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Therapeutic relationships and care in addressing vulnerability in the psychiatric revolving-door phenomenon

Relações terapêuticas e cuidado no enfrentamento da vulnerabilização na porta giratória psiquiátrica

Relaciones terapéuticas y cuidado en el enfrentamiento de la vulnerabilización en la puerta giratoria psiquiátrica

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ABSTRACT

Objective: To analyze therapeutic relationships in psychosocial care and their role in addressing the vulnerability of people involved in the revolving door phenomenon.

Method: A qualitative case study, grounded in historical-dialectical materialism, was conducted in health and social assistance services in southern Brazil between March and August 2023. Participants included eight patients over 18 years of age, all with at least two psychiatric

hospitalizations between 2021 and 2023. Data collection included guided discursive interviews, information from the hospitalization system, and field notes. Data were analyzed, supported by NVivo® 14, in stages: segmentation, qualification, and individuation.
Results: The narratives revealed multiple vulnerabilities: individual (severe mental disorders, problematic substance use, low therapeutic adherence), social (unemployment, family breakdown, precarious housing), and programmatic (weaknesses in the care network, limited access to social assistance). It was evident that experiences of integration between Psychosocial Care Centers and social assistance services provide concrete alternatives to rehospitalization, such as access to benefits, housing support, rights mediation, and community strengthening.
Final considerations: Therapeutic relationships, guided by acceptance, shared responsibility, community support, and the guarantee of rights, constitute essential technology for the continuity of care in freedom and the confrontation of vulnerability.
Descriptors: Mental health; Social vulnerability; Social support; Social work; Psychiatric nursing.

RESUMO
Objetivo: Analisar as relações terapêuticas na atenção psicossocial e seu papel para enfrentar a vulnerabilização em que se encontram pessoas envolvidas no fenômeno da porta giratória. **Método:** Estudo de caso qualitativo, fundamentado no materialismo histórico-dialético, realizado em serviços de saúde e assistência social do Sul do Brasil, de março a agosto de 2023. Participaram oito usuários maiores de 18 anos, todos com, ao menos, duas internações psiquiátricas no período de 2021 a 2023. A coleta incluiu entrevistas discursivas guiadas, informações do sistema de internação e anotações de campo. Os dados foram analisados, com apoio do NVivo® 14, em etapas: segmentação, qualificação e individuação. **Resultados:** As narrativas revelaram múltiplas vulnerabilidades: individuais (transtornos mentais graves, uso problemático de substâncias, baixa adesão terapêutica), sociais (desemprego, rupturas familiares, moradia precária) e programáticas (fragilidades na rede de atenção, acesso limitado à assistência social). Evidenciou-se que experiências de integração entre Centros de Atenção Psicossocial e serviços da assistência social possibilitam alternativas concretas à reinternação, como acesso a benefícios, apoio habitacional, mediação de direitos e fortalecimento comunitário. **Considerações finais:** As relações terapêuticas, pautadas pelo acolhimento, corresponsabilização, suporte comunitário e garantia de direitos, constituem tecnologia essencial para a continuidade do cuidado em liberdade e do enfrentamento da vulnerabilização.
Descritores: Saúde mental; Vulnerabilidade social; Apoio social; Serviço social; Enfermagem psiquiátrica.

RESUMEN
Objetivo: Analizar las relaciones terapéuticas en la atención psicosocial y su papel en el abordaje de la vulnerabilidad de las personas involucradas en el fenómeno de las puertas giratorias.
Método: Se realizó un estudio de caso cualitativo, basado en el materialismo histórico-dialéctico, en servicios de salud y asistencia social del sur de Brasil entre marzo y agosto de 2023. Participaron ocho pacientes mayores de 18 años, todos con al menos dos hospitalizaciones psiquiátricas entre 2021 y 2023. La recolección de datos incluyó entrevistas discursivas guiadas, información del sistema de hospitalización y notas de campo. Los datos se analizaron, con el apoyo de NVivo® 14, en etapas: segmentación, calificación e individuación.
Resultados: Las narrativas revelaron múltiples vulnerabilidades: individuales (trastornos mentales graves, consumo problemático de sustancias, baja adherencia terapéutica), sociales (desempleo, desintegración familiar, vivienda precaria) y programáticas (debilidades en la red de atención, acceso limitado a la asistencia social). Se evidenció que las experiencias de

integración entre los Centros de Atención Psicosocial y los servicios de asistencia social ofrecen alternativas concretas a la rehospitalización, como el acceso a beneficios, el apoyo habitacional, la mediación de derechos y el fortalecimiento comunitario.
Consideraciones finales: Las relaciones terapéuticas, guiadas por la aceptación, la responsabilidad compartida, el apoyo comunitario y la garantía de los derechos, constituyen una tecnología esencial para la continuidad de la atención en libertad y la superación de la vulnerabilidad.
Descriptores: Salud mental; Vulnerabilidad social; Apoyo social; Servicio social; Enfermería psiquiátrica.

INTRODUCTION

The revolving door phenomenon is characterized by repeated psychiatric admissions within a short period of time, involving those with severe mental disorders that repeatedly come back to hospital services, even after policies to reduce institutionalization and lead to community reassimilation are implemented[1-2]. In Brazil, studies show readmission rates from 16% in 30 days to 22% in a year, showing how persistent this issue is and the need for strategies that ensure the continuity of care[3-4].

The Brazilian psychiatric reform consolidated the Psychosocial Support Network (RAPS) as an axis of mental health policies, replacing the asylum model by territorial and community services, such as the Centers for Psychosocial Care (CAPS), articulated with Primary Health Care and social work. However, the structural shortcomings and the discontinuous nature of care units compromise the possibility of integral care, maintaining a cycle of hospitalizations[5].

Reference Centers Specialized in Social Work (CREAS) have a strategic role in protecting those in vulnerable situations and in articulating with mental health, which is recognized by users as essential to ensure access and the continuity of care[6]. Still, given the insufficient funding of the RAPS, the turnover of professionals, and the precarious nature of the position, hinder the possibility of conducting interdisciplinary practices, building therapeutic projects, and consolidating psychosocial approaches to replace medical and hospital-centered approaches[5,7].

In recent years, mental health policies have become tensioned by restricted resources and encouragement to hospitalization, increasing the discontinuation of care and worsening the phenomenon of the revolving door. On the other hand, experiences with integrated models, which articulate hospitals and community services, have decreased in readmissions and urgent care[1-2,5].

These shortcomings express processes of vulnerabilization that stem from the interaction between individual (persistent disorders, treatment adherence), social (low educational level, limited family support), and programmatic (interruptions in care, restricted access to services) dimensions. This is, therefore, a social and historical production of vulnerabilities, associated with policies, economy, territory, and power relationships[5-8]. The World Mental Report 2022 reiterates that programmatic and social failures explain why many people with psychosis do not seek mental health services, showing that the revolving door cycle is less a result of individual factors than of structural inequality[5,8,9].

In this context, therapeutic relationships maintained by the multiprofessional team of the CAPS form the central technology so users can receive care while being free, and to deal with vulnerabilization, as they promote integrated and corresponsible practices among professionals and users[7,10]. Continuous and territorial care favors trust bonds, treatment adherence, and decreases readmissions[1,3,7,10].

Psychiatric nurses have a fundamental role in this process, as they develop clinical, relational, and ethical competences that help overcome hospital-centered practices and consolidate humane approaches for rehabilitation[10]. Thus, understanding how therapeutic relationships help face vulnerabilization enables us to improve practices of care to ensure that those with severe mental disorders can have continuous care and autonomy.

As a result, this study seeks to answer: How do therapeutic relationships formed during psychosocial care contribute to deal with the vulnerabilization of those involved in the revolving door phenomenon? Its goal is to analyze the therapeutic relationships in psychosocial care, and their role in dealing with the vulnerabilization of these people.

METHOD

This is a qualitative case study, whose methodological-theoretical framework was historical-dialectic materialism, which understands reality as a dynamic and contradictory process that is constructed historically, which allows for a critical analysis of social relationships and the processes of vulnerabilization in psychosocial care[11]. This framework guided both the delineation of the study object and data analysis, guiding our interpretation of the contradictions between public policies, institutional practices, and the experiences of subjects, in order to understand the mediation between individual, social, and programmatic dimensions of the phenomenon being studied.

The case study design was chosen as it allows for a profound analysis of the revolving door phenomenon, articulating multiple sources of evidence and enabling us to understand the complexity of providing care in the territory[12].

The study was developed in a health district of a region in the South of Brazil, from March to August, 2023. The territory has approximately 100 thousand residents, divided into six neighborhoods, with social vulnerability indexes such as a 3.48% illiteracy rate and a mean per capita income of 3.8 minimum wages. Three public services were investigated: one CAPS II, one Alcohol and Drugs CAPS (CAPSad), and one CREAS. These were chosen as they presented a consolidated presence of the RAPS and intersectorial articulation between health and social care, which are seen as essential when providing care to those with severe mental disorders.

This study included eight users, above 18 years of age, selected via intentional sampling, according to a typification technique[13], considering the diversity of sociodemographic profiles and experiences of care. The inclusion criteria was having experienced two or more psychiatric hospitalizations from September 2021 to September 2023, which is a consolidated indicator of the revolving door phenomenon in national and international studies about psychiatric readmissions[1-4]. Exclusion criteria included people with clinical or cognitive impairments that would prevent their communication, but none were identified during data collection.

Collection was carried out by the main researcher, a male nursing PhD with previous experience in multiple studies involving qualitative data collection. Three complementary strategies of data collection were used: guided discursive interviews, field journal, and secondary data analysis. The interviews took place in private spaces at CAPS II and CAPSas, ensuring privacy and comfort. Participants were also invited individually during the waiting periods in these services and referred by the specialized teams. Each participant provided a single interview, which was guided by a progressive thematic script that addressed life and care experiences, admissions and readmissions, therapeutic relationships and expectations for the continuity of care. All interviews were recorded in audio, from 40 to 60 minutes, and concluded after reaching theoretical saturation[14]. Interviews were conducted in the presence of a researcher and a participant. There was not individual or collective feedback to the participants in regard to the results, nor external validation by other researchers.

The field journal was filled in after each day, recording observations and initial analytical hypotheses. It gave support to understanding the territory and was integrated to the interviews in the analysis, ensuring that the data sources were coherent. Secondary information

was obtained in the Admission Management platform (Gerint), from the Municipal Health Secretariat, and used to characterize the profile and the history of participant admissions.

Data analysis happened in three parts: segmentation in units of meaning; qualification, by attributing analytical codes and categorization; and individuation, targeted at identifying standards and contrasts. The NVivo® 14 software was used as tool for organization and systematization; the critical interpretation of data was conducted in the light of historical-dialectic materialism, articulating contradictions between context, subjects, and practices of care.

As this is a qualitative research, our rigor was not only focused on statistical reproducibility or typical generalization as it would be in a quantitative research. It was based on the appearance of procedures, their argumentative consistency and the plausibility of conclusions achieved from the interaction between data and theory[13]. These principles were adopted when describing in detail the data collection and analysis procedures, coding and categorizing data in a system using NVivo®, and explaining the limitations of the inferences.

The anonymity of participants was ensured as they were identified using pseudonyms associated with the main participants of the 1922 Modern Art Week, in addition to the omission of any data that could enable their identification. The study report was elaborated according to the Consolidated Criteria for Reporting Qualitative Research (COREQ)[15]. All ethical procedures respected Resolution No. 466/2012 from the National Council of Health, and were approved by the Research Ethics Committee (CAAE 61283622.3.3001.5338, Opinion No. 6.161.725). All participants signed two copies of an informed consent.

RESULTS AND DISCUSSION

The study included eight RAPS users, all of whom had a history of psychiatric readmissions. Ages varied from 21 to 63 years old. Seven participants were men and one, a woman. Most were single, with a low educational level and weakened or broken occupational bonds, being affected by unemployment and early retirement. The number of admissions in the period varied from two to six, to a total of eight in the personal history. The predominant diagnoses included schizophrenia, severe depression, and alcohol and cocaine abuse, often associated with weak support networks and social instability.

Two cases demonstrate this context. Anita, 48 years old, the only woman in the group, diagnosed with schizophrenia, was admitted twice in 2023, presenting a low adherence to the medication treatment. She was readmitted two weeks after the interview. Her report highlights social isolation, trouble connecting to services, and the permanence of drug-centered practices.

Emiliano, 21 years old, black, single and unemployed, was readmitted six times from 2021 to 2023, to a total of eight in his entire history, in association with severe depression and cocaine abuse. His experience shows superposed individual and social vulnerabilities: psychic disease, psychoactive substance consumption, and the lack of family and community support.

The narratives of these participants reflect interdependent dimensions of social, programmatic, and individual vulnerabilities that are not isolated, but historically articulated to produce vulnerabilization[5,8]. The programmatic shortcomings of the support networks, expressed by the discontinuous care and the lack of intersectorial articulation, have a direct repercussion on the social conditions of users, leading to distancing from family, exclusion from work, and recurring admissions. Thus, the vulnerabilization is a structural and relational process that takes place throughout the life of these subjects and maintains the phenomenon of the revolving door[1-4,5,8]. These findings reiterate that integrated and territorialized care strategies are essential to break the cycle of readmissions and improve the continuity of care.

Experiences in health services

The reports of the participants (Victor, Emiliano, Mário, Manuel, Oswald, Anita, Guilherme, Ronald) show experiences affected by individual, social, and programmatic vulnerabilities, which express themselves in the way the participants experience the health network. Although each trajectory has its own particularities, certain aspects converge: the centrality of medication use, the trauma from previous admissions, the CAPS as a space for belonging, and the additional challenges imposed by the COVID-19 pandemic. These experiences show the structural contradictions that inform the phenomenon of the revolving door in Brazilian mental health.

The psychiatric admissions are repeatedly reported, associated with the centrality of routine pharmacological treatments. Victor illustrates this by reporting how his regular use of clonazepam gave him relief from auditory hallucinations:

> *I started to improve more when I started taking clonazepam. Because then the effect of the medication, it made me calmer. And I wouldn't care that I was listening to voices. Or that I was having hallucinations.* (Victor)

Victor expressed the protective dimension of medication, recognized by literature as a factor associated with the reduction of readmissions among people with severe mental disorders[16]. However, the dialectic analysis suggests that the use of psychotropic medication, despite necessary in certain contexts, is often implemented as the only therapeutic resource,

expressing the historic trend of medicating psychic suffering and the limitation of psychosocial practices.

This perspective becomes broader when participants state that listening voices do not always mean disease, but an experience that can be shared, and to which new meanings can be attributed. Experiences such as the Groups of Voices Listeners have a therapeutic potential as they promote autonomy and reduce social isolation[17,18]. These practices, despite being incipient in the public network, face the obstacle of the biomedical hegemonic model and the lack of knowledge of professionals[10]. The result is the perpetuation of strategies centered around pharmacological silencing, which do not address the subjective and social dimensions of suffering.

The phenomenon of medicalization is an expression of a "palliative society", characterized by anesthetization of pain and the invisibility of its structural determinants[19]. In the field of mental health, this process manifests in hospitalization cycles, in which the medication ensures momentary stabilization, but does not prevent new crises, seeing as it is not coupled with psychosocial rehabilitation strategies. The programmatic vulnerabilization, expressed in the discontinuity of care and insufficiency of integrated practices, leads to social vulnerabilization, which translates into unemployment, isolation, and family distancing.

A dialectic analysis also enables us to understand the specificities of nursing care, integrating the use of medication to the process for the autonomy of the subjects during psychosocial rehabilitation. The use of medication, as one of the working tools of nursing, is different from the medicalization process, since it is mediated by its relationship with the subject, which involves embracing, an evaluation of use needs, and the joint negotiation between users and the team, information, and orientation. These types of care require nurses to use strategies so the user and their family internalize the information related with medication therapies, developing skills for the safe administration of these drugs during treatment in the territory[7,10].

Victor also describes the negative impact of hospitalizations in contexts that are not welcoming:

> *I was there, having trouble in the hospitalization due to trauma. I started feeling really bad there. Do you understand? Because my heart started beating too fast there. I started to feel fear. [...]They kind of control you, let's say, in a neutral way. They treat you, how can I put it, as if they have a specific goal, I think.* (Victor)

The neutrality of the professionals and the institutional control, seen as a form of distance, weaken the possibility of creating therapeutic relationships. These bonds, formed by listening, embracing, and co-responsibility, are central elements in a therapeutic relationship, according to international literature in psychiatric nursing[10,16]. Its absence prevents the development of mutual trust and autonomy, increasing the probability of readmissions.

The comparisons between different institutions made by the participants reiterate this analysis:

> *Hospital [X] had an open space where we could stay, playing ball, or just staying in the sun. There were workshops, cinema debates, art workshops. At hospital [Y] I had nothing but a TV... It was simply too closed. And that started to make me feel claustrophobic.* (Mário)

Environments that promote interaction and socialization favor better clinical results and decrease risks of readmissions[20]. This evidence has been corroborated by European and Latin-American studies that associate humane hospital structures to the continuity of care and the reduction of compulsory hospitalizations[2,20]. The concept of programmatic vulnerability helps interpret this reality as it shows the structural issues in public health policies, which include the fragmentation between levels of care and their lack of resources, which increase the risk of readmissions.

On the other hand, the CAPS are mentioned in the statements as places where one can belong and establish bonds. Emiliano describes his routine:

> *I come here everyday. Everyday. From Monday to Friday. Every morning, and I stay the afternoon, mostly. I have lunch here, I participate in the activities in the afternoon, such as gardening, cinema debates, and the radio. [...] it's an amazing space. They embraced us. Not only me, all of us, right. In practice, they help us a lot inside here.* (Emiliano)

Guilherme complemented:

> *I'm coming here on Tuesdays now, which is when there's a morning workshop. [...] On Thursdays there's gardening in the morning, music in the afternoons. [...] Now, I can say that, at 60 years old, I really like reading, I got back into reading.* (Guilherme)

The workshops, gardens, and collective activities are described as experiences of socialization and production of meaning, increasing their feeling of belonging. In these spaces, the therapeutic relationship manifests in attentive listening, in the co-authorship of a therapeutic project, and in the shared responsibility between team and user. This form of relational and

continuous care is associated with a reduced number of readmissions and an increased autonomy[5,7,21].

Furthermore, Oswald reports how important the diet is, and shows another dimension of social vulnerabilization: food insecurity.

> *I drank, I drank, I wouldn't eat... I got to 68 kg. Now I'm 75 kg. I'm still thin, but now, the food here is good, it's fantastic.* (Oswald)

By integrating practices of nutrition and gardening, the CAPS address basic needs and promote dignity, showing that intersectorial activities can mitigate the effects of programmatic vulnerabilization.

Still, for some participants, the medication control in CAPS was decisive. Anita states:

> *Now, here, I got better. Because I wouldn't take the drugs. They didn't really explain it well, too. Then, after I started coming here, then I started taking the right medication (Anita)*

This report shows how the CAPS helped her adherence to the pharmacological treatment and early clinical improvements. However, data from the Gerint suggest that Anita was readmitted again, two weeks after our interview. This shows the limitations of the continuity of care, even among users who are following their treatment in community services. These readmissions show the programmatic weaknesses of the network of care, related to a low-intensity follow-up and the lack of permanent psychosocial strategies, factors which are broadly understood in literature as associated with the risk of early readmissions[1,5]. Thus, a psychosocial support that is articulated with individualized clinical care is essential to support therapeutic advances, reiterating the relevance of individualized care.

Finally during the COVID-19 pandemic, nursing reconfigured its practices to preserve therapeutic bonds at a distance, combining monitoring via phone and applications, distance health education, organization and delivery of drugs in the territory, early identification of risk, and in-person visits when there were sufficient justification. This hybrid organization helped mediate the contradiction between sanitary demands and the need for continuous care, reducing avoidable decompensations and keeping the user connected to the network[22,23]. Mário reports:

> *We were attended online. So, I couldn't really be there so frequently. The issue of CAPS access was quite limited with the situation of the pandemic. I think that was a really bad moment.* (Mário)

The abrupt transition to remote care restricted the access of users in a situation of vulnerability, affecting the continuity of therapeutic relationships. In low-income contexts, the lack of necessary devices and low digital literacy limited the effectiveness of remote care[22,23]. Victor reports a crisis during a period of grief in the pandemic:

> *When my mother died in the pandemic, in 2021, I tried suicide. I had an overdosis. I ended up passing out. [...] I took thirty-two pills. Then I passed out. And I woke up in the hospital.*(Victor)

The sanitary crisis, therefore, increased the already existing programmatic and social vulnerabilities, showing the need for hybrid care strategies that could bridge the gap between digital technologies and physical presence. For extremely vulnerable populations, in-person contact is still irreplaceable, as it maintains therapeutic bonds, trust, and co-responsibility, which are essential pillars to deal with vulnerabilization and the continuation of care with liberty.

Experiences in social work services

The analysis of the reports showed a diversity of experiences with the social work services, from the lack of knowledge about how they work, the single-time support in emergencies, and the frustration concerning the bureaucratic nature and fragility of the relationships established. This heterogeneity shows the unequal way in which social work policies materialize in the territories. This has a direct repercussion on the maintenance of minimal life conditions and the vulnerabilization of people undergoing psychic distress, understood as the ongoing social and historical process that expresses mediation between public policies, territory, and the hierarchical positions of power[8]. In the field of social work, this process manifests in the production of institutional dependence and the loss of subject autonomy.

The Single Social Work System (SUAS), formalized by Law 12.435/2011, is the main public policy for social protection in Brazil. It is structured in two levels: basic social protection, mostly operated by the Social Assistance Reference Center (CRAS), and the special social protection, represented, among other units, by the CREAS. Even with their universal and territorial character, studies have shown structural and operational limits to CREAS, which lead to significant inequalities to the access and quality of the care provided[24,25].

In the reports analyzed, users expressed not having knowledge about the CREAS or contact with it, in addition to a mostly bureaucratic interaction with CRAS, which is restricted to the updating of the Single Register or the continuity of welfare:

> *Not in the CREAS. I've never been there. I haven't had the opportunity of going there. [...] As for the CRAS, I went to one that was down below, where I have to go to update by single register. [...] So, I went there below, near (Street X). But they only gave me the address of places I had to go to update my single register, right? So I have to go somewhere else. Which is where I'm going tomorrow.*(Emiliano)

This report shows the bureaucratic mediation as a way to access the right which fragments the trajectory of the user by referring them and requiring them to go elsewhere. In the light of dialectics, this is programmatic vulnerability, since the policy presents itself as universal, but the materialization of its presence in the territory is unequal and intermitent[5,24,25]. This setting converts what is a right into a procedural obligation, exhausting the user, and leading to discontinued care and low effectiveness in their protection. This has an indirect repercussion in mental health care[6,8].

> *Last time, I was interviewed for an interview at CRAS, and I did. You have to go there every two years. [...] For the LOAS benefit.[...] Me, only [go to CRAS] when I'm called.* (Anita)

The episodic relationship with the CRAS (biannual update to maintain the LOAS) shows a reactive and tutored connection to social care, focused on maintaining welfare benefits and without continued social follow up. From the point of view of dialectics, the low intensity of follow-up is a mechanism that reproduces vulnerabilization: there is a minimum income, but no daily mediation to deal with food insecurity, poor living conditions, and isolation[24,26,27].

> *NOne, not the CRAS, not the CREAS.* (Mário)

The lack of a bond with social care suggests a lack of protection on a basic and special level, reiterating the separation between formal right and real access. The loss of social protection, expressed in the underfunding and bureaucratization of SUAS, leads to poor conditions in material and symbolic levels, increases psychic suffering, and re-updates the cycle of readmissions[5,8,26,27].

On the other hand, some experiences where significant support was received have been reported. The role of the CRAS was highlighted as a tool to ensure survival in situations of vulnerability:

> *I enrolled at CRAS to get the benefit. Otherwise I'd be on the streets. I got it, thank God. You have to be kind of a Spartan, right? Things are too expensive, prices have doubled. I started back when it was the Auxílio Brasil Benefit.* (Oswald).

Oswald's report shows that the welfare received is a social determinant of mental health, by ensuring a minimal income for food, housing, and dignity. However, the instability in the access and the recent budget cuts in SUAS, have compromised the protection provided, worsening the vulnerability of groups that are already marginalized[26,27].

> *I went to the CRAS, they said I do not have this right.* (Manuel)

These experiences show that the promise of universal care is not equally effective for all subjects, showing failures in institutional communication that lead to misunderstandings and exclusion. The lack of material support worsens psychic suffering and helps psychiatric admissions to become, once again, the result of basic needs that are not met.

The experience of other participants show positive efforts to articulate between CAPS and CREAS, despite varying results.

> *I looked for the CREAS when I needed a place to stay, right? So much that I tried in CAPS, but then CAPS did not work, so the next day I went to CREAS. And CREAS could not do it for me, so I came back here to the CAPS, and the CAPS managed to do it. But I searched for CREAS at the time because of that, but now they're helping me get back another benefit.* (Ronald)

This scene shows a dialectic mediation between public policies, in which CAPS open the doors for CREAS and social benefits. When the articulation between CAPS and SUAS takes place, it results in material responses that reduce the exposure to crises and give support to receiving care in liberty[5,28,29].

Furthermore, the bond between workers at CRAS and CREAS and the users can be understood as an expanded form of the therapeutic relationship, based on listening, embracing, and social corresponsibilization. When this relationship is present, the continuity of care and connection to the territory increase, associating psychosocial and material dimensions of the rehabilitation process[5,7,8]. Nursing professionals, by working at the RAPS, in articulation with the SUAS, has an essential role in this type of mediation, as they can identify social determinants in reception and during visits, registering needs in the Single Therapeutic Project and resorting to intersectorial flow, which transforms clinical needs in concrete social demands, helping prevent further admissions[7,21,28,29].

The poor conditions at the SUAS show a dialectic contradiction between the formal university of rights and the managerial rationality that, with neoliberalism, requires budget cuts and fragments social work. This historic contradiction is materialized in the territory itself, where subjects experience exclusion and suffering as expressions of their vulnerabilization[8,26,27]. The COVID-19 pandemic made this setting even worse, burdening the services and making the access of vulnerable persons more difficult. The reports show that the poor conditions of SUAS compromised the effectiveness of social support during the pandemic[29,30]. Similar processes, involving the loss of social protection and overload of basic services, were observed in other Latin-American countries, where the underfunding of public policies led to a cycle of exclusion and institutionalization[25,29].

In general, reports and studies about psychiatric readmissions suggest that the phenomenon of the revolving door in mental health is a result of the interaction between clinical, social, and programmatic determinants, and cannot be understood as only a failure of the hospital or the individual[1,3,5,8,26]. It also expresses the insufficiency of social policies, which do not ensure that the subject has their basic material needs of survival covered, making it unfeasible for them to live as free people, and perpetuating the cycle of readmissions. Poor living conditions, food insecurity, unemployment, and stigmatization are elements of the vulnerable conditions of these subjects, making them more susceptible to hospitalization. Therefore, psychiatric hospitalizations are often a contingency to deal with the collapse of the social and health support network, not an inherent necessity of mental health care.

On the other hand, positive experiences in the CAPS-SUAS integration show that, when the different sectors become articulated, concrete alternatives to readmission can be found. Access to welfare and housing, mediations so individuals can be enrolled in public services, and enhanced community bonds show that coordinated policies increase the strength of therapeutic projects and reduce vulnerability. These practices reiterate the principle that the continuity of care in mental health depends both on clinical interventions and on the social conditions that maintain life.

In this process, nursing occupies a strategic position in the mediation between health and social work. Through territorial follow up and the continuous bond with their users, nurses identify emerging social needs and articulate the different units in the network, helping prevent further hospitalization and improving the care provided to these users as free people[5,7,21,28].

Therefore, dealing with the revolving door phenomenon requires strengthening the SUAS as a strategic public policy, with stable investments; recognizing the value of workers; and increasing territorial coverage. At the same time, it requires overcoming the bureaucratic

logic that transforms rights into barriers to access. Possible ways to move forward include participative territorial management; an active approximation between teams and users; and a qualified hearing of their demands, recognizing the value in the uniqueness and dignity of each subject. A robust intersectorial network can, thus, help overcome the cycle of vulnerabilization and consolidate the care provided to free subjects as the axis around which psychosocial care is structured.

FINAL CONSIDERATIONS

The study showed that the phenomenon of the revolving door in mental health is a result of the interaction between individual, social, and programmatic vulnerabilities, which remain due to structural contradictions found in the Brazilian system of social protections. The readmissions cannot be explained by the severity of the disorder, but by the shortcomings of community networks and the fact that policies to ensure material conditions for a free life are insufficient.

The main theoretical advancement achieved here is the analysis of the phenomenon of the revolving door from the perspective of vulnerabilization, understood here as the historical and relational process that articulates a lack of social protection, psychic suffering, and the reproduction of inequality. Methodologically speaking, this study reiterates how powerful the dialectic-historical framework is to analyze mediations between care, territory, and public policies, as it allows us to understand the contradictions that lead to further readmissions.

From a practical standpoint, the study highlights that therapeutic relationships are an essential axis to deal with vulnerabilization and reduce psychiatric hospitalization. By promoting bonds of trust, co-responsibilization, and qualified listening, these relationships increase the autonomy of users, and help them continue to be treated in freedom. Mental health nursing shows itself as a strategic category in this process, as it integrates clinical monitoring, psychosocial support, and an intersectorial mediation with the SUAS, helping consolidate territorial care networks that ensure continued social protection in the fight against the stigma.

Dealing with the revolving door phenomenon requires, therefore, more than reorganizing the services: it requires recognizing, in the therapeutic relationships, the ethical-political center of care, which is based on the dignity, autonomy, and social rights of the subject. Strengthening these relationships is a path to transform psychosocial care in an effectively emancipatory practice that promotes a life of freedom.

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Data and material availability
The access to the set of data can be made via request to the corresponding author.

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