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Autonomy in the field of mental health: a review of the national literature

Autonomia no campo da saúde mental: uma revisão da literatura nacional

Autonomía en el campo de la salud mental: una revisión de la literatura nacional

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This study aimed to analyze the definitions used for autonomy in mental health in the years 2014 and 2015 in Brazil. A bibliographic review was performed on the electronic databases PubMed, Lilacs and SciELO. Of the 25 references, 12 met the inclusion criteria and were included in the synthesis of the work. The texts link the concept of autonomy to the exercise of citizenship and knowledge of rights, reinforcing the need to value the individual, increasing their capacity to understand and take actions with respect to themselves, taking responsibility for their lives. It is concluded that autonomy restores the care of one's own health, facilitates social reintegration and the opportunity for new health-promoting experiences.
Descriptors: Health promotion; Personal autonomy; Mental health.

Este estudo teve como objetivo analisar as definições utilizadas para autonomia em saúde mental nos anos de 2014 e 2015 no Brasil. Foi realizada revisão bibliográfica nas bases de dados eletrônicas PubMed, Lilacs e SciELO. Das 25 referências, 12 atenderam aos critérios de inclusão e compuseram a síntese do trabalho. Os textos vinculam o conceito de autonomia ao exercício da cidadania e do conhecimento de direitos, reforçando a necessidade de valorização do sujeito, ampliando a capacidade de compreenderem e atuarem sobre si mesmos, assumindo responsabilidades sobre sua vida. Conclui-se que a autonomia restitui o cuidado da própria saúde, proporciona a reinserção social e a oportunidade de novas experiências promotoras da saúde.
Descritores: Promoção da saúde; Autonomia pessoal; Saúde mental.

Este estudio tuvo como objetivo analizar las definiciones utilizadas para autonomía en salud mental en los años de 2014 y 2015 en Brasil. Fue realizada revisión bibliográfica en las bases de datos electrónicas PubMed, Lilacs y SciElo. De las 25 referencias, 12 atendieron a los criterios de inclusión y compusieron la síntesis del trabajo. Los textos vinculan el concepto de autonomía al ejercicio de la ciudadanía y del conocimiento de derechos, reforzando la necesidad de valorización del sujeto, ampliando la capacidad de comprender y actuar sobre sí mismos, asumiendo responsabilidades sobre su vida. Se concluye que la autonomía restituye el cuidado de la propia salud, proporciona la reinserción social y la oportunidad de nuevas experiencias promotoras de la salud.
D**escriptores:** Promoción de la salud; Autonomía personal; Salud mental.

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INTRODUCTION

Being autonomous is basically having the possibility of making choices to have a better quality of life. This implies the understanding of autonomy as relational, that is, the relationship with others, a process of joint construction and "coproduction" of life[1].

In this sense the choices of the subject, are not only individual, exclusive and determined by personal wills. As individuals are always relating to others, no choice can be individualized; hcoices depend on the scenario and the relationships that enable, liberate or constrain such choices. From this perspective, autonomy refers to the ability to deal with networks of relationships and dependencies in the world.

The issue of autonomy is closely related to the referential of health promotion, since the concern is in the potential of each individual to choose to achieve health in a constant search for emancipation[2].

This affirmation is in line with the National Policy for Health Promotion, revised in 2014, which aims to "promote equity and improvement of conditions and ways of living, increasing the potential of individual and collective health and reducing the vulnerabilities and risks brought about as consequences of social, economic, political, cultural and environmental determinants". One of its specific objectives is: "to promote empowerment and the capacity for decision-making and autonomy of individuals and communities through the development of personal skills and competences in health promotion and defense"[3].

This theme of autonomy in the field of mental health requires new reflections. What is it like to think about the autonomy of individuals who have been deprived of their ability to choose? Deprived of their rights to be heard? How has literature in recent years been reflecting this situation? The creation of new spaces for mental health care, from the 1990s onwards has contributed to the construction of the autonomy of such individuals. This study aimed to analyze the definitions used for autonomy in mental health in the years 2014 and 2015 in Brazil.

METHOD

In order to better understand what the national scientific production has reflected on autonomy in the field of mental health, the contribution of the studies produced on the theme was systematized, seeking to answer the question: How has the scientific literature addressed the issue of autonomy in the field of mental health?

This is a bibliographic review about autonomy in the field of mental health. The databases used as sources of information were: Scielo, Pubmed and Lilacs. The Health Sciences Descriptors (DeCS) used were: "autonomy" and "mental health". The search was carried out in January 2017.

As strategy for choice of articles, the inclusion criteria adopted were: thematic coverage, in which a document was considered for inclusion whenever its content can be described using the chosen terms, were used as eligibility criteria, and whenever its content presented a substantial development of the theme studied; chronological coverage, in the period from 2014 to 2015; geographical coverage bounded to Brazil; idiomatic coverage, articles in Portuguese; complete texts available on the web and articles published in scientific journals.

An Excel table was built for the organization of the articles found and consulted. Duplicated articles were deleted. Texts not published in scientific journals were excluded. The titles and abstracts were read and articles that were not related to the theme under study were excluded. Thus, the step of careful reading (complete texts) and interpretation of the selected articles was carried out. Figure 1 shows the search status.

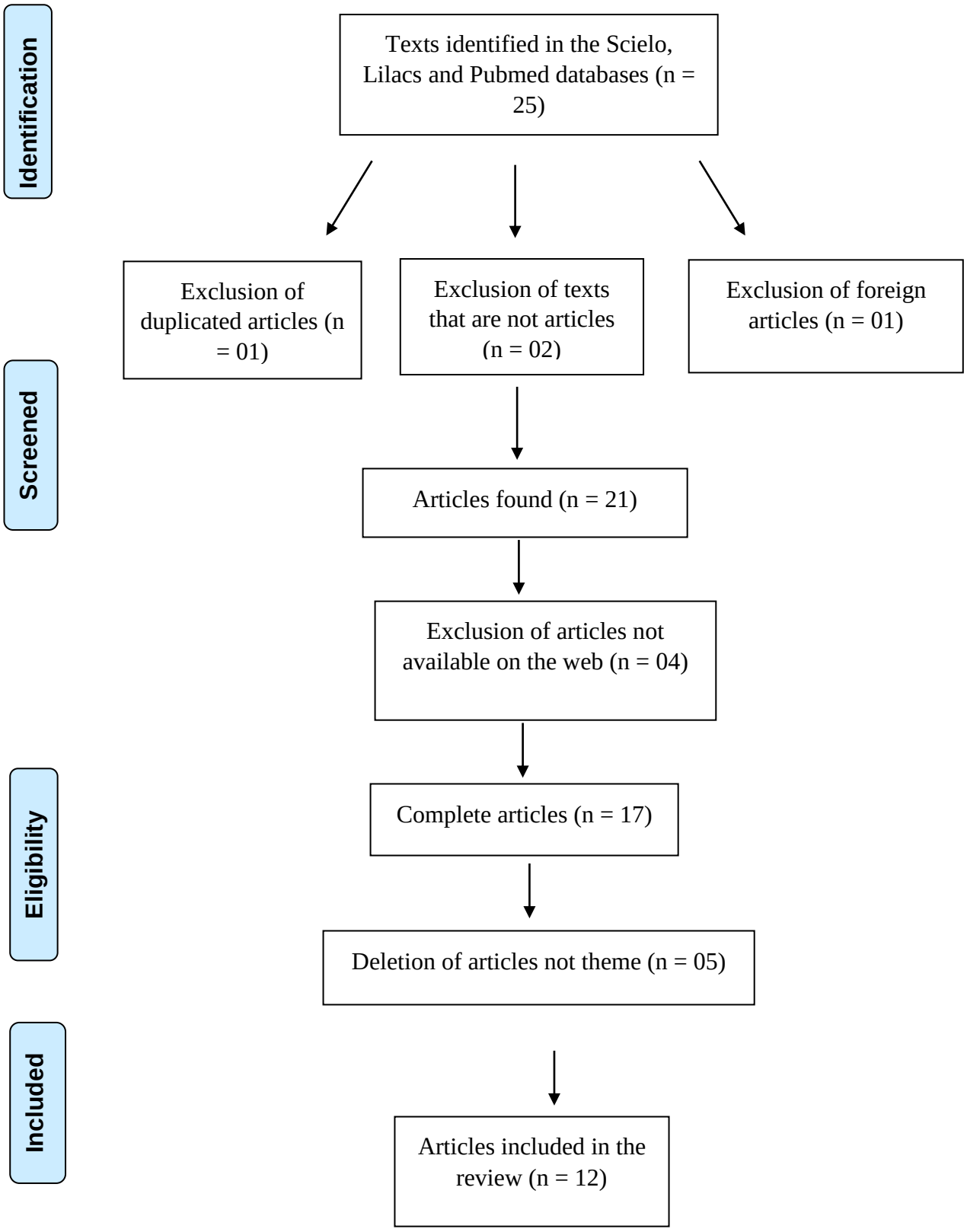

Figure 1. Flowchart of the search strategy. Brazil, 2017.

RESULTS

Of the 25 references retrieved in the searches, 12 met the inclusion and eligibility criteria and composed the descriptive synthesis. The journals where the articles were published are shown in Figure 2. In turn, the description of the selected articles is found in table 1.

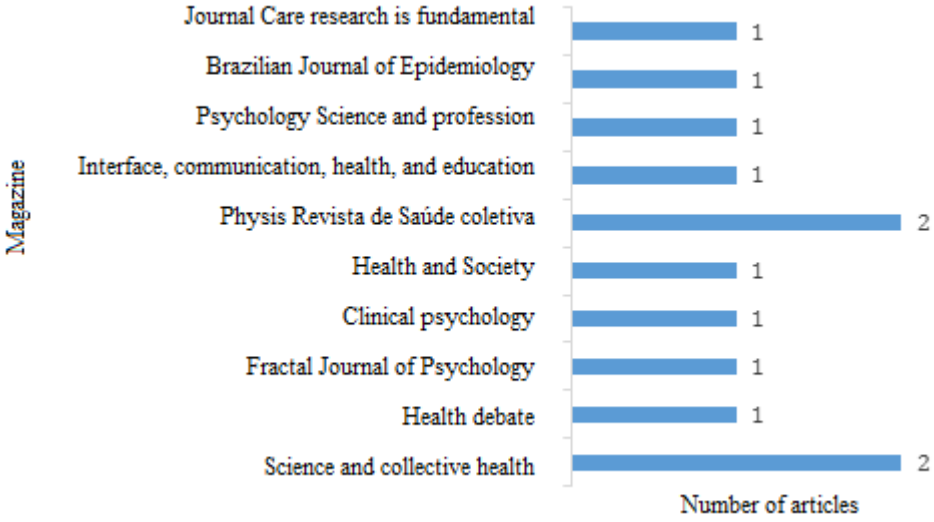

Figure 2. Distribution of scientific articles, Brazil, 2017.

Table 1. Characteristics of the included studies (n = 12) regarding title, author and database.

Nº	Title	Authors, year	Database
1	Overload of care, solidarity and strategy to cope with the experience of relatives of Psychosocial Care Centers	Delgado PG, 2014	Scielo
2	Rights in madness: what users and managers of the Psychosocial Care Centers (CAPS) say	Emerich BF, Campos RO, Passos E, 2014	Scielo
3	"Is this security measure infinite or does it have a due date?" Interlocutions and challenges between Law and Psychology in the judicial context	Silva EQ, Brandi CQACS, 2014	Scielo
4	Prevention and promotion of mental health in aging: concepts and interventions	França CL, Giardini Murta SG, 2014	Scielo
5	From the Back Home Program to the conquest of autonomy: paths necessary for the real process of deinstitutionalization	Lima SS, Brasil AS, 2014	Scielo
6	Social determinants of (mental) health: evaluating a non-governmental experience from the perspective of actors involved	Bosi MLM, Melo AKS, Carvalho LB, Godoy MGC, Ximenes VM, 2014	Scielo
7	Care practices in mental health in primary health care: an analysis based on experiences developed in Florianópolis, Brazil.	Frosi RV, Tesser CD, 2015	Scielo
8	Human Rights in the Psychosocial Care Centers of Northeast Brazil: an evaluative study with reference to Quality Rights - WHO.	Pitta AMF, Coutinho DM, Rocha CM, 2015	Scielo
9	Perception of emotions among CAPS II users: an experience report	Botelho JV, Lima MV, 2015	Scielo
10	Psychosocial Rehabilitation and Therapeutic Follow-up: equating the reinsertion in mental health	Gruska V, Dimenstein M, 2015	Scielo
11	Experiences of caregivers of people with psychic illness in the face of psychiatric reform: production of care, autonomy, empowerment and resolubility	Firmo AAM, Jorge MSB, 2015	Scielo
12	The work of teams guided by the motivations of users in the CAPSad: a phenomenological study	Nasi C, Oliveira GCd, Lacchini AJB, Camatta MW, Everling EM, Schneider JF, 2015	BVS

DISCUSSION

Just as all the achievements take time to happen, since the 1970s the Brazilian psychiatric reform movement has gained force, especially after the national conferences on mental health and municipal and state laws that culminated in Federal Law nº 10,2016 of 2001[3].

From this moment on, subjects are seen as actors of their own treatment and no longer as objects of the violence of asylums. After the reform, CAPS were built with the mission of providing clinical care without restraint in asylums, providing patients with care and support, trying to preserve the strengthening of social bonds and promoting their social integration through intersectoral actions.

The creation of these institutions was essential for the embracement of large numbers of patients, for according to the World Health Organization (WHO), about 47,500,000 Brazilians are estimated to have been affected in past, or be currently affected by mental disorders[4].

Despite the magnitude of the problem, there is little investment in actions to promote care, treatment and respect for rights. Autonomy must be thought of as a concept linked to the exercise of citizenship and knowledge of rights and the ability to claim for rights that are not respected.

The creation of CAPS can represent an important tool for users of these services to become autonomous actors of their own lives. As Psychosocial Care Centers positively influence the lives of users by encouraging them to be autonomous, co-responsible for care and socio-cultural and political protagonism in services and in their communities[4].

However, instruments to portray this reality need to be incorporated in order to enable the creation of indicators that, besides contributing to management, foster the development of inclusive and participative practices, and contribute to the construction of a dignified life with freedom[4].

Taking into account the view that society has on mental health, a historical rescue of madness was observed in the articles, which provided a description of how individuals considered crazy were seen as people who lived in a logic contrary to the one of society[5].

This view has changed with the psychiatric reform. Subjectivity and citizenship started to be taken into account in this period, valuing care for families and deinstitutionalizing mental illnesses.

With the creation of the Psychosocial Care Centers (CAPS), psychiatric hospitals started to be replaced. These centers have the function of providing care and clinical follow-up in a daily care regime for people with mental disorders, trying to promote their social reintegration. The care provided at the CAPS presupposes the use of medication and psychotherapy[5].

The report of the experience of a Psychology student with CAPS II users [5] discussed the perceptions and emotions seen in relation to the services provided by the institution. The report discussed how the care and the embracement make possible the social reintegration because in this action it is possible to offer support so that CAPS users can act in their community with freedom and dignity and develop their autonomy. In this sense, the way in which the patient is treated can contribute or not to his freedom of expression and autonomy. This generates the need to adopt a different look at the individuality of the users[5].

Other articles [6] affirm that health professionals need to adopt a differentiated view in their work to contribute to the provision of a better service to users. They also mention that mental health care practices in primary health care (PHC) point to the identification of demands, working together with the community agents (CHA).

Care practices are acts of work in which means and instruments are used in an object, with a view to resolving situations. Family Health Strategy (FHS) Teams are important for access and follow-up of cases with emphasis on continuous drug treatment. The difficulties of achieving care actions that value the development of autonomy are also considered important. In this way, care practices are adapted to a form of care similar to that of community or preventive psychiatry, which had importance in the prehistory of the Brazilian psychiatric reform[6].

However, the close relation between mental health and PHC presents challenges, namely: the identification of demands,

embracement and diagnosis; a tendency to see mental health as the object of specialized knowledge; prevalence of drug treatment, or other biomedical interventions; implementation of listening and guidance, which are often not perceived as interventions by the professionals themselves, or the implementation of improvised actions; referral of cases, often to emergencies due to psychotic crises.

Mental health actions carried out by FHS teams are still marked by a fragmented work, keeping nursing professionals and CHA focused on the access and monitoring of cases while follow-up is seen as the responsibility of physicians. Emphasis on continued pharmacological treatment was also identified, as well as difficulties in performing care actions that value the singularity and development of autonomy, references that are the basis of the difference between the psychosocial and asylum-psychiatric care models. Interventions that work for the autonomy of subjects are underutilized[6].

The understanding of autonomy must permeate the valorization of the subjects in their singularized dimension, not only aiming at the elimination of symptoms but rather the capacitation of patients to seek a singular transformation. Therapeutic offers are therefore necessary, supported by expression in playful socialization[6].

The work done on mental health through interventions brings a significant contribution to the growth of the subject. The current scenario of mental health is characterized by the reorientation of work and rethinking of health actions. It is a privileged field of social interaction that enables social exchanges among all patients during the care process. Autonomy happens when individuals with mental suffering manage to deal with their dependencies. From this starting point, increasing the autonomy of users and their capacity to understand and act upon themselves is very important[7].

A survey carried out with health workers from a CAPSad of a municipality of Grande Porto Alegre, Rio Grande do Sul[7] identified the importance of this type of institution in the provision of care for users and promotion of autonomy. It was evidenced that mental health actions such as social interaction should advance, because this allows social exchanges among patients[7].

In another publication[8], the need for self-care is reinforced, since autonomy happens when subjects are able to cope with their limitations. The ability to develop self-care helps in the routines of families that have a member with mental health problems. These families are often blamed as responsible for the development of the mental illness. For a long time, families were seen as a triggering factor of the mental illness of the individual. The family is an institution that should be protected from madness and sickness[8].

The cohabitation of the sick individual with other vulnerable family members could harm the family. Only in the mid-1960s, after studies with schizophrenic patients, was it possible to state that the family environment in certain situations constitutes a factor that acts as a source of stress. In the family nucleus, power relations in the care become explicit; they are permeated by conflict of the guardianship and liberation of the sick subject. These relationships of power, care and autonomy point to the family as a product and producer of health practices[8].

Understanding the place (role) of the family in the care process is a matter discussed among health professionals and their families, as not everyone knows their place. In fact, for a long time the family was seen as a factor responsible for the development of mental health.

Based on this idea, it was common to understand and overburden the caregivers of these sick individuals who carried the responsibility of caring for the sick individuals. Nowadays, the development of strategies for these individuals to be able to take care of themselves is common, allowing them to build their autonomy. Autonomy is described as the attribution of the concept of responsibility, making individuals responsible for their self-care with their

health, thus taking that assignment away from the caregivers[8].

Field experiences of the rehabilitation of mental health happen on a complex plane of forces. Rehabilitation practices revolve around three axes: role and scope of rehabilitation, definition of rehabilitation scenarios, and conceptualization and operationalization of the autonomy construct. Psychosocial rehabilitation must design and align its efforts with the concrete needs presented by each user, such as housing, work and socialization, expanding actions on psychic suffering, as well as facilitating a restoration of the best possible form of autonomy[9].

The work of therapeutic follow-up (TF) with long-term psychiatric hospitalizations is understood as a strategy that contributes to increasing the degree of autonomy, psychosocial functioning and community integration. If multiple political, economic and sociocultural factors that make up the mental health theme are not considered, adaptive models of rehabilitation tend to take autonomy as a measurement gradient of adjustment to standards of normality[9].

Therapeutic follow-up (TF) is seen as an emancipatory therapeutic strategy for life that seeks the recovery of self-esteem, community integration and the social and political empowerment of users. This is because, the construction of an autonomous life requires the reduction of functional limitations of users through the teaching of skills and competences for daily life and through the introduction of changes in the environment in which they live. By doing so, new forms of care based on freedom, autonomy and exercise of rights will be built[9].

As social inclusion is based on the ability to assume the responsibility for the own actions, the acquisition of autonomy and accountability are prerequisites for social inclusion.

In the judicial context, dealing with people who comply with a judicial sentence that defines them as ill and criminals has two alternatives: outpatient treatment or hospital custody and psychiatric treatment. In this context, assisting the sentenced persons to think of themselves, on their subjectivity and their criminal situation is essential[10].

In this scenario there is a need for dialogue between Psychology and Law to encompass a complex question: being able to reconcile the truth of the person and his irreducible singularity before general rules and external norms. Thinking of autonomy in subjects involved with the judicial sector, thus, calls for a balanced position, without overvaluing or neglecting the relationship between psychiatric disorder and violent behavior. This is because autonomy and accountability for actions are conditions for social inclusion[10].

The issue of social insertion of psychiatric patients is problematic because even inside psychiatric hospitals, individuals are part of society[11]. In order to contribute to the resolution of this issue, the Brazilian government, in an attempt to improve the living conditions of these individuals, created the Return to Home Program (RHP) with the aim to stimulate autonomy and the recovery of skills and competences. This program contributes to the social insertion of people who have been hospitalized in psychiatric hospitals[11].

Although it is a compensatory policy, the RHP is an important tool in the process of deinstitutionalization. It can contribute to the dismantling of the asylum discourse and the place established for madness through the replacemente of the idea of subjects constrained in asylums by the idea of autonomous subjects[11].

The aging process must be experienced with autonomy, safety, dignity, well-being and health[12]. Therefore, interventions for the prevention of mental disorders and health promotion are necessary. The focus must be on the development of skills and solutions to address vulnerabilities. Although aging is a natural process of life, there are still few health interventions directed to this phase. Therefore, the concept of autonomy must be linked to interventions to prevent mental disorders and promote health in the aging process[12].

The acquisition of autonomy results in a greater practice of care with the implicit

valuation of subjectivity and the possibility of daily exchanges, taking into account the social and cultural dimensions[13].

The process of creating autonomy occurs in the movement of construction of individual and collective organizations. Thus, autonomy can be achieved to a greater or lesser extent during different moments in the lifetime. By increasing the empowerment to act upon oneself and upon the context in which the person is inserted, it is possible to create support networks, allowing for greater degrees of autonomy. Autonomy is seen as the construction of subjects and collective institutions, and therefore, can be achieved to a larger and smaller extent during moments of life[13].

As for the sharing among individuals with the same issues, active construction of solidarity stimulated by the enthusiasm of family members is essential, allowing corrections to be made in the course of the intervention[14].

Terms such as solidarity, mutual help, sharing of experiences and knowledge, responsibility and militant commitment to the supervision of public services are fundamental for the functioning of a proposal aimed at the autonomy of users. Strategies developed by the health services (CAPS) are needed as well as the collaboration of family members in this process of health education and autonomy[14].

It should be pointed out that strategies in the health education and autonomy process must take into account social determinants, defined as social, economic, cultural, racial, psychological and behavioral factors pertinent to health problems[15]. Interventions that stimulate personal and collective transformation in terms of empowering people and the community contribute to the improvement of the local reality and also foster the autonomy of individuals.

Actions emphazing the social subject; inclusion of new ways of producing health; dialogue between multiple actors; participative management; training and professionalization; reorganization of the work process; and valorization of the activities woven in the daily life are all aspects that contribute to a greater autonomy, because besides the professional, the community is also involved. The factors defined as social determinants affect the daily life of individuals and the perspective of mental health workers. It was possible to understand that actions that stimulate personal and collective transformation also contribute to the autonomy of individuals[15].

CONCLUSION

The analysis of the twelve articles made it possible to describe and understand how autonomy is defined and how important it is in the process of care and rehabilitation of subjects.

The texts link the concept of autonomy to the exercise of citizenship and knowledge of rights. There is a need to value the subjects in their singularity, increasing their capacity to understand and act upon themselves, assuming responsibilities.

It is imperative to build actions aimed at the expansion of skills and competences that respect the freedom of each one.

The increase of this autonomy brings benefits to the subjects and caregivers. The care with the own health is restored as the responsibility of the ill person, promoting social reintegration, opportunity for new experiences, and well-being in these experiences.

The analysis of the journals provided a macro view on the production of scientific knowledge in relation to the issue of autonomy in mental health in Brazil. However, the option to search for articles between the years 2014 and 2015 can be pointed as a limitation of the study, considering that it was a short period of time in the face of the vast academic production.

In addition, the diversification of approaches and research methods on the theme emerges as promising paths to continue the development of this theme.

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CONTRIBUTIONS

Laiane Lima da Silva participated in the collection and interpretation of data and writing of the manuscript. **Elisabete Agrela de Andrade** contributed to the interpretation of the data and writing of the manuscript.

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