

**Violation of human rights and humanized care: perspectives of workers in psychosocial care network\*****Violação de direitos humanos e atenção humanizada: perspectivas de trabalhadores da rede de atenção psicossocial****Violación de derechos humanos y atención humanizada: perspectivas de trabajadores de la red de atención psicossocial****Received: 17/01/2021****Approved: 02/07/2021****Published: 25/08/2021****Rafael Silvério Borges<sup>1</sup>****Paulo Fernando Guarato de Moraes<sup>2</sup>****Pedro Henrique Misson Milhorim<sup>3</sup>****Rosimár Alves Querino<sup>4</sup>**

This is a cross-sectional, descriptive and qualitative study carried out in 2016 in the countryside of the state of Minas Gerais. It aims to analyze the understanding of psychosocial care workers about human rights in the daily life of services. Questionnaires and audio-recorded focus groups were used, and the data were interpreted by thematic analysis. Fifteen workers participated, including two physicians, four social workers, five psychologists, a nurse, a nursing technician, a pharmacist and a nutritionist. Two categories were constructed: Violation of human rights; and Humanized care. As violations were cited: problems in emergency care such as physical violence, inadequate containment; lack of accessibility to services and social assistance rights, prejudice and stigma. Humanized care was understood as an expanded approach to health and the needs of users, autonomy, community insertion activities, expansion of care devices and teamwork. Although it reveals advances in the implementation of the psychosocial care model, the urgency of initiatives aimed at the defense of human rights was signaled.

**Descriptors:** Mental Health; Human Rights; Community Mental Health Services; Humanization of Assistance.

Trata-se de estudo transversal, descritivo e qualitativa realizado em 2016 no interior de Minas Gerais, com o objetivo de analisar a compreensão de trabalhadores da atenção psicossocial acerca dos direitos humanos no cotidiano dos serviços. Utilizou-se questionários e grupo focal audiogravado, e os dados foram interpretados por análise temática. Participaram quinze trabalhadores, sendo dois médicos, quatro assistentes sociais, cinco psicólogas, uma enfermeira, uma técnica de enfermagem, uma farmacêutica e uma nutricionista. Duas categorias foram construídas: *Violação de direitos humanos*; e *Atenção humanizada*. Como violações, citou-se: problemas no atendimento às urgências como violência física, contenções inadequadas; falta de acessibilidade aos serviços e aos direitos sócio assistenciais, preconceitos e estigmas. A atenção humanizada foi compreendida como abordagem ampliada da saúde e das necessidades dos usuários, autonomia, atividades de inserção comunitária, ampliação dos dispositivos de cuidado e trabalho em equipe. Embora revele avanços na efetivação do modelo de atenção psicossocial sinalizou-se a urgência de iniciativas voltadas à defesa de direitos humanos.

**Descritores:** Saúde Mental; Direitos humanos; Serviços comunitários de saúde mental; Humanização da assistência.

Se trata de un estudio transversal, descriptivo y cualitativo realizado en 2016 en el interior de Minas Gerais, con el objetivo de analizar la comprensión de los trabajadores de atención psicossocial sobre los derechos humanos en el día a día de los servicios. Se utilizaron preguntas y grupo focal audiogravado, y los datos fueron interpretados por el análisis temático. Participaron quince trabajadores, entre ellos dos médicos, cuatro trabajadores sociales, cinco psicólogas, una enfermera, una técnica de enfermería, una farmacéutica y una nutricionista. Se construyeron dos categorías: *Violación de los derechos humanos*; y *Atención humanizada*. Como violaciones se citaron: problemas en la atención de urgencias como violencia física, contenciones inadecuadas; falta de accesibilidad a los servicios y derechos de asistencia social, prejuicios y estigmas. La atención humanizada se entendió como un enfoque ampliado de la salud y las necesidades de los usuarios, la autonomía, las actividades de inserción en la comunidad, la ampliación de los dispositivos de atención y el trabajo en equipo. Aunque revela los avances en la eficacia del modelo de atención psicossocial, se señaló la urgencia de iniciativas dirigidas a la defensa de los derechos humanos.

**Descritores:** Salud Mental; Derechos Humanos; Servicios Comunitarios de Salud Mental; Humanización de la Atención.

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## INTRODUCTION

In Brazil, the Psychiatric Reform Movement (PRM) was created in the 1980s, and defends the process of deinstitutionalization of people with mental disorders, with the replacement of the asylum model by new care and treatment devices<sup>1,2</sup>. One of the first steps in the construction of the psychosocial care model was the denunciation of human rights violations during the Brazilian military dictatorship, which laid the foundations for delineating the rights of people with mental disorders<sup>1</sup>.

Rethinking the inhumane and segregationist practices in use until then, the MRP proposed a community-based mental health care model, consolidated in territorial devices and with broad social inclusion<sup>1,2</sup>. In this sense, national efforts are in line with the experiences of deinstitutionalization at the international level<sup>3,4</sup>.

The first community services were implemented in the 1990s, even before state regulation<sup>1</sup>. Law No. 10216/2001, known as the Paulo Delgado Law<sup>5</sup>, represents an advance in the field of rights and contributed to the structuring of the various components of the psychosocial care network (*Rede de Atenção Psicossocial* - RAPS)<sup>1,2,5,6</sup>.

Parallel to the sedimentation of the psychosocial model, the academic production on care services and devices and evaluative research was expanded<sup>7</sup>. Since the definition of RAPS as one of the priority networks by the Brazilian state, studies have been intensified on how, in different locations, institutions are articulated in a network<sup>8,9</sup>.

Research<sup>4,10</sup> has indicated as advances in the Brazilian psychiatric reform, among others, the expansion of substitute services, the investment of financial resources with primacy of community services over hospitals and expansion of the articulation of health services, although they are reported differences in the various locations.

The following challenges to the consolidation of the care model are highlighted: underfunding<sup>11</sup>, disparities in Brazilian regions in relation to the existence of community services<sup>12</sup>, stagnation in the expansion of substitute services, challenges to expand the care offered in primary care, welcoming families, guardianship relationships with users and low political participation of users and family members<sup>10</sup>.

Research carried out with health professionals has occupied a strategic place<sup>7,9,13</sup>, as they allow us to understand the daily life of services, the sedimentation of psychosocial care and the challenges faced for working in a network. However, it appears that the theme of human rights, so important in the constitution of the MRP<sup>1</sup>, has been little explored in recent years<sup>14</sup>. Given the relevance of the micro-politics of live work and light technology in psychosocial care<sup>13</sup>, it is important to understand how workers from different parts of the RAPS understand human rights and humanized care gain traction by allowing them to problematize the remnants of the asylum model in community services.

In the psychosocial field, studies that seek to understand recent changes in the conduct of mental health policy<sup>15</sup> are important, as they can directly affect the deinstitutionalization of the psychiatric reform process<sup>2,10</sup>.

Given the importance of research that addresses the realization of the rights of people with mental disorders and the consolidation of the psychosocial care model, this study aims to analyze the understanding of psychosocial care workers about human rights in the daily life of services.

## METHODS

This is a cross-sectional and descriptive study conducted with qualitative methodology<sup>16</sup>, carried out in 2016. The research scenario was constituted by the Psychosocial Care Network (RAPS) of a municipality in the interior of the Minas Gerais state, which, at the time of data construction, had: a team from the Mobile Clinic (*Clinica na Rua* - CR), a matrix support team in mental health (MSMH), a Psychosocial Care Center for Children and Youth (*Centro de Atenção*

*Psicosocial Infanto-Juvenil - CAPSi*), a CAPS Alcohol and drugs (AD) type III, two CAPS type II adults (one municipal and the other linked to the philanthropic institution), a philanthropic psychiatric hospital associated with the Unified Health System (*Sistema Único de Saúde - SUS*), five Therapeutic Residence Services (TRS), of which three are municipal and two are maintained by a philanthropic institution.

The study participants were workers from various RAPS institutions. At first, a meeting was held at each of the network's institutions. Next, considering the recommendations for conducting focus groups<sup>17</sup>, two workers from each institution specialized in mental health who met the following inclusion criteria were invited to participate in the meetings: working in mental health services for at least twelve months, regardless of education level and function.

Exclusion criteria were: working in positions of coordination of institutions and programs, being on vacation or on leave for health reasons during the period of data construction.

The instruments for data construction were focus groups (FG) and self-administered questionnaires, with questions regarding the socio-demographic and professional profile of the participants.

The FG is a space for dialogue in which subjects can express themselves, exchange experiences and, through interaction, build new knowledge. In the groups there is an animator, promoting the participation of all, avoiding dispersion of the intention of the work and monopolization of speech; and a reporter, with the role of recording all the details of the meetings<sup>17</sup>.

Two FG meetings took place in October 2016, in a space with conditions of secrecy and privacy. The average duration of each meeting was ninety minutes. Both had their audio recorded and transcribed in full for analysis.

In the treatment of the data obtained, thematic content analysis<sup>18</sup> and the recommendations of the Consolidated criteria for qualitative reporting research (COREQ) were used to conduct qualitative studies<sup>19</sup>.

In light of the research assumptions, the six stages defined by Clarke, Braun and Hayfield<sup>18</sup> were carried out: a) familiarization; b) encoding; c) code grouping with pattern mapping creation; d) review of themes, evaluating the relevance of the coded data in relation to the themes and the data set; e) definition and naming of themes; f) writing the final report.

The research was approved by the Research Ethics Committee (CAAE No. 46346415.2.0000.5154). Adherence to the survey was voluntary. Before the start of the FG sessions, the ethical responsibilities of the participants in relation to the shared information were clarified. After clarification on the research objectives and methodology used, each participant gave their own informed consent and received a copy of it. At the end of the analysis, the results were shared with the participants. In order to guarantee anonymity of the participants, names of flowers were assigned to each worker.

## RESULTS

Fifteen workers participated: one from TRS, two from a psychiatric hospital, three from adult CAPS type II, three from CAPS Ad type III, two from CAPSi, two from CR and two from MSMH. There was no adhesion of professionals from the philanthropic TRSs and from the philanthropic CAPS.

Most were female (13), self-declared white (10), in a civil union (08), aged from 30 to 39 years (06), and had completed higher education (15), of which three had specialization and two had master degrees (Table 1).

As for the professions, two were doctors, four were social workers, five were psychologists, one was a nurse, one was a nursing technician, one was a pharmacist and one was a nutritionist.

The time working in the health area ranged from two to 21 years. Those who had from

five to ten years of experience prevailed (06). Professionals with a shorter period of experience entered the area in the last four years (08) and one worker had been in health for 21 years (Table 1).

Regarding work in the area of mental health, more than half of participants had been working for up to four years (08). Among the participants, public servants with statutory regime predominated (09) (Table 1).

**Table 1.** Sociodemographic profile of psychosocial care workers. Municipality in the interior of Minas Gerais, 2016.

Variable		N
<b>Gender</b>	Female	13
	Male	2
<b>Age group</b>	20 to 29 years	4
	30 to 39 years	6
	40 years of more	5
<b>Ethnicity</b>	White	10
	Black	1
	Brown ( <i>pardo</i> )	4
<b>Marital status</b>	Single	5
	Civil union	8
	Divorced/separated	2
<b>Educational level</b>	High school	1
	Complete high education	14
<b>Time working in Health</b>	Up to 4 years	5
	5 to 10 years	6
	11 years or more	4
<b>Time working in Mental Health</b>	Up to 4 years	8
	5 to 10 years	4
	11 years or more	3
<b>Employment relationship</b>	CLT*	2
	Statutory	9
	Temporary	4

\* Consolidação de Leis Trabalhistas

The articulating themes built from the focus groups: *Violation of human rights*; and *Humanized care*.

### ***Violation of human rights***

The highlights were: problems in attending psychiatric emergencies, inadequate restraint practices, physical violence, constant readmissions related to the way psychiatric emergencies are treated in the Emergency Care Units (*Unidades de Pronto Atendimento - UPAs*) and lack of accessibility to various points of the network, lack of access to social assistance rights and reproduction of prejudices:

*This week we were there at the UPA [...] and there was a patient tied up, with his arm already all bruised from struggling so much. [...] It is inhumane, the way they are treated. (Azalea)*

*The patient arrives at the emergency room, sometimes even after [sexual] abuse and they are treated in the worst way. (Gerbera)*

*I had a case of a user [...] [who] works with recyclables all day long. He broke his leg, went to the UPA and they didn't look at him! He broke the entire UPA [...]. Then they called the police and took him to prison instead of providing care. [...] It is a violation of rights, one after another, very complicated. (Azalea)*

The unpreparedness of UPAs to deal with the demand for mental health and the recurrent use of the psychiatric hospital as a "*first option*" is pointed out:

*What happens? They want to get rid of them, as if we [the psychiatric hospital] were forced to accept it. (Edelweiss)*

Difficulties in dealing with the demands of mental health were related to restraint practices carried out in an unmeasured and irregular manner, understood by workers as a violation of physical integrity and human rights:

*[...] a drug user who was on the streets and they took him to the UPA, tied up. He was all bruised. I needed to have referred him [...] they returned [the user] to the street. Within two days, he freaked out again, came back again, and nothing. (Azalea)*

*I've seen the UPA making referrals and correct prescriptions, and I've seen others too, which is a horrible thing! I have seen a patient restrained without medication, without being properly medicated. And I've seen the patient hurt on purpose too. (Lily)*

Therefore, the UPAs have prioritized physical or mechanical restraint rather than other therapeutic resources, causing suffering in users:

*What I would like to say is this: that physical restraint without chemical restraint is torture! [...] [Restraint] is a medical indication, it has to come with medication too, understand? So, the physical restraint that is done without medical advice, just keeping them tied up there, because the family did it, because someone did it, that is wrong. (Chrysanthemum)*

The recognition of inappropriate and violent practices of physical restraint had as a counterpoint the resumption of a training course on restraint offered to workers by the municipality, which would have generated improvements:

*This part of containment has improved a lot due to the group of doctors, works in which we [the matrix support team] are talking. (Acacia)*

*The team makes a lot of difference. The verbal management with the patient, the environmental management, will no longer contain several patients, because of the team. I'm talking about anyone, a doctor, a technician, a nurse, an assistant, any health professional who is in the place and who can handle it. (Lily)*

Problems that occur in the UPAs are discussed, such as lack of qualification of professionals, lack of knowledge of the network and, also, difficulties with reference and counter-referral:

*The impression I have is very lucky and unlucky for those who are [working] on the day. Because I've seen the SAMU several times who [refuses] to do it or, then, comes and goes without taking the patient. I've already talked to people at SAMU and I have the impression that it's according to whoever is working that day, and at the UPA as well. (Lily)*

Otherwise, situations in which the support of the Fire Department and the SAMU were considered of quality stand out:

*Because SAMU is what you said. The other day there was the case of a patient who was released from the UPA, absolutely freaked out. That's what I kept holding him [with verbal management at CAPS] until the SAMU arrived [...] The SAMU's conduct was incredible that day, because the person who was there was certainly quite adequate and went to the [psychiatric hospital]. My biggest peace of mind is that he managed to do the chemical containment. (Daisy)*

The violation of human rights was also pointed out in cases of admission to a psychiatric hospital with the presence of the military police and in relation to the approach of the homeless person in town squares:

*SAMU only knows how to arrive at the [psychiatric hospital] with the police. If you saw what happened last week. The patient was in crisis and the policewoman said, "Can I hit him with a club?" [...] The nurse said: "No. You can do it, but then we'll have to report it to the prosecution!". [...] The nurse turned around, was asking [the user] to get up, he wouldn't get up and [the police] said: "I have more to do!" She grabbed a glass of water and splashed the patient in the face. (Edelweiss)*

The violation of the rights of people with mental disorders was also described as a lack of accessibility to the SUS network, due to the delay in accessing specialties through the electronic queue system:

*There are patients that you see and it's a matter of outpatient care and you release them. It is by no means a CAPS patient [...] It will be three months in the electronic queue to access it again and then the prescription has expired, he is hospitalized again or he returns spontaneously to the CAPS. (China pink)*

The chronification of users in CAPS and the impossibility of "discharge" is described:

*Patients who leave the CAPS are abandoned in treatment. [...] Discharge is extremely complicated. If they are sent to UBS [basic health unit], how long will it take? [...] Waited 3, 4 months to be seen. He arrived at UBS and was attended to in 5 minutes, quality drops in relation to reception and being well attended. Then he arrives and says he didn't like the doctor and decides to go back to CAPS. (Chrysanthemum)*

The difficult role played in the decision of priorities understood as denial of rights and transfer of responsibilities:

*But there comes a point that we try, like this. "Look, this one, let's take care of it, the one that's more urgent, let's leave this one." Then we have to stay, you know?! Selecting the most serious! (Azalea)*

The narratives highlighted difficulties in accessing other social assistance rights. There was an explanation of the denial of rights due to prejudices in relation to homeless people:

*[...] I have two homeless patients who have had a long time to register and I managed to get them through [...] the INSS [National Social Security Institute]. [...] sometimes the staff have the right, but they end up not looking for the CRAS [reference center for social assistance] to set up the process or documentation for aid and illness. There was a*

nurse who said: "I don't see any benefit in finding benefits for an alcoholic, drinking everything in a drip!". I said "Look, my experience totally says the opposite. Because when you get a benefit, the person really benefits [...] they find a place, get off the street, improve their quality of life, reduce alcohol and drug consumption. (Azalea)

### **Humanized care**

Five nuclei of meaning were identified: difficulties in understanding the person with a mental disorder beyond the diagnosis, users' autonomy, community insertion. expansion of care devices, teamwork. It is described that the reduction of the subject to their diagnosis by family members, and even by health workers, is frequent:

*This is something that, if you pay attention, it contaminates. When we say "Oh, so-and-so is schizophrenic". No. He may have schizophrenia, but he is not schizophrenic. (Amaryllis)*

*Last week I attended a case where the father said exactly that. And I said: "Look, what do you expect from the case?" [...] And he said: "Can you fix her head". (Daisy)*

*And there are a lot of people who even demand a "head exam" to see what's wrong in there! Something mechanical must be wrong. It's a little button that you press and fix. (Lily)*

Differently from this reduction of a user to their diagnosis, dialoguing about the conceptions of man and health advocated by the principles of integrality and equity, it was reported:

*I believe that humanization is based on this principle: that you take into account the subject's history. You see them as a person, who has the right to access, prevention, humanized, ethical, dignified care, just like we study. (Daisy)*

There was a need for users' understanding of mental health care to be considered in the process of formulating comprehensive and humanized care, with a view to enhancing autonomy and uniqueness of subjects and building horizontal relationships:

*And they have to go where they feel good, and that's part of the person's treatment. It's good when you feel good in one place, you even recover faster. And learn too. It's not just because we're professionals that we know more [than] them, no! They also know and can teach us, we can learn. Through stories, teachings, listening. (Lotus)*

The autonomy of users emerged at other times, when difficulties were reported for residents of the TRSs and PSR to be treated at the services without the monitoring of workers:

*Our audience [from the TRSs], we got a little more openness now. Will the team follow up? [...] If the team does not follow up, the dentist does not attend. (Acacia)*

*People have a lot of resistance to meet homeless people! But we are managing to improve this [...] with flexibility and better explaining this issue of law [...]. Before, if any user at night needed to access the UPA, there was no service! We came back the other day and had not been assisted, the UPA had broken, the business was worse. [...] Now, even when they go alone, they access the service better. (Azalea)*

Circulation in territories and access to public spaces were indicated as strategies for humanized care:

*There at the hospital [...] we have made partnerships with some places, such as the therapeutic residence, to occupy public spaces. [...] and there were patients who had never seen a swimming pool. [...] a water slide [and went for a ride at the club]. (China pink)*

*There are activities that I think are important and that are sometimes not considered by the team: external activities. It is very important to put CAPS on the street, to occupy the city. For example, there are people who were born here, lived here and until two weeks ago had never entered the SESI theater and we went there and did a play. [...] this contact is being able to make social inclusion and this is a form of humanized work. Taking it to the occupation of public spaces in the community is even an act of resistance. Shopping, for example, is an anthropological experience when you see people's faces. (Camellia)*

*And we have this practice of humanizing a lot: "Let's have a coffee?" "So, let's go to the bakery". And it's even funny because, in the beginning, this issue of resistance is very clear [...] And the people at the bakery are already used to this movement, we like to go a lot. [...] The other [user] likes to eat sitting and crouching at the door [of the bakery] and nobody says anything. (China pink)*

Accessing public spaces, going to the mall, club, theater, cinema and even having coffee in a bakery were described as constitutive moments of resistance, essential for the construction of bonds with other existential territories, beyond the field of specialized services. Feeling welcomed in services and the expansion of care devices are materializations of humanized care:

*Why did I accept the challenge of being at CAPS and CAPSi? To bring music [...]. Because talking about illness, caring for patients, saying that they are different and privileging difference is not easy, but showing that they can be like everyone else. So, you ask, "What's the bonus, what's the gold medal?" It's just having managed to bring music into service. (Wisteria)*

*Taking care of their food at the hospital is a very human part, in my point of view. [...] The issue of celebrating the*

*birthdays of the month. There are people who have never had a birthday party and if they are there in the hospital, there will be a party, there will be cake, they will sing happy birthday, it's really cool. (China pink)*

Teamwork aimed at the creation of joint strategies by the workers of the psychiatric hospital, the CAPS and the matrix support team to face rehospitalization and favor the adherence of users and families to community services was highlighted:

*If a patient screams, they go to the UPA and the referral goes straight to the [psychiatric hospital]. We have been trying to create alternatives [...] We make a joint visit and tell the patient that we are about to leave [the hospital] and we are already talking about them coming here [CAPS], working with the family, doing the joint visits. This has been very successful, in order to avoid further hospitalizations. (China pink)*

*The family makes a big difference in adherence to treatment [...]. If the patient has a family that helps, that goes with them, they are often able to do everything right, take medication. [...] So, we have to do this back and forth movement [joint visits and family involvement]. (Lily)*

*Matrix support brings this opportunity for this conversation with everyone. Because when we sit down to discuss the case, it's the FHT doctor [family health team], the nurse, the dentist, the community worker, who takes care of that person, the psychiatrist, the psychologist. So, everyone, everyone has a part of the responsibility for that person's improvement. (Wisteria)*

## DISCUSSION

Psychiatric hospitalization was identified as a consequence of difficulties faced by UPAs in providing care to psychiatric emergencies, lack of qualification of professionals to manage crises, lack of accessibility to specialized services and medicines, in addition to social conditions experienced by families and users.

Faced with a care network that struggles to meet the demands for access to medical specialties and diagnostic support technology, and that has made little progress in addressing mental health in the community and territories, specialized services have established themselves as a privileged locus of care.

Given the advances in rights and comprehensive care for people with mental disorders<sup>1,2,5,6,10</sup>, it was expected that the exercise of citizenship and respect for human rights of these people would be consolidated in the country<sup>14</sup>. Otherwise, the study revealed that HR violation is still recurrent in the daily lives of users of mental health services.

Study participants are faced daily with the remnants of the asylum logic and with the "desires of asylums"<sup>20</sup>, in addition to all sorts of prejudices, violations of HR and challenges for humanized care. The way RAPS workers perceived human rights violations in the municipality of Minas Gerais is in synergy with the reflections built by the World Health Organization (WHO) team in the WHO QualityRights Project<sup>21</sup>.

The WHO study<sup>21</sup>, developed with users from eighteen low and middle-income countries, identified that human rights violations were understood by the participants as: sexual abuse/violence; physical abuse/violence; financial exploration; denial of access to health services/mental health services/physicians; lack of conditions/means to enable people to live independently in communities; denial of the right to found a family/denial of the possibility of marriage; restrictions/denial of employment opportunities; arbitrary arrests; marginalization, exclusion and discrimination in the community<sup>21</sup>.

Participants showed a keen eye for identifying violations related to physical abuse/violence; denial of access to health services and other social assistance rights and prejudice/marginalization suffered in services and in the community and marginalization, exclusion and discrimination in the community<sup>21</sup>.

Other dimensions of human rights violations were not addressed in the survey: financial exploitation; lack of conditions/means to enable people to live independently in communities; denial of the right to found a family/denial of the possibility of marriage; restrictions/denial of employment opportunities<sup>21</sup>. These dimensions extrapolate the daily life of health services, housing other services and users' life contexts and signal the "challenges beyond institutional walls"<sup>22</sup>.

The WHO Quality Rights Project team<sup>21</sup> warns that the lack of access to mental health services and the occurrence of abuse and mistreatment by health professionals are worrying. As seen in the study of the city in the interior of Minas Gerais, the participants highlighted the occurrence of ill treatment involving professionals from the UPAs and the SAMU, especially in attention to psychiatric emergencies. Physical violence by police officers was also mentioned, which indicates the importance of broadening the discussion on emergency care with other professional categories and sectors.

Physical violence was related by professionals to inadequate physical restraint of users. Situations such as those described by the participants refer to its use throughout history, often applied as punishment by professionals<sup>23</sup>.

A study carried out in Australia<sup>24</sup> with users of mental health services, family members and their supporters explored their perceptions about isolation and containment practices in health services, and revealed that they consider such practices unnecessary and responsible for exacerbating problems for users, family members, caregivers and workers.

The Australian study highlighted as factors that affect poor practices: stigma, fear, scarcity of resources for care, physical environment and organizational culture<sup>24</sup>. In Brazil, a survey with health workers participating in a course on crisis and urgency in mental health, offered in partnership by the Ministry of Health and the federal university, revealed that, in the professionals' understanding, mechanical and drug restraints and hospitalization in emergency care are predominant<sup>25</sup>. It is therefore necessary to deepen studies on the reproduction of containment practices and assess their relationship with the difficulties of professionals and services in developing other strategies for managing cases of psychiatric emergency<sup>25</sup>.

In this sense, the management of crises and emergencies requires overcoming an approach centered on signs and symptoms<sup>25</sup>. The workers and health services are hardly prepared to provide care for demands that are divergent from the order of usual symptoms and parameters of the biomedical clinic and, for this reason, care is quickly understood as alien to the emergency<sup>23,25</sup>.

The comprehensive approach to people with mental disorders is essential for the construction of psychosocial care beyond symptoms and signs and with broad community involvement, as recommended by the MRP<sup>14,26</sup>.

Understanding the demands of users in a comprehensive and contextualized way can lead to changes in order to ensure social reintegration through the exercise of civil rights, strengthening family and community ties, as well as combating the discrimination suffered and felt by these people in their social relationships<sup>22</sup>. The stigma of mental disorders and the condition of life characterized by constant restrictions in exercising any right are difficulties that need to be overcome in order to strengthen social and family ties and even expand the search for support<sup>21</sup>.

Due to the workers' narratives, it is understood that it is necessary to undertake efforts to (co)build a new social space for madness and difference that excels in the defense of human rights. Given the diversity of dimensions involved in human rights violations, it is not possible for the health sector, alone, to overcome such challenges<sup>21</sup>. It is necessary to invest in intersectorial initiatives and broad community mobilization, especially in the involvement of users<sup>21</sup>.

As for humanized care, the expanded understanding of the subject and health proved to be essential for structuring the workers' reflections, as it supports care practices and the relationships between workers and users.

To humanize is to understand the subjects involved in health practices as a whole. In this sense, it is added that the subjects of health care, as well as mental health, must be recognized in their social, political and historical dimensions, in the relationship with the family, community and society<sup>26</sup>.



Attention to the co-construction of autonomous subjects and in a relationship of reciprocity, a perspective according to which workers, users and family members are in constant relationship and construction<sup>27</sup>. Encouraging society's participation and protagonism goes against the asylum logic and gives rise to new practices of inclusion in the community<sup>28</sup>.

In general, those surveyed exposed a broadened understanding of the historical subject, considering, in addition to their pathology, the biopsychosocial dimension of the user integrated into the environment of which they are a part of. Such understanding constitutes one of the pillars of the psychosocial care model<sup>26</sup>.

Involving users in the production of knowledge in mental health and problematizing the understanding of the practices offered to them is to value the essence of substitutive services, that is, to ensure progressive care in a perspective not only of care, but also integral, perceiving the user as protagonist and subject in its entirety<sup>28</sup>.

Once their needs are fully understood and considered, users of mental health services, along with workers, are able to design therapeutic projects capable of embracing the dimension of comprehensiveness in different levels of care and health policies.

In this regard, it is important to discuss and make all the subjects involved in such an agreement co-responsible, aiming to escape the tutelage incorporated in the therapeutic projects and, above all, to prevent the users' desire from being again denied<sup>22-29</sup>. These are the risks that substitute services need to avoid under penalty of rewriting a new look for mental asylums.

The worker's mediation in accessing and attending to other services in the SUS Network and other policies can be presented, contradictorily, as a guarantee of rights and protection<sup>22-29</sup>. In addition, the workers' narratives refer to the crucial issue of advances already achieved in specialized mental health services and the difficulty of accessing other points in the health and social care networks.

Overcoming these challenges requires the involvement of workers in the fabric of the network, since, far from being a mere legal provision, it is built in the daily service<sup>13</sup>.

When analyzing the articulation of RAPS with other institutions, advances are considered, as well as "unwelcoming practices" arising from processes of de-accountability for care<sup>30</sup>. Such practices may be related to numerous factors, including: lack of training of teams, insecurity of professionals, work processes that do not encourage actions such as welcoming and a asylum culture that crosses the social imagination<sup>30</sup>.

The lack of co-responsibility for care can also be linked to tutelary views on users that hinder the development of autonomy and community insertion. The breakup with visions finds a strategic element in the activities "extra walls" and the expansion of the circulation of users through the urban fabric. Such actions contribute to the resumption of life, construction of new bonds and the effective construction of new places for madness<sup>28,29</sup>.

The insertion of "mental health" users in the living territory of the community contributes to the deconstruction of stigmatizing labels, to the expansion of their existential territories and, more broadly, to the return of madness to the city, a place of social exchange<sup>27</sup>. Such initiatives also contribute to the development of autonomy and protagonism of users, expansion of bonds of solidarity and co-responsibility, and to breaking the so-called "chronification" in mental health services<sup>29</sup>.

The experiences reported by the workers allowed a glimpse of the way in which RAPS has undertaken efforts to increase the capacity for exchange, value and single out the subjectivity of service users. For this purpose, care devices installed in the community and in the territory where social life takes place are used, such as theater, clubs, bakeries, shopping malls<sup>22, 29</sup>.

The production of care, little diversified and exclusively within mental health services where "madness circulates", ends up becoming inefficient and contradictory to psychosocial care<sup>20</sup>.

The deinstitutionalization and deconstruction of practices and knowledge in community-based services must go hand in hand with the expansion and articulation of care in the basic and substitute network, to strengthen the work of a CAPS, in the form of a transitional device that works, preferably, in the interface with the community, enhancing the existing social support resources and promoting the debate of the asylum culture that permeates the most different spaces of interaction<sup>20,22,29</sup>.

It is pertinent to analyze whether health care practices in substitutive services would not be promoting new chronicities<sup>20,22,29</sup> and going back to the hospital-centric mode, in which discharge is not effected by the supposed (in)ability of users to access the services to which they are entitled and, above all, generate bonds in the territory by themselves. In addition, of course, to restricted spaces where “madness circulates”<sup>20</sup>.

There is, however, the possibility that service users may no longer be reduced to strata, docile bodies to produce new territories, a house, a good encounter managed by the body in its movements in the social fabric. In addition to the chronified and discredited body, the links in the territory can give rise to the unprecedented and the possibility of (re)existing in new territories other than that of chronification, nor of medical records, psychopathological descriptions and expected behaviors in the daily life of mental health services<sup>22</sup>.

For this, it is important to think that the reinsertion of subjects in the social body, through the promotion of access to the network, external activities in the community or discharge, is discussed with the user themselves, showing them that it will not be a suffering not to go to the specialized service, but the achievement of another important phase in the treatment. With this move, it will be possible to build new links with other services and people, expanding your social network.

Another important aspect is that mental health services started to perform important care work, becoming references in public mental health policies and a strategic training field for professionals for the process of Brazilian psychiatric reform<sup>1,2</sup>. In this regard, it was even perceived that, in order to provide assistance aimed at guaranteeing human rights and citizenship, it would be necessary, therefore, to urgently recognize the need to invest in training and continuing education initiatives aimed at the of the psychosocial care model<sup>13,21,25</sup>.

## CONCLUSION

It was observed that mental health workers are sensitive to various forms of disrespect and violation of human rights, including: physical violence by health professionals and the police; difficulties in emergency care by professionals from the UPA and SAMU; inadequate physical restraint; lack of welcoming; reduction of subjects to their diagnoses; family and professional movements aimed at hospitalization; lack of accessibility to other points of the SUS network and other social assistance services and, finally, prejudice and stigma in relation to users that impact on access to health and other rights.

With regard to humanized care for people with mental disorders, workers reported several practices aimed at ensuring access to rights, valuing care and rebuilding the perspective of mental health subjects. The actions highlighted by the workers as expressions of humanized care point to the extent of psychosocial care, anchored in an understanding of the subject and health that is not limited to the assistance and biomedical dimension. Workers valued community inclusion activities as strategies for resistance and occupation of the social fabric, central to the success of deinstitutionalization.

As this is a qualitative study that explored the reality of a municipality in the interior of Minas Gerais, it is understood that the results are not generalizable. However, it is considered that the findings can stimulate further research, which is fundamental in the current context of setbacks in relation to mental health policies.

It emphasizes the importance of developing studies with users, family members and members of civil society in order to incorporate their perceptions about the realization of

human rights and humanized care in mental health services. In this intent, it is considered that the focus group technique can contribute to the creation of a space for mutual recognition and qualified listening, valuing the space for speech and exchange between the subjects involved.

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**Paulo Fernando Guarato de Moraes** and **Pedro Henrique Misson Milhorim** contributed to the analysis, writing and reviewing. **Rafael Silvério Borges** and **Rosimár Alves Querino** participated in the design, collection and analysis of data, writing and reviewing.

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