REFACS

Review
Rev. Fam., Ciclos Vida Saúde Contexto Soc.
http://seer.uftm.edu.br/revistaeletronica/index.php/refacs/index
ISSN: 2318-8413 DOI*:* 10.18554/refacs.v14i00.9254

Mental health care transition in rural contexts

Transição do cuidado em saúde mental em contextos rurais

Transición del cuidado en salud mental en contextos rurales

Thaís Resende Araújo Borges Bonfim[1], Letícia Alves de Carvalho[1], Angélica Maluf Caetano Silva Costa[1]
Amanda Helena Leão Gonçalves[1], Sérgio Henrique Marçal[1], Álvaro da Silva Santos[1]

Received: 24/01/2026 **Accepted:** 16/06/2026 **Published:** 28/07/2026

Abstract:
Objective: to analyze scientific evidence regarding the transition of mental health care in rural contexts. **Methods:** a narrative review conducted in 2026, based on searches in the LILACS, MEDLINE/PubMed, SciELO, PsycINFO, Scopus, CINAHL, BDENF, Redalyc, and Psicodoc databases, covering publications from 2021 to 2025. Controlled and uncontrolled descriptors related to mental health, care transition, continuity of care, and rural populations were used. The analysis focused on relevant literature in the field. **Results:** a total of 5,107 records were identified, of which 4,592 were initially considered. Following screening and full-text reading stages, three studies formed the analytical corpus: one from the United States, one from India, and one from Brazil. The main challenges regarding mental health care transition in rural contexts were related to geographical barriers, the unequal distribution of specialized services, weaknesses in care coordination, limited integration between levels of care, and difficulties in ensuring continuity of care. **Conclusion:** scientific literature on mental health care transition in rural contexts remains scarce. Available studies indicate that improving the quality of care depends on strengthening Primary Health Care and the Psychosocial Care Network, as well as implementing strategies that foster care coordination and continuity of care.
Keywords: Mental Health; Continuity of Patient Care; Rural Population; Primary Health Care.

Resumo:
Objetivo: Analisar as evidências científicas acerca da transição do cuidado em saúde mental em contextos rurais. **Método**: Revisão narrativa, realizada em 2026, a partir de buscas nas bases de dados LILACS, MEDLINE/PubMed, SciELO, PsycINFO, Scopus, CINAHL, BDENF, Redalyc e Psicodoc, considerando publicações entre 2021 e 2025. Foram utilizados descritores controlados e não controlados relacionados à *saúde mental, transição do cuidado, continuidade do cuidado e população rural*. A análise se deu com produções da área. **Resultados:** identificou-se 5.107 registros, dos quais 4.592 foram considerados num primeiro momento. Após as etapas de triagem e leitura na íntegra, três estudos compuseram o corpus analítico, sendo dois internacionais (Estados Unidos e Índia) e um brasileiro. As principais dificuldades para a transição do cuidado em saúde mental em contextos rurais relacionaram-se às barreiras geográficas, à distribuição desigual de serviços especializados, às fragilidades na coordenação da atenção, à limitada integração entre os níveis assistenciais e aos desafios para garantir a continuidade do cuidado. **Conclusão:** A produção científica sobre transição do cuidado em saúde mental em contextos rurais ainda se mostra escassa. Os estudos disponíveis indicam que a qualificação da assistência depende do fortalecimento da Atenção Primária à Saúde, da Rede de Atenção Psicossocial e de estratégias que favoreçam a coordenação da atenção e a continuidade do cuidado.
Palavras-chave: Saúde Mental; Continuidade da Assistência ao Paciente; População Rural; Atenção Primária à Saúde.

Resumen:
Objetivo: Analizar las evidencias científicas sobre la transición del cuidado en salud mental en contextos rurales. **Método:** Revisión narrativa realizada en 2026, a partir de búsquedas en las bases de datos LILACS, MEDLINE/PubMed, SciELO, PsycINFO, Scopus, CINAHL, BDENF, Redalyc y Psicodoc, considerando publicaciones entre 2021 y 2025. Se utilizaron descriptores controlados y no controlados relacionados con la *salud mental*, la *transición del cuidado*, la *continuidad del cuidado* y la *población rural*. El análisis se realizó con las publicaciones del área. **Resultados:** Se identificaron 5.107 registros, de los cuales 4.592 fueron considerados en una primera etapa. Tras las etapas de cribado y lectura del texto completo, tres estudios conformaron el corpus analítico, de los cuales dos eran internacionales (Estados Unidos e India) y uno brasileño. Las principales dificultades para la transición del cuidado en salud mental en contextos rurales se relacionaron con las barreras geográficas, la distribución desigual de los servicios especializados, las debilidades en la coordinación de la atención, la limitada integración entre los niveles asistenciales y los desafíos para garantizar la continuidad del cuidado. **Conclusión:** La producción científica sobre la transición del cuidado en salud mental en contextos rurales sigue siendo escasa. Los estudios disponibles indican que la mejora de la atención depende del fortalecimiento de la Atención Primaria de Salud, de la Red de Atención Psicosocial y de estrategias que favorezcan la coordinación de la atención y la continuidad del cuidado.
Palabras clave: Salud Mental; Continuidad de la Atención al Paciente; Población Rural; Atención Primaria de Salud.

Corresponding Author: Thaís Resende Araújo Borges Bonfim - thaisdtrd@gmail.com

1. Universidade Federal do Triângulo Mineiro. Uberaba/MG, Brazil

INTRODUCTION

Mental disorders represent one of the major contemporary challenges for health systems worldwide, given their high prevalence, impact on quality of life, and social, economic, and familial repercussions. According to the World Health Organization (WHO), approximately one in eight people lives with a mental disorder, representing a significant global public health issue[1]. Beyond individual suffering, these conditions are associated with increased disability, reduced productivity, impaired social and family relationships, and the exacerbation of health inequalities[1].

Although significant progress has been made in recent decades regarding the recognition and treatment of mental disorders, care needs continue to exceed the capacity of health systems to respond effectively. This necessitates the strengthening of strategies capable of expanding access, improving the quality of care, and ensuring continuity of care[1,2].

Care transition (CT) can be understood as a set of actions designed to ensure the coordination, continuity, and safety of care as service users navigate between different professionals, teams, services, or levels of care[3-5]. It is a complex process involving effective communication among those involved, the sharing of clinical information, therapeutic planning, the definition of care responsibilities, and the active participation of users and their support networks. CT aims to ensure that care is delivered in an integrated manner, minimizing risks associated with care fragmentation and fostering better health outcomes[3,4].

Research indicates that failures in care transition processes can result in the loss of relevant information, treatment interruptions, poor therapeutic adherence, duplicated interventions, increased use of emergency services, and deterioration of clinical conditions[3,5]. Conversely, well-planned transitions foster continuity of care, strengthen coordination between services, and contribute to better clinical and psychosocial outcomes[4,5].

Although the concept of CT was initially developed in studies regarding hospital discharge and the care of individuals with complex chronic conditions, its application has progressively expanded to various care settings, including mental health, where the need for longitudinal follow-up and service integration makes care coordination particularly relevant[4,5].

CT is closely linked to the concepts of continuity and coordination of care. Continuity of care (CoC) refers to the care experience undergone by users over time, characterized by the coherence, integration, and complementarity of actions carried out by different professionals and services[6]. Care coordination (CC), in turn, refers to the health system's capacity to organize these actions in a coordinated manner, ensuring that user needs are met comprehensively and in a timely fashion[6]. While distinct, these concepts are complementary and constitute central

elements for consolidating Health Care Networks (HCNs), especially in situations requiring continuous monitoring and shared responsibility across multiple points of care.

In the field of mental health, CT becomes even more complex given the needs presented by users and the multiplicity of services involved in their therapeutic trajectories. Individuals experiencing psychological distress often need to move between primary, secondary, and tertiary care (such as specialized services, hospital care, and community resources) throughout their care journey.

A lack of coordination between services can compromise treatment continuity, weaken the therapeutic bond, and hinder the development of therapeutic plans aligned with user needs[4,5,7]. Thus, mental health care transition goes beyond the mere transfer of information between services; it involves establishing care pathways capable of ensuring continuous monitoring, comprehensive care, and shared responsibility among the various actors involved in the care process.

In Brazil, mental health care is organized through the Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS), established to coordinate various points of care and ensure comprehensive care for individuals experiencing mental distress or disorders[8]. The network comprises facilities such as Primary Health Care (PHC), Psychosocial Care Centers (*Centros de Atenção Psicossocial* - CAPS), urgent and emergency services, hospital care, and psychosocial rehabilitation services. Within this framework, PHC holds a strategic position as the network organizer and care coordinator, responsible for the longitudinal monitoring of service users, the identification of mental health needs, and coordination with other components of the care network[8,9].

Successful transitions in mental health care depend directly on the integration between PHC, RAPS, and referral and counter-referral mechanisms. When properly structured, these processes facilitate the safe movement of users across different levels of care, promote shared responsibility among teams, and contribute to continuity of care. However, weaknesses in interprofessional communication, the absence of well-defined care pathways, and difficulties in coordination between services remain significant challenges for mental health care coordination[5,7].

In Brazil, the organization of mental health care entails the integration of PHC, the RAPS, and other components of the HCNs, grounded in the principles of comprehensiveness, longitudinality, care coordination, and intersectoral collaboration[6,7].

Furthermore, limitations in the training and qualification of professionals to handle mental health needs, combined with weaknesses in coordination between PHC and specialized

services, remain significant obstacles to consolidating the psychosocial care model within the Unified Health System (*Sistema Único de Saúde* - SUS)[7].

When analyzed from the perspective of rural areas as spaces distinct from urban ones, the organization of mental health care presents additional challenges. Rural populations have historically faced inequalities in access to health services, a shortage of specialized professionals, long geographic distances, transportation difficulties, and a concentration of care resources in urban areas[10-11]. Such conditions can hinder access to services, delay the start of treatment, and compromise the continuity of care, thereby exacerbating health vulnerabilities.

In addition to structural barriers, sociocultural factors, such as rural lifestyles, ways of recognizing psychological distress, and the stigma associated with mental disorders, significantly influence therapeutic pathways and the pursuit of care[10,11]. In Brazilian rural settlements, mental health care is complicated by challenges related to poor coordination within the care network, difficulties in accessing specialized services, and weak care coordination mechanisms[10]. These factors can directly impact care transition processes, hindering the continuity of care and the effective implementation of the psychosocial care model.

Evidence from the United States indicates that expanding the supply of specialized services improves access to mental health care in rural areas, although barriers related to geographic distance and the unequal distribution of care resources persist[11]. Similarly, a study conducted in India demonstrates that rural populations remain disproportionately affected by shortages of specialized professionals, limited service availability, and structural inequalities that hinder access to mental health care[12].

Despite the growing emphasis on continuity and coordination of care within health systems, there is a scarcity of studies specifically addressing the intersection of care transitions, mental health, and rurality. Existing literature focuses on urban contexts or discussions of access to mental health services, leaving our understanding of how care transition processes are experienced and organized in rural areas limited.

This gap is particularly significant given the need to strengthen care coordination mechanisms, improve referral and counter-referral pathways, and expand the capacity of PHC and the RAPS to address the needs of populations historically exposed to territorial vulnerability.

Given the importance of continuity of care in mental health and the limited body of scientific literature on this topic in rural settings, it is necessary to gather and critically analyze

the available evidence. Thus, this study aims to analyze publications regarding the transition of mental health care in rural contexts.

METHODS

This is a narrative review that allows for an in-depth interpretation of the findings and a critical analysis of the available scientific literature[11,12]. Narrative reviews constitute a relevant strategy for understanding complex and under-explored phenomena, enabling the integration of knowledge, the identification of research gaps, and an expanded theoretical discussion of the topic under investigation[11].

The search was conducted between January and April 2026, covering the following databases: SciELO, LILACS, MEDLINE/PubMed, PsycINFO, Scopus, Redalyc, Psicodoc, BDENF, and CINAHL. The selection of these databases aimed to increase the sensitivity of the search strategy and reduce the risk of missing potentially relevant studies, encompassing various fields of knowledge related to mental health, psychosocial care, public health, and rural health.

The search strategy was developed using controlled descriptors from the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH) vocabularies, combined with free-text terms related to the research topic.

Key terms used included: Mental Health; Mental Disorders; Mental Health Services; Care Transition; Transitional Care; Continuity of Patient Care; Care Coordination; Rural Population; Rural Health; Rural Communities; Primary Health Care. Descriptors were combined using the Boolean operators AND and OR, in accordance with the specific requirements of each database consulted.

Inclusion criteria covered scientific articles addressing mental health in rural contexts; discussing continuity of care, care coordination, service integration, or elements related to care transition; fully available; published between 2021 and 2025; and written in Portuguese, English, or Spanish. Editorials, letters to the editor, commentaries, theses, dissertations, book chapters, and studies not aligned with the research topic were excluded.

Titles and abstracts were screened, followed by a full-text review of potentially eligible studies. Included studies underwent an exhaustive reading and interpretive analysis. Data extracted included authors, year of publication, country of study, objectives, methodological design, main results, and contributions to understanding mental health care transitions in rural contexts.

Data analysis was performed using a narrative synthesis, aiming to identify convergences and divergences among the selected studies. The results were interpreted in light

of the frameworks regarding continuity of care and care transitions, particularly the contributions of Haggerty *et al*.[3] and Coleman and Boult[4], as well as the organizational principles of the Brazilian National Primary Care Policy and the Brazilian National Mental Health Policy, notably through the lens of Psychosocial Care[6,8].

RESULTS

The initial search yielded 5,107 results. After removing duplicates, 4,592 studies remained for analysis. Following the review of titles and abstracts, the application of exclusion criteria, and the full-text reading of eligible studies, only three articles met the criteria for inclusion in the analytical corpus.

The three selected studies were published between 2021 and 2024 and conducted in different national contexts, specifically Brazil, the United States, and India. The first study, "Challenges for mental health care in rural contexts," published by Cirilo Neto and Dimenstein (2021)[13], investigated the challenges faced by health and social care professionals in organizing mental health care within rural settlements in the state of Rio Grande do Norte; it highlighted aspects related to care coordination, continuity of care, the territorialization of practices, and the organization of the RAPS.

In 2022, Shiner *et al*.[11] published the study "*Evaluating Policies to Improve Access to Mental Health Services in Rural Areas,"* which aimed to assess the effects of public policies designed to expand access to mental health services in rural areas of the United States. The study evaluated the impact of these strategies on the utilization of specialized services, highlighting the progress made and the persistent challenges regarding access, professional availability, and the organization of care in rural regions.

More recently, Gupta (2024)[12] published the article "*Rural-Urban Divide in Mental Health Care in India: Bridging the Gaps,"* discussing the existing disparities between urban and rural areas regarding the provision of mental health care in India. The primary obstacles identified were structural, economic, geographic, and sociocultural, all of which limit rural populations' access to specialized services. The article proposed strategies to strengthen PHC, decentralize care, and enhance the integration of care networks.

Although conducted within distinct health systems and employing different methodological designs, the three studies converge in recognizing that rural populations face significant barriers to accessing and remaining in mental health services. Furthermore, all of them address, either explicitly or implicitly, components related to continuity of care, care coordination, and the organization of care networks, which are aspects that underpin this

review. Chart 1 presents a comparison of the three selected articles to facilitate a more detailed analysis.

Chart 1. Studies on care transitions in rural contexts. Uberaba/MG, Brazil, 2026.

Studies	Country	Type of study	Main issue found
1. Cirilo Neto and Dimenstein (2021)[13]	Brazil	Qualitative	Network fragmentation and fragile care coordination
2. Shiner *et al.* (2022)[11]	USA	Assessment of public policies	Persistent inequalities in access
3. Gupta (2024)[12]	India	Review	Concentration of specialized resources in urban areas

DISCUSSION

The study by Cirilo Neto and Dimenstein (2021)[13], titled "Challenges for mental health care in rural contexts," aimed to discuss the main obstacles faced in delivering mental health care in rural settlements in Northeastern Brazil, from the perspective of professionals working directly in these areas. This qualitative study, derived from a master's thesis, was conducted in eight rural settlements in the state of Rio Grande do Norte, involving 53 workers linked to the Family Health Strategy (*Estratégia Saúde da Família* - ESF), Expanded Family Health Support Centers (*Núcleos Ampliados de Saúde da Família* - NASF), CAPS, Social Assistance Reference Centers (*Centros de Referência de Assistência Social* - CRAS), and Specialized Social Assistance Reference Centers (*Centros de Referência Especializados de Assistência Social* - CREAS). Data were collected through semi-structured interviews and analyzed using Bardin's thematic analysis technique.

The challenges regarding mental health care in rural areas are organized around four central axes: service organization, the central role of Primary Health Care, intersectoral practices, and the continuing education of workers. Key problems identified by participants included weak care coordination, discontinuity in psychosocial care, a lack of shared responsibility among teams, difficulties accessing specialized services, and limited alignment between the RAPS and the concrete needs of rural territories. The study also highlighted that many service users navigate long therapeutic pathways in search of care, facing geographical barriers, a scarcity of specialized services, and regionalization processes that often perpetuate territorial inequalities[13].

Primary Care must be strengthened as a form of coordination of care, building place-based networks, and expanding intersectoral strategies capable of addressing the sociocultural, economic, and geographic specificities of rural populations.

In the United States, Shiner *et al*.[11] evaluated policies aimed at expanding access to mental health services in rural areas. Their study, published in the Journal of Rural Health,

sought to assess the impact of policies implemented by the U.S. Department of Veterans Affairs to increase rural populations' access to mental health services. The research was longitudinal and based on electronic health records, analyzing a cohort of over 3.3 million rural users served between 2002 and 2019. The study focused on two key public policy milestones: the expansion of mental health services at community clinics affiliated with the veterans' system, initiated in 2008, and the increased funding for care provided by community-based services outside the traditional veterans' healthcare system, implemented starting in 2014.

The results demonstrated a significant increase in the rural population's use of mental health services over the period analyzed. The proportion of rural users accessing mental health care rose from approximately 11.4% at the beginning of the time series to 19.8% in the most recent years evaluated. The sharpest increase occurred following the mandate to provide mental health services in community clinics, indicating that the geographic proximity of services has a significant impact on the utilization of specialized care. However, the authors observed that the expansion of service availability did not completely eliminate disparities between urban and rural areas; difficulties persisted, particularly among the elderly over the age of 75 and residents of more isolated regions[11].

Although expanding access is essential, it is insufficient unless accompanied by care coordination strategies, integration between services and organization of care modalities capable of guaranteeing continuous monitoring throughout the therapeutic trajectory[11]. The physical availability of services represents only one dimension of the problem, with continuity of care dependent on broader organizational mechanisms.

The results demonstrated that the increase in the availability of services was associated with the growth in the use of mental health assistance by rural populations. However, the expansion of supply was not enough to eliminate existing inequalities between urban and rural areas, especially among elderly individuals and residents in more remote regions[11].

The work by Gupta (2024)[12], published in the Indian Journal of Social Psychiatry, discusses the profound inequalities that exist between urban and rural areas in mental health care in India, addressing structural, social, and cultural aspects that limit the rural population’s access to specialized care. Unlike the other studies included, this is a reflective and critical analysis of the organization of mental health services in the country, highlighting the historical concentration of professionals, hospitals, and therapeutic resources in large urban centers. The author argues that the rural population faces multiple simultaneous barriers, including poverty, difficulty with transportation, a shortage of specialized professionals, low availability of public services, and a strong stigma associated with mental disorders.

The rural-urban divide cannot be understood merely as a geographical issue, but rather as the result of economic, educational, and sociocultural inequalities accumulated over time. Gupta[12] highlights that, in many rural communities, users' initial contact is with community leaders, traditional healers, or informal support networks, which delays access to specialized services. Low actual utilization of existing services, even when formally available, has also been observed, due to cultural barriers and the gap between biomedical care models and local care practices[12].

Strategies proposed to reduce these inequalities include strengthening PHC, decentralizing specialized care, training community health workers, integrating local stakeholders into mental health care, and expanding the use of digital technologies such as telemedicine and telepsychiatry. Understanding the challenges associated with continuity of care in resource-scarce settings demonstrates that the organization of care networks must take into account territorial, cultural, and community dimensions to ensure access and effective follow-up for the rural population.

Difficulty accessing mental health services was identified as a common feature across the three studies[11-13]. In Brazil, the distance between places of residence and specialized services was observed to be a significant obstacle to continuity of mental health care. Furthermore, the limited availability of specialized services in rural areas places a strain on PHC and hinders coordination among the various points of the care network. Similar results were observed in international studies. In the United States, despite the expansion of available care in recent years, significant disparities in service utilization between urban and rural populations persisted[11]. In India, the unequal distribution of human resources and specialized facilities was identified as a key factor contributing to the access challenges faced by rural populations[12].

Another identified aspect concerns the economic and geographic barriers associated with traveling to urban centers, which is often necessary to obtain specialized care[11,13]. These difficulties tend to directly impact the continuity of care and adherence to proposed treatments. Care coordination emerged as a major challenge in mental health care in rural areas.

In the Brazilian study, Cirilo Neto and Dimenstein[13] highlighted that the delivery of psychosocial care depends on coordination between different sectors and services within the local area. However, weaknesses were identified in communication among care facilities, difficulties in operationalizing referral pathways, and limitations in the network's capacity to respond to users' needs.

The findings of Shiner *et al*.[11] reinforce this perspective by demonstrating that simply expanding the supply of services does not guarantee continuity of care. The effectiveness of policies aimed at expanding access depends on the existence of mechanisms capable of integrating the various components of the care network and promoting longitudinal follow-up for users. Similarly, Gupta[12] emphasizes that the availability of specialized services must be coupled with the development of coordination strategies capable of ensuring continuity of care throughout the patient's care journey. Service fragmentation constitutes a significant barrier to the effectiveness of mental health interventions in rural areas.

The challenges faced by rural populations stem not only from a scarcity of services but also from the way care networks are organized[11-13]. In Brazil, the need to strengthen intersectoral actions and territorial coordination has been identified as a key factor in improving the quality of psychosocial care. The complexity of mental health needs demands responses that extend beyond the health sector, incorporating initiatives related to social welfare, education, employment, and community development[13].

In the United States, initiatives aimed at expanding access have yielded positive results, yet they have proven insufficient to eliminate the structural inequalities historically present in rural areas[11]. In India, strengthening community-based care, decentralizing specialized services, and utilizing digital technologies have been identified as promising strategies for reducing disparities between urban and rural areas[12]

Together, the studies show that the organization of mental health care networks in rural settings remains characterized by challenges regarding access, care coordination, and continuity of care, aspects directly linked to care transition processes[11-13].

This review identified a significant gap in the scientific literature regarding mental health care transitions in rural settings. Despite the broad search strategy, which initially yielded 5,107 records across various national and international databases, only three studies met the eligibility criteria. Rather than representing only a limitation of this review, this finding highlights that the intersection of care transitions, mental health, and rurality remains under-explored[11-13].

Brazil's rural landscape is characterized by extensive territorial, social, economic, environmental, and cultural diversity; it cannot be understood merely as a site dedicated to agricultural and livestock production. The rural environment constitutes a complex territory where family farming, agribusiness, Indigenous peoples, and *quilombola*, *ribeirinhos*, and extractive communities coexist alongside agrarian reform settlements and other forms of social organization. From this perspective, "rural" must be understood as a space of multiple functions

and territorial relationships, the dynamics of which extend beyond agricultural production to encompass economic, environmental, cultural, and demographic aspects that directly influence the living and health conditions of the populations residing there[14,15].

Brazil possesses one of the largest rural land areas in the world, playing a strategic role in the production of food, fiber, energy, and raw materials. The agricultural sector is a key component of the national economy, contributing significantly to Gross Domestic Product (GDP), job creation, exports, and food security. At the same time, family farming remains of great economic and social importance, accounting for a significant share of food destined for domestic consumption and enabling thousands of families to remain in rural areas, thereby underscoring the importance of strengthening public policies aimed at rural populations[14].

The challenges identified in the analyzed studies become even more significant when viewed in light of the characteristics of the Brazilian territory. According to the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística* - IBGE), Brazil's rural areas exhibit great territorial, social, economic, and environmental diversity, encompassing everything from family farming areas to traditional communities, agrarian reform settlements, Indigenous peoples, *quilombola* and *ribeirnhos* communities. This heterogeneity demonstrates that the health needs of these populations go beyond what a one-size-fits-all approach can address, requiring the organization of care networks capable of responding to the specificities of each territory. Thus, the implementation of mental health care transition strategies must consider not only the availability of specialized services but also geographical characteristics, travel conditions, population distribution, and the social determinants that influence access to and continuity of care across the country's diverse rural realities[14].

Despite this significant economic and social importance, major inequalities persist between urban and rural areas regarding access to public policies, particularly healthcare services. Rural populations face geographical barriers, vast distances between communities and services, transportation difficulties, a scarcity of specialized professionals, and a concentration of high-complexity care in urban centers. These conditions directly impact the organization of Health Care Networks, hindering coordination across different levels of care and compromising continuity of care, especially for conditions requiring longitudinal follow-up, such as mental disorders[16].

In this context, investigating the transition of mental health care in rural settings is particularly relevant, given that the effectiveness of this process depends on coordination between different points of the HCN and the capacity of PHC to coordinate care pathways.

Considering the territorial, social, and organizational specificities of rural areas, understanding how scientific literature has addressed this topic can contribute to strengthening the RAPS, supporting the development of strategies to reduce territorial inequalities and improve the quality of care provided to rural populations.

The scarcity of identified studies contrasts with the growing importance attributed to continuity of care within health systems. Haggerty *et al.*[3] highlight that continuity is a key attribute of care quality, especially for users requiring long-term monitoring and coordination across different services. In the field of mental health, this need is even more pronounced due to the often chronic and multifaceted nature of mental disorders, which require longitudinal follow-up, interdisciplinary interventions, and integration among various care services[1,2].

Although the selected studies did not explicitly use the concept of care transition, they all addressed central elements of this process. Aspects related to care coordination, continuity of care, coordination between services, and the integration of care networks appear recurrently in studies conducted in Brazil, the United States, and India[11-13].

The findings suggest that the transition of care constitutes an implicit dimension of mental health care in rural contexts, even though it is rarely recognized as a specific object of investigation. There is a consensus that rural populations face significant barriers to accessing mental health services[11-13]. These barriers involve geographical, economic, organizational, and cultural aspects, reflecting historical inequalities in the distribution of care resources.

Two international studies (conducted in the USA and India) indicate that a lack of specialized professionals in urban areas to receive and assist people arriving from rural areas remains a major challenge for mental health care in these regions[11,12]. This reality results in care pathways characterized by long journeys, delays in starting treatment, and difficulties in maintaining follow-up over time. In many cases, the need to travel to urban centers can pose a significant obstacle that may interrupt or prevent continuity of care.

In Brazil, these challenges are compounded by territorial characteristics and the heterogeneity of rural populations. Cirilo Neto and Dimenstein[13] identified that the delivery of mental health care in rural settlements depends heavily on the services' capacity for territorial coordination and the development of strategies that align health interventions with local realities. The mere formal availability of services does not guarantee effective access; it is essential to consider factors related to the territory, living conditions, and the sociocultural specificities of rural communities[13].

Access to healthcare should not be understood solely in terms of service provision; it also requires institutional responses that align with the concrete needs of populations,

including geographic availability, cultural acceptability, continuity of care, and the capacity to resolve the demands presented[6].

Another aspect widely identified in studies[11-13] concerns care coordination. Although health systems often invest in expanding service provision, the effectiveness of mental health interventions also depends on the existence of mechanisms capable of integrating different points within the care network[11-13].

Care coordination is recognized as a core attribute of PHC and is fundamental to establishing integrated care pathways[6,7]. Weaknesses in referral flows, communication, and information sharing increase the likelihood of fragmented care, therapeutic discontinuity, and a loss of connection with services.

In this regard, the review's findings align directly with the propositions made by Haggerty *et al*.[3] concerning the managerial continuity of care. The mere existence of multiple services does not guarantee continuity of care. Coordination among the various entities involved in care is essential, ensuring that users perceive the interventions as part of an integrated process[4]. Achieving such coordination remains a significant challenge in rural settings. Weaknesses in team communication, difficulties in operationalizing referral and counter-referral processes, and insufficient integration strategies across different services were recurring issues[11-13].

Given this context, PHC plays a strategic role in organizing mental health care in rural areas[6,7]. PHC holds a privileged position within care networks due to its proximity to local communities and its potential to support users over time. This role is particularly crucial in rural areas, where PHC often serves as the population's primary or sole point of contact with the health system[13]. However, in practice, such services are often geographically inaccessible in most rural areas.

The studies analyzed revealed that adequate structural and organizational conditions are influencing factors. Challenges identified included a shortage of specialized human resources, team overload, limited diagnostic and therapeutic resources, and difficulties in coordinating with specialized services[11-13].

In Brazil, mental health care coordination requires close collaboration between PHC and the RAPS. The RAPS model presupposes integration among various care settings and the sharing of responsibilities across teams and services[8]. However, these principles face obstacles linked to regional inequalities and the specific characteristics of rural areas.

Although the term "care transition" was not explicitly used in the studies included, its fundamental components are present in all the works[11-13]. Care transition can be defined as a

process aimed at ensuring continuity of care as the service user moves between different care settings[5]. This definition encompasses communication among professionals, information sharing, care planning, and the coordination of actions carried out throughout the therapeutic journey.

The challenges identified in studies[11–13] can be understood as obstacles to care transition processes. Difficulties in access, weaknesses in care coordination, and a lack of service integration tend to compromise continuity of care and increase the risk of interruptions in mental health follow-up.

Care transition emerges as an important analytical category for understanding the needs of rural populations. Its incorporation into the field of mental health can contribute to improving care practices, strengthening service integration mechanisms, and enhancing health systems' capacity to respond to users' needs. The main implication of this review concerns the need for further research on the subject. The limited number of studies identified indicates that mental health care transition in rural contexts remains underexplored, both nationally and internationally[11-13].

CONCLUSION

This review reveals that the study of mental health care transitions in rural settings remains an underdeveloped field of scientific inquiry, despite representing a strategic component for organizing care networks and ensuring continuity of care. The analysis of the selected studies demonstrates that the challenges faced by rural populations extend beyond the mere availability of specialized services; they also encompass aspects related to care coordination, integration across network components, interprofessional communication, and the organization of care pathways.

Although the analyzed studies do not explicitly address care transitions as their central focus, their principles are evident in discussions regarding continuity of care, service access, coordination between levels of care, and the organization of mental health care networks. This finding underscores the need to incorporate "care transition" as an analytical category in rural mental health research, thereby broadening the understanding of processes that facilitate or hinder the development of comprehensive and effective care trajectories.

The study highlights the strategic role of Primary Health Care in coordinating care and the Psychosocial Care Network as the organizational structure for various care services. However, the effectiveness of these networks relies on strengthening referral and counter-

referral mechanisms, fostering team integration, enhancing professional qualifications, and adopting strategies to mitigate the territorial inequalities characteristic of rural settings.

Limitations include the limited volume of existing literature and the lack of comprehensive engagement with the core elements defining care transitions (and, by extension, care coordination) within rural contexts.

By bringing together the concepts of care transitions, mental health, and rurality, this study proposes a research agenda aimed at understanding care pathways, care coordination processes, and the experiences of users, professionals, and managers across diverse rural realities.

REFERENCES

1. World Health Organization. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022.

2. World Health Organization. Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021.

3. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ*. 2003 [cited in 10 May 2026]; 327(7425):1219-21. DOI: 10.1136/bmj.327.7425.1219

4. Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc*. 2003 [cited in 11 May 2026]; 51(4):556-7. DOI: 10.1046/j.1532-5415.2003.51186.x

5. Starfield B. Primary Care: Balancing Health Needs, Services and Technology. New York: Oxford University Press; 1998.

6. Ministério da Saúde (Brasil). Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica. Brasília (DF): Ministério da Saúde; 2017.

7. Ministério da Saúde (Brasil). Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas. Brasília (DF): Ministério da Saúde; 2011.

8. Rother ET. Revisão sistemática X revisão narrativa. *Acta Paul Enferm*. 2007; 20(2):v-vi.
Snyder H. Literature review as a research methodology: an overview and guidelines. *J Bus Res*. 2019; 104:333-9.

9. Snyder H. Literature review as a research methodology: an overview and guidelines. *J Bus Res*. 2019;104:333-339.
Aromataris E, Munn Z, editors. JBI Manual for Evidence Synthesis. Adelaide: Joanna Briggs Institute; 2020.

10. Aromataris E, Munn Z, editors. JBI Manual for Evidence Synthesis. Adelaide: Joanna Briggs Institute; 2020.

11. Shiner B, Gottlieb D, Rice K, Forehand JA, Snitkin M, Watts BV. Evaluating policies to improve access to mental health services in rural areas. J Rural Health. 2022; 38(4):805-16. DOI: 10.1111/jrh.12674.

12. Gupta R. Rural-Urban Divide in Mental Health Care in India: Bridging the Gaps. Indian J Soc Psychiatry. 2024; 40(1):15-22. DOI: 10.4103/ijsp.ijsp_41_24.

13. Cirilo Neto M, Dimenstein M. Desafios para o cuidado em saúde mental em contextos rurais. Gerais, Rev Interinst Psicol. 2021; 14(1):1-26. DOI: 10.36298/gerais202114e15627.
14.Instituto Brasileiro de Geografia e Estatística (IBGE). Classificação e caracterização dos espaços rurais e urbanos do Brasil: uma primeira aproximação. Rio de Janeiro: IBGE; 2017.
15. Ministério da Saúde (Brasil). Política Nacional de Saúde Integral das Populações do Campo, da Floresta e das Águas (PNSIPCFA). Brasília (DF): Ministério da Saúde; 2013.
16. Ministério da Saúde (Brasil). Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Política Nacional de Saúde Integral das Populações do Campo e da Floresta. 1ed. 1. reimp. Brasília: Ministério da Saúde; 2013. Available from: https://renastonline.ensp.fiocruz.br/sites/default/files/arquivos/recursos/politica_nacional_saude_populacoes_campo.pdf.

Associated Publisher: Vania Del Arco Paschoal

Conflict of Interests: the authors declared there is no conflict of interests

Financing: none

Contributions:
Concept – Bonfim TRAB, Gonçalves AHL, Santos AS
Investigation – Bonfim TRAB
Writing – first draft – Bonfim TRAB
Writing – revision and editing – Bonfim TRAB, Carvalho LAD, Costa AMCS, Gonçalves AHL, Marçal SH, Santos AS

How to cite this article (Vancouver)
Bonfim TRAB, Carvalho LA, Costa AMCS, Gonçalves AHL, Marçal SH, Santos AS. Mental health care transition in rural contexts. Rev Fam, Ciclos Vida Saúde Contexto Soc. [Internet]. 2026 [cited in *insert day, month and year of access*]; 14:e026020. DOI: https://doi.org/10.18554/refacs.v14i00.9254

How to cite this article (ABNT)
BONFIM, T. R. A. B.; CARVALHO, L. A.; COSTA, A. M. C. S.; GONÇALVES, A. H. L.; MARÇAL, S. H.; SANTOS, A. S. Mental health care transition in rural contexts. **Revista Família, Ciclos de Vida e Saúde no Contexto Social**, Uberaba, MG, v. 14, e026020, 2026. DOI: https://doi.org/10.18554/refacs.v14i00.9254. Access in: *insert day, month and year of access*.

How to cite this article (APA)
Bonfim, T. R. A. B., Carvalho, L. A., Costa, A. M. C. S., Gonçalves, A. H. L., Marçal, S. H., & Santos, A. S. (2026). Mental health care transition in rural contexts. Rev. Fam., Ciclos Vida Saúde Contexto Soc., 14, e e026020. Retrieved in *insert day, month and year of access* from https://doi.org/10.18554/refacs.v14i00.9254