and socio-occupational units.

It is clarified that the former does not depend on the degree of psychosocial disability attributed and focuses on the rehabilitation of relational skills, personal and domestic organization and access to community resources at home.²⁶ It is pointed out that the care team must include: nurse, preferably with specialization in Mental Health and Psychiatry; psychologist; social worker; psychosocial rehabilitation technician and direct action helper. The second is aimed at people with reduced or moderate degree of psychosocial disability and focuses on rehabilitation programs of relational, occupational and social integration, and the professionals who ensure this type of care: psychologist; social worker; psychosocial rehabilitation technician; monitor; administrative and auxiliary worker.²⁶

Precisely in this aspect of care, the perspective of the transition process regarding the post-discharge hospital is considered, which is considered as “an essential phase that requires specific interventions and programs, applied by highly qualified professionals and facilitators of the passage. a protected environment for the community”.^{16:48} The question arises: “Does the hospital-home transition, even without ICMHC criteria, deserve the same specificity of interventions and programs that should also be marked in the NMHP?”.

There is also the implementation of the weak ICMHC Network due to heterogeneity in access and provision of psychosocial rehabilitation care.^{16,27} This network is still in a pilot project phase and is therefore not available to all severely mentally ill patients with psychosocial disability. Continuity of care is therefore at risk due to the absence of a continuing care network that responds to LMHS needs.¹⁶ Therefore, one of the goals for 2020 is precisely the creation of 1500 places for adults in ICMHC that aims to improve the quality of continuity of care of the mentally ill, especially those that are serious and disabling.²²

With regard to the National Suicide Prevention Plan, it was stipulated as one of the objectives for its first phase (2013-2014), precisely to “Improve follow-up after discharge from hospital”^{28:20}, since it is established as a period of higher suicidal risk exactly during or after psychiatric hospitalization. It was found, however, that it acknowledges that underreporting of suicides does not reflect the reality of this phenomenon which calls for greater attention by policy makers with regard to the planning of mental health services.²⁹

In the context of describing the procedures effectively implemented, a study carried out in nine mental health care facilities that included

psychiatric hospitals, psychiatric services integrated in general hospitals, a public-private partnership social and private nature.²⁰ It is in the evaluation of the follow-up of patients after discharge: regarding the follow-up of post-discharge, namely by making a subsequent appointment and the prescription of the necessary drugs until that date, the public providers report that or the user is notified of subsequent appointment on the day of discharge, or is contacted for that purpose afterwards, and is prescribed medication until the approximate date of the appointment; On the other hand, in case of hospitalization to patients referred by other hospitals [...], the patient returns to the hospital of origin and the guarantee, or not, of the follow-up is the responsibility of this hospital.^{20:99}

Thus, difficulties in following up post-discharge patients were found when hospital care is provided by a different institution from outpatient care. In cases where this interinstitutional transition does not take place, the guarantee of the appointment of a subsequent psychiatric medical appointment and the provision of prescriptions.²⁰ However, it is stressed that “the readmission rate increased slightly between 2012 and 2013, as did the second episode rate for the same cause”.^{20:109}

In an analysis of the continuation of care in Portugal, a comparison was made between 1998 and 2012 and it was emphasized that the external consultation of psychiatrist was now mainly provided by general hospitals, rather than psychiatric hospitals, that home treatment the same level, and as for the assertive treatment or other psychosocial interventions it was not possible to obtain concrete data, and the post-discharge follow-up is the same - that of the psychiatrist's external consultation.²⁵ A more recent document clearly indicates this trend of reduced investment in multidisciplinary teams, with funding centered on the medical act, revealing that in 2016 726 680 medical psychiatry consultations were made in the mainland public service, versus 251 799 day / hospital sessions and 23,904 home visits.¹⁶

To illustrate the report, some good examples of clinical practice were chosen, one of them being from the Vila Nova de Famalicão Mental Health Unit, where it was implemented, as a measure to improve adherence to therapy of the discharged from the hospitalization service, a first outpatient psychiatry consultation within 15 days.³⁰ Another example is that of the Department of Psychiatry of Hospital Fernando da Fonseca, which integrates four community units of Mental Health. In 2011, there were 14,756 Psychiatry consultations in community units, due to the 980 home visits that year.³⁰

However, it is described that measures such as the assertive follow-up program for people with the first psychotic outbreak, psychological consultations and evaluations, psychotherapy, evaluations and social interventions have been implemented, but it is not possible to understand in which measure are applied.³⁰ It was also decided to set a deadline of 15 days for the appointment of a psychiatric medical appointment after discharge from the psychiatric hospital service.³⁰

It is clear in nursing that the role of nurses is considered to be of great relevance, being considered “the human resource that should be made available to the population with mental health problems in greater numbers”.^{20:42}

However, in addition to reducing their number, it is clear that the recognition of the specialist nurse falls far short and does not go beyond the mere numerical distinction of the general nurse.¹⁶ In addition, the roles to which it is linked are related to the general care nurse, not indicating other possible interventions that would be within the reach of the specialist nurse. As an example, there are adult home care teams (ICMHC) whose stipulated services are to promote the autonomy of basic and instrumental life activities, access to occupational or recreational activities, sensitization and involvement of caregivers, drug supervision and management.²⁶ The same is true of the competencies described for nurses who are part of the T / CMHU, the only ones to have, in their designated competences, a list of actions that only reflect the competencies of general care nurses.

Note that they are also the only ones to have mentioned in their competences “Overseeing and managing medication”,^{19:9} placing them clearly in line with the biomedical model which, furthermore, emphasizes interdependent and non-autonomous intervention in what is designated as its own competences. Moreover, it is assessed that their competences in scientific research are not recognized, particularly when talking about specialist nurses, who often have completed their masters in the same area and have developed research competencies with a view to Nursing discipline and profession development and inherently health care.

DISCUSSION

It is argued that, although the various possibilities of ensuring continuity of care in the transition of the person from psychiatric hospitalization to the home are described, those that emerge from the consulted documents are centered on the follow-up consultation by psychiatrist and do not show other activities or procedures of this post-discharge follow-up.

First of all, it is emphasized in the NMHP that “the interval between discharge and subsequent consultation, associated with the proportion of readmissions that occurred without any outpatient contact [...] suggests the existence of continuity of care problems”.^{18:8} This scenario is really reinforced when the gap between hospital discharge and post-discharge psychiatry consultation is facilitated as readmission facilitator, which clearly shows the inefficiency of the health system as responsible for maintaining citizens' health.³¹ Other valid points of contact of the patient with the health system that could guarantee their follow-up, such as the family doctor or the nursing consultation, or the home visit, etc., omitted in the reports, are seen, which limits the evolution and structuring of health care beyond the biomedical and hospital-centric model.

Far from contesting the intervention of follow-up consultation by psychiatrist, it is considered that it reflects a reality that provides an insufficient and possibly silent response to the impact that hospitalization in Psychiatry can have on the person, particularly if it is a first episode or even a compulsory internment.^{5,8} It has been reported for a long time and repeatedly how hospitalization affects the individual who questions his self-concept and sense of identity, as he perceives difficulties in adjusting to the changes experienced in himself, in his daily life and in the expected role performance, post-hospitalization. This is further complicated when there is a reduced presence or lack of awareness of the implications of a mental illness crisis, a psychiatric internment and a psychiatric treatment on return home to their existence and sense of Si.^{1,7,8,11}

Increasingly, advocates have been advocated for nurse specialists in mental health and psychiatry for a majority presence in the various contexts of mental health care provision (such as in the T / CMHU or ICMHC units and teams) in detriment of the presence of general care nurses.^{32,33} This position derives from the specificity and evolution of history and representations of health / mental illness that are also associated with a need for differentiated responses that give credibility and security in the global context of care in this area.^{32,34}

The therapeutic relationship is essential as a basis in this context of care and, therefore, an imperative to include in the competences of any professional who intervenes in it.³² Nurses specializing in Mental Health and Psychiatry are at the forefront of the provision of nursing care in this area, as they have enhanced their skills in establishing therapeutic relationships and can therefore mobilize psychotherapeutic, sociotherapeutic, psychosocial and psycho-educational interventions.^{32,35} All of these

constitute potentializers in the establishment of the therapeutic relationship, which acquires greater consolidation and breadth of expression. Moreover, in the regulation of quality of care standards, there is the recognition of acting in the face of maladjusted human responses to the transition processes equally envisaged as an experience: “the promotion of the client's mental health potential through the optimization of human responses to transition processes: developmental, situational, random”^{36:7}, but also as a passage: “coordinating the transition of patients and families between specialized mental health care settings”.^{36:10}

It is considered that, although there are numerous works, mainly academic, that are elaborating the various potentialities inherent to the performance of the specialist nurse in Mental Health and Psychiatry, the inherent gains are not yet clearly evident to policy makers and other actors in the constitution of public health policies, justifying their reduced visibility in the various documents consulted. It is judged, as the roles to be fulfilled by the general care nurse in this area are described, that it would be equally important to emphasize some skills of the specialist nurse to perform within these multidisciplinary teams.

Finally, it is considered that, although this study does not have a review of systematic references regarding the defining documents of the Portuguese mental health policies, its research process is quite specified, allowing to check and ensure the credibility of the information analyzed here.

CONCLUSION

It is believed that this analysis and reflection on the status quo of mental health policies and their repercussions has allowed us to re-think and rethink the paths that have been built in mental health care.

In Portuguese mental health policies, the post-discharge of psychiatric hospitalization as a transitional human challenge that needs to include the provision of specific transitional care is not yet clearly evident. They need a proper demarcation and intervention, emphasizing the continuity of health care that, in addition to tracing the usual therapeutic project of the individual, can focus on the impact that hospitalization had on the person, facilitating the understanding of their experiences and its possible embarrassments after discharge and promote the achievement of meaning for a clearly marked experience such as psychiatric hospitalization.

In addition, another noteworthy aspect concerns the asymmetry present in established health care, the way it is implemented and the number of human resources available that

undermine equity and access to health care. Insufficient human resources and community structures are recognized in a funding model centered on the medical act and constraining community interventions. It is cautioned that, in a procrastination tone, the hegemony of the hospital-centric attitude, centered on the biomedical model, has long been refuted by the scientific literature in the provision of healthcare. Therefore, although health policies are in line with what scientific research has shown, a pragmatic scope of mental health policies falls short of what is necessary and established, which has led to the extension of the NMHP to 2020.

The participation of nurses as essential in mental health policies is emphasized, with special emphasis on multidisciplinary teams. However, it is considered that there is no clear recognition of the particular contribution that the specialist nurse in mental health and psychiatry can make in relation to the general care nurse.

Through this reflexive analysis, it is possible to raise awareness of the scope that health policies may have on the clinical practice of the Mental Health and Psychiatric nurse, who do not see their specific competences properly assumed by health policy planners. This may have repercussions on the progress of nursing discipline and profession in this particular area, as, as an area of practical knowledge, it will be depleted of the development that is inherent in clinical practice. In other words, without investing in the clinical practice of Mental Health Nursing and Psychiatry care, it will be more difficult to evolve in order to increase their capacity to respond to the needs of people with illness. mental. It is considered that it is up to the specialist nurses to take responsibility for producing the necessary evidence to weave the arguments that support their indispensable presence in the multidisciplinary mental health care teams, clarifying the specialist nurses and general care nurses in the composition of these health services.

In conclusion, the establishment of mental health policies, especially in view of the end of the current NMHP, should include the active inclusion of nurses who, through their own mechanisms - such as the Order of Nurses, the Schools but also nursing professionals themselves - do not interfere with sensitizing and expressing to policy makers the need for specific and specialized mental health care for people with mental illness, particularly those who return home after psychiatric hospitalization.

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