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Psychiatric Reform based on the Practices of Mental Health Professionals at CAPS Ad: Between the Nosocomial and Psychosocial Models

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***Abstract*—** *The object of this research is to verify the performance of the practices of the professionals of the Psychosocial Care Center (CAPS-AD), in the light of Law 10.216 / 2001, of the Psychiatric Reform, making it possible to detect possible distortions, enabling the adequacy of the requirements of the psychosocial model established by mentioned Law. Firstly, we sought to understand how professionals have applied the Psychiatric Reform Law. Second, as a secondary objective: the present research aims to detect possible behaviors that reflect practices of the asylum model, with a view to psychiatric reform. To this end, it was verified, through an interview, the performance of mental health professionals during contact with users, the development of treatments applied and the types of interventions used; aiming to improve their service and consequently minimize or stabilize social stigma. As it is a qualitative research, it used Bardin's content analysis as a method. The data collection instruments were: non-directive interviews and notes taken in a field diary. The participants of the research sample work in three shifts, in a total of 15 professionals, namely: a) Psychiatrist (1); b) Coordinator (1); c) Psychologists (04); d) Nursing technicians (03); e) General Physicians (02); f) Nurses (02), and; g) Social Assistants (02). The results obtained indicate that most professionals do not have specific training to work in the mental health area, except for the psychiatrist with specialization in mental health and chemical dependency.*

Keywords— ***Psychiatric Reform, Mental Health, Asylum and Psychosocial Model, CAPS ad.***

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I. INTRODUCTION

1.1. Brief journey about madness.

In Ancient Greece, the "madman" was considered a person with different powers. Madness was seen as a manifestation of the gods, being then recognized and valued socially. There was no need for its control or exclusion. (ALVES; et al, 2009, p.86). Madness was not always seen under the medical eye, but as a way of manifesting the human, going from the field of Mythology to Religion. Illness came to be understood as punishment and punishment and thus, the patient was then blamed for his illness.

According to Alves et al, (2009) madness was explained through religious thought, concepts of demonic possessions and witchcraft prevailed throughout society, so that the consequence was the treatment given to the "madman", this was done through work of magic and exorcism practices.

In the Middle Ages, according to Alves et al (2009), madness was seen as an expression of the forces of nature or something of the order of the non-human. It was exalted, in a mixture of terror and attraction. With the birth of Rationalism, madness ceases to belong to the context of the forces of nature or divine, assuming the side of unreason, the madman being the one who transgresses or ignores rational morality, yet in this context there is the association of madness with dangerousness.

It is, then, in the Modern Age, that several attempts to name and address madness occur, with the greatest challenge so far, that of treating madness. Even in the Modern Age, the notion of private property emerges, as a response to this proposal, everyone should produce, and anyone who did not produce should be "excluded". Linked to this, with Mercantilism, everyone who in some way could not contribute to the movement of production, trade and consumption, according to Jacobina (2000) "[...] started to be incarcerated; old people, abandoned children, cripples, beggars, people with venereal diseases, start to occupy real human deposits, those who rebelled, were locked in cages and chained "(p.94).

It was only at the end of the 18th century that the first medical specialty in psychiatry appeared. Its origin brought the hope of treatment to the population interned in European asylums and hospitals of that time. The psychiatrist who introduced the clinical view in this area was Philippe Pinel (1745-1827) (STOCKINGER, 2007).

According to Alves; et al, (2009) from this moment then madness is seen as a synonym for mental illness. Pinel orders the alienated to be chained, so madness seen as a disease should be treated medically.

Pinel's initiatives pointed out two important issues: if, on the one hand, such initiatives create a field of therapeutic possibilities, on the other hand it defines a pathological and negative status with madness. Finally, Pinel's ideals end up reinforcing the separation of the insane, in order to study them and seek their cure. As a result of these initiatives, the asylum is seen as the best therapy, where seclusion and discipline are applied, with moral treatment as its objective.

As Goffman (1961) explains in Asylums, Prisons and Convents ... "This whole process of isolation and control, named by the author of 'Mortification of the Self', promotes a kind of deculturation, due to the distance from the routines and cultural transformations that occurred in the external world, generating dependence on the institution and fear of reintegrating into social life "(p.16).

We can assimilate that through the various efforts, and despite what seemed to be the "efficient solution" for the treatment of madness, medicine has not been able to give a satisfactory return to madness, the exclusion or imprisonment of these individuals who ran away from said normality, it had not been seen quite well by everyone.

According to Artoni (2004), even with all the ideas of naming madness as an organic disease and the possibilities of understanding it subjectively, none of these attempts since antiquity has managed to take the stigmas that society attributed them from mad people.

As Desviat (1999) clarifies. Criticisms of the "effectiveness" of the hospital model arose from the initial moment of its construction, but it was after World War II that professionals and society came to the conclusion that such a model should be rethought.

In Brazil, complaints of fraud in the service financing system started to emerge, which would be related to the abandonment, violence and mistreatment of psychiatric patients, initiating the Psychiatric Reform movements.

As a consequence, there was: "[...] the approval of the Reorientation Program for Social Security Psychiatric Assistance of the Ministry of Social Security and Assistance (MPAS), in 1982, the creation of a mental health policy engaged in fighting to the hospital-centered culture of the time "(ALVES et al., 2009, p.93).

Despite the Psychiatric Reform movement advocating a transformation in the way we look at mental illness, this was not enough for there to be an improvement in the service provided to this population, regarding the care of the mentally ill. From then on, conferences, meetings and even changes in legislation were made so that the mentally ill person had the right to be seen as a citizen and similarly, treated as such.

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In 1987, the 1st National Conference on Mental Health and the 2nd Meeting of Mental Health Workers took place, with the theme: "For a Society without Asylums". Alves; et al, (2009, p.93). From these meetings and conferences, Social Reinsertion is then seen as the main objective of Psychiatric Reform. Organizations, associations, health authorities, mental health professionals, legislators and lawyers met at the Regional Conference for the Restructuring of Psychiatric Care within Local Health Systems.

It is at this historic moment that, aiming at the rupture of these asylum assistance models, the presentation of the Bill 3657/89, 1989, by Deputy Paulo Delgado, appears, aiming to regulate the rights of the mentally ill in relation to the treatment and effect the extinction, in a progressive, public and private asylums and their subsequent replacement by extra-hospital services.

The aforementioned project gave rise to Law no. 10,216, of April 6, 2001, which is in effect, proposing the gradual replacement of beds in psychiatric hospitals, as well as, of the old asylum institutions by Day Hospitals, Nucleus and Center Psychosocial Care and Therapeutic Residences, Community centers in addition to other mental health care devices. A favorable environment is thus created so that those who suffer psychically can have the necessary support to re-enroll themselves in the world as a social actor.

Based on these general ideas, we can say that it is only possible to consider that two models of action in the field of mental health are alternative if they are contradictory. And two models will be contradictory if the essence of their practices leads in opposite directions as to their basic parameters. (AMARANTE, 2012, p.144.)

It is in accordance with these ideals that the construction of a substitute network for the psychiatric hospital and the traditional hospital-centered model began, starting with the creation of extra-hospital mental health care services.

In this context, services such as the Psychosocial Care Centers - CAPS, the Psychosocial Care Center for child care - CAPSi and the Psychosocial Care Center for Alcohol and other Drugs - are created for prevention and treatment actions (CAPSad) (ALVES et al, 2009, p.94).

1.2. General Objectives

This research aimed to detect possible behaviors that reflect practices of the asylum model, with a view to psychiatric reform. To this end, it will be verified, through an interview, the performance of mental health professionals during contact with users, the developments of treatments applied and the types of interventions used; aiming at improving their service, and consequently, minimizing or stabilizing social stigma.

This project intends, in the light of the Psychiatric Reform, to verify how the practices of mental health professionals at CAPS AD in Porto Velho take place, whether or not they are in accordance with the Reform.

1.3. Specific objectives

a) Understand how professionals have exercised the applicability of the Psychiatric Reform Law in their practices.

b) To know how the methods, resources, parameters, techniques or management that these mental health professionals have used in the exercise of these practices take place.

II. METHODOLOGY

2.1. Research methods

This project presents a qualitative approach. Qualitative research is characterized by investigating situations in the human universe, such as meanings, ideas, behaviors and others. In the face of such adversity, it was decided to carry out the content analysis of this study, the stages of the technique proposed by Bardin, since it is the most cited work in qualitative studies. According to Bardin (2009, p.121) "These steps are organized into three chronological poles: 1) pre-analysis, 2) exploration of the material and 3) treatment of results, inference and interpretation".

The first phase, pre-analysis, is developed to systematize the initial ideas put forward by the theoretical framework and establish indicators for the interpretation of the information collected. This moment includes the general reading of the material surveyed, especially the interviews, which are already transcribed, for a better analysis of the theme.

The second phase is the exploration of the material; it consists in the construction of the research wording, considering the excerpts of the statements in units of records, the classification and aggregation of information in thematic categories (BARDIN, 2009). In this phase, the responses of the interviews, and of all the collected material, are cut into record units and added to the research text, as well as document texts, or field diary notes.

The third and final phase is the treatment of the results obtained and interpretation; "Gross results are treated in a meaningful and valid manner" (BARDIN, 2009, p.127). Also according to BARDIN (2009), which allows the establishment of results tables, figures and models, which condense and highlight the information provided by the analysis.

2.2. Subjects

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The participants in this research were the mental health professionals who work at CAPS AD; in the initial forecast, 18 professionals who work in the three different service periods at the CAPS, however (three) were unable to participate; one for being on sick leave, another for having been returned to SEMUSA to work in another institution, and the third, refused to participate in this research. We then carried out the research with the 15 collaborating professionals, dealing with: a) Psychiatrist (1); b) Coordinator (1); c) Psychologists (04); d) Nursing technicians (03); e) General Physicians (02); f) Nurses (02), and; g) Social Assistants (02). A copy of the Informed Consent Form (Appendix 01) was delivered to all research participants, which was signed.

2.3. Inclusion criteria:

a) Be a professional in the mental health network.

b) That in their practices they provide assistance to users of Caps Ad.

c) Professionals who signed their express informed consent to participate in the research in accordance with the applicable legislation.

2.4. Exclusion criteria:

a) Professionals who do not work in the Mental Health network.

b) Professionals who do not serve the public of the Caps Ad network.

c) Professionals who did not want to participate and did not sign their express informed consent to participate in the research in accordance with the applicable legislation.

2.5. Instruments and procedures for data collection

The present research was carried out through recorded non-directive interviews, with the interviewee's consent, and notes described in a field diary. Having done this, a study of the data obtained was carried out, and of the information collected in order to carry out a comparative study with the theoretical framework raised. As Chizzoti (2010, p.92) clarifies, "[...] the non-directive interview is a way of collecting information based on the interviewee's free speech".

Care measures were taken in case of any discomfort at the time of the interview. The researcher, being a student in the last year of psychology, is prepared to reduce any emotional damage that any question asked during the interview would cause to the collaborating interviewee, and if there is any discomfort, the professional would have psychological support for emotional support.

The interviews were conducted individually with each professional, according to the availability of this and the researcher. The place where the interviews were conducted was CAPS AD itself. The interview was conducted as follows: the researcher asked the question and the collaborating professional had the necessary time to verbalize their ideas and answers about it. To guarantee the reliability of the data collected, the interviews were recorded and later transcribed.

2.6. Research Location

This research was carried out at the Psychosocial Care Center for Alcohol and other Drugs, located at Av. Guaporé, nº 3929; Neighborhood: Agenor de Carvalho in Porto Velho, Rondônia.

2.7. Data analysis and discussion

We emphasize that for a better understanding of the collected data, we will perform the analysis after the transcriptions. Content analysis is presented under several categories, thus enabling many styles of analysis, however, the category we will use is called "thematic analysis".

As Bardin (2009, p. 96) explains to us "By focusing more on the topic of investigation, we can extract the meanings associated with the topic, in the mind of the person interviewed". The thematic data analysis technique is known as text inference in which latent content is sought for the subject's said and unspoken content. Likewise, according to Bardin (2009), the thematic analysis method is one that, from the material transcribed, read and reread, will allow the researcher to observe the major themes that stand out from the content, which are evident in the discourse.

According to Lima and Pacheco (2006, p.120) "The interpretation of the results of the content analysis is necessarily subordinate, in the first place, to the search for answers to the research questions that have been asked".

2.8. Performance time and function of each professional interviewed.

The mental health professional must think beyond the simple duty to "cure and treat" the person with a mental disorder; in his performance, it is expected that the subject as a person will be prioritized and valued, instead of looking only at the symptoms and diagnoses placed on him, understanding that this user of the mental health service needs to be seen under three prisms; being the physical, psychic and social aspects.

The service time in the mental health area and, specifically in the CAPS-AD, of each of the professionals who participated in this research: The participants in this research have an average of 03 (three) to 09 (nine) years of experience in the CAPS– AD, and still two professionals present, in addition to their time at the institution, another

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five and four years working in mental health at other institutions.

These were the collaborating professionals of this research and their respective activities: psychiatrist, service coordinator, nursing technicians, general practitioner, nurses, social workers and psychologists. Only one professional at the institution has a specialization in mental health and chemical dependency, another is still studying in the same area. The others have specialization in psychiatry, psychoanalytic clinic, organizational psychology and cognitive behavioral therapy. Data obtained from the interviewees themselves.

Table 1 - Justifications of those who did not participate in the research

Employee Role	Amount	Reason
Nurse	03	He refusedtoparticipate.
Psychiatrist	02	Medical Leave.
NursingTechnician	04	Returned to the Health Department.

In view of the data presented above, we agree with Boarini's ideals: "Mental Health professionals, faced with the difficulties of entering or without maintaining in the labor market, have increasingly sought to work in public services without having, however sufficient preparation and commitment to your proposals and purposes "(BOARINI, 2011, p.167).

In the table below, the justifications of the 03 (three) employees who did not participate in this research; according to the initial forecast for it.

III. A MODEL OF PRACTICES OF MENTAL HEALTH PROFESSIONALS AT CAPS AD.

It is thinking about these practices and these diverse functions that mental health professionals at CAPS-AD were offered a look at themselves and the other, through their practices, in order to verify the application of the Psychiatric Reform Law, by the various professionals of this institution , seeking to understand how they practice in the mental health area, with the bonus of the possibility of reviewing their practices, and who knows, possible errors or insufficiencies resulting from professional practice.

An example of this form of action in the light of psychiatric reform, and the importance of the work of the multidisciplinary team, so that there are case studies and possible advances in the treatment of the CAPS AD user, appears in the speech of one of the psychiatrists interviewed;

Table 2 - Performance ofprofessionals

Employee Role	Time experience	Testimonial
Psychiatrist 1	03 years in Mental Health	*I develop clinical activities, as a psychiatrist, so I try to listen to the patient and explain the importance of him carrying out all the treatment not only with me, but with all the professionals, and when I see that it was not with colleagues, I pull my ear even , you know I can't do the treatment alone, and I explain that it is for their good and their family too, I always reinforce the importance of the family in the treatment, they really spend most of their time with the patient, so they have to know how to deal , I always call them together and explain some things, I raise doubts from the family for them to give this strength to them, you know ..., I also do activities outside the institution, such as lectures and dissemination of CAPS work, I am part of the multidisciplinary team and Traveling CAPS.*

It is in order to replace the professional asylum of professionals in the new substitutive devices, that the proposal of the multidisciplinary and interdisciplinary team emerged. "The work of the team should include a permanent rethinking of its daily practice and of the relationships established between the team itself, with users and with the community" (FRANÇA 2005, p.156).

Regarding the professional being attentive to his way of acting and concerned with the patient's well-being, it can be seen clearly in another testimony:

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Table 3 - On the attention of professionals

Employee Role	Time experience	Testimonial
Coordinationo f CAPS-AD	06 years in Mental Health	*I started in the administrative, I did my administrative work and whenever I could I listened, supported or welcomed some patients that I saw and felt that I needed special attention. Then I became technical manager and director of CAPS AD, and in these 6 years, I try to receive each patient with attention, perform a good listening, look in the eyes of the patients, so that he sees that I am listening to him and giving importance to what he is speaking, but I don't see it in the majority of my team, some don't even listen to patients who will say to look them in the eye, the CAPS AD public, demand specific care and extra attention and I try to stop what I'm doing and listen a little them.*

According to this way of acting, we sought to promote a bond with CAPS users, and as a consequence, avoid disconnecting them from their community "by introducing an extra-hospital care model that could gradually break with the hospital-centered practice, whose task we understand that it is the responsibility of all mental health institutions, substitutes and committed to psychiatric reform" (FRANÇA 2005, p.148).

This view was clear that the patient is not a single professional, but that he "belongs" to the entire team, as seen in another statement:

Table 4a - The professional as a member of the multidisciplinary team

Employee Role	Time experience	Testimonial
General Physician 1	*01 year in Mental Health*	*It is part of a whole, you know, we are a team here, I always like to emphasize to the patient, he likes to arrive at the office and he thinks that the medicine is the solution to all problems, and the medicine is just a part of the whole construction of the work, what will consecrate the treatment is the set, not only the work of the doctor, but also the work of the psychologist, Social Worker, patient participation in the groups is the whole set, I tell them, they think that getting here and renewing the prescription solves all the problems and no, the important thing for the work to really succeed is that he participates in all the team's practices.*

We perceive this concern in becoming a team to provide the best service to the CAPS AD user, through the testimony of another professional of the institution:

Table 4b - The professional as a member of the multidisciplinary team

Employee Role	Time experience	Testimonial
Social Worker 01	*04 years in Mental Health*	*We don't work alone. We are a multidisciplinary team. We do case studies, there is interdisciplinarity in our team. You seek to do the best for the patient within the scope of the legislation.*

Still on this theme of the importance of acting as a team, not seeing the patient as the mentally ill without recognizing him with his subjectivity, plurality and as a reflection of that, the team showed at times, dedication and special attention to the entire history of the CAPS - AD user, as well as their social and emotional background.

More and more professionals have recognized the need to dialogue with the rest of the team, so that they can see the user as a subject in its entirety and there is no fragmented planning of the therapeutic plan, which was clarified in the speech of the following professional:

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Table 4c - The professional as a member of the multidisciplinary team

Employee Role	Time experience	Testimonial
Nurse 01	07 years in Mental Health	*My practice occurs with the multidisciplinary team, there are several professionals all in full communication, to be better directing the treatment and monitoring of the patient, this is done with all professionals and with the various services offered by CAPS, on my part I stay at part of the screening, reception and initial interview. As it is a very small team, it facilitates contact, we always exchange pertinent information and we have a lot of openness and confidence to give suggestions for various situations, even with doctors who are generally closed, those here at least are super calm and open to study and discuss cases.*

Another professional also in the nursing area stressed the importance of the work of the multidisciplinary and interdisciplinary team.

Table 4d - The professional as a member of the multidisciplinary team

Employee Role	Time experience	Testimonial
Nurse 02	04 years and 07 months in Mental Health *at CAPS AD)*	*"... I am never alone, I am always working with a psychologist or social worker. I supervise the technicians so that they perform better care for the patient and adjusted to the CAPS model, I participate in multidisciplinary meetings, I also make home and institutional visits, trying to provide the best care for the patients here, you know ".*

The team showed a unique discourse about acceptance, understanding and the importance of carrying out a joint work, where each professional has its fundamental role and everyone exchanges ideas and plans, so that all together, assemble the best therapy for each CAPS user AD.

As França explains (2005, p.156):

> It also proposes, in view of the growing expansion of knowledge and the complex nature of the mental illness object, the intervention of the interdisciplinary team as a privileged work tool, as it offers a place for knowledge to be tested, limited, criticized and expanded, producing new knowledge and new crisis intervention practices, giving new meaning to the knowledge already established and providing a new production of meanings.

3.1. Real practices of professionals in the face of a psychotic break.

It is in the face of impasses, some uncertainties and countless challenges that the various mental health professionals at CAPS AD, try to walk at a slow (micro) pace towards Psychiatric Reform.

According to Boarini (2011, p. 87):

> Certainly the high rate of medical consultations, with a degree of resoluteness of the care provided practically null, even when the complaints refer to organic problems, but the clinical examination is negative, generates impasses and challenges that are sometimes not adequately addressed.

These are exactly questions similar to these challenges, impasses and uncertainties about what would be the best conduct in the face of a psychotic outbreak, for example, which we will see in the statements of some of the interviewees of this research.

Table 5a - Defining professional conduct

Employee Role	Time experience	Testimonial
Psychiatrist 1	03 years in Mental Health at CAPS AD	*I make a welcome, I try, right, the verbal restraint directs to the bed (bed), I activate the SAMU. If it gets worse, we use mechanical restraint, because we do not have the necessary instruments, we use these resources. Sometimes chemical containment is necessary, but soon SAMU arrives and provides emergency care. There is always this interface between the team and CAPS AD.*

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It was noticed in the speech of some of the interviewees, aspects of uncertainty, fear and lack of clarity as to how to deal with this adverse situation, but so expected in an institution that deals with mental health;

Table 5b - Defining professional conduct

Employee Role	Time experience	Testimonial
Social Worker 02	*06 years in Mental Health at CAPS AD*	*In the face of the psychotic break, I don't have much to do, right? I call Samu, and I am already taking him to the nursing room, to try to talk and try to understand him. I ask someone on the team to call the family and try to explain to her what is happening.*
Coordinationof CAPS-AD	*06 years in Mental Health*	*I try to perform first aid, as far as possible and what I know how to do, I call the doctor who is in our unit to perform the necessary procedure for the moment, after the doctor is treating the patient and applying the medication for contain, only if medication is necessary, you know, I warn the multiprofessional team, so that if this patient is stabilized and stays in the unit, he will go through the team to see better referrals.*

In several speeches we can witness the predominance of attention more focused on the biological aspects of the patient, represented by most professionals when resorting to medication, containment and SAMU care, demonstrating very limited views, and which generate these impasses in the day-to-day care of the patient. institution, precisely because they exclude subjective content as part of the person's illness.

> "It is possible to suppose that both the user and the professional experience frustrations: the first for not having their suffering diminished and their complaints answered and the second for realizing that they are not coping with the situation, although they often place the responsibility for the cure on the first one". (BOARINI, 2011, p.88).

These other professionals also presented in their speeches a speech of attempts and uncertainties:

Table 5c - Defining professional conduct

Employee Role	Time experience	Testimonial
General Physician 02	*02 years in Mental Health at CAPS AD*	*Here we usually refer to UPA, depending on the outbreak we contain it and take the medication that we have here, although I don't know if there are these medications. When we have it, we do "Diazepam" and "Haldol" and Fenergam when we have it and call SAMU, and contain the patient, tie him up, let me talk soon, there is a beautiful name, right.*
NursingTechnician 01	01 year in Mental Health at CAPS AD	*First I'm going to call SAMU and Fireman; trying to contain it looks like holding it, if a doctor has a prescription, we administer the usual haldol - fenergam. If you don't have it, try to calm him down until the SAMU help comes, Fireman, the police itself, if you are not aggressive, simply try to listen carefully and try to talk calmly with him. Never debate or contradict the individual, I believe that he moves from this phase to aggression.*

The referral can even be done, but not with the characteristics of this perspective discussed above. It is important to note that all the professionals interviewed said that at these times they prefer that these users be attended by psychologists and or psychiatrists, with the justification that they have “more ways” to deal with these cases, according to the literature.

According to Guedes, Nogueira and Camargo Jr. (2008 apud Boarini, 2011, p.89): the most indicated therapeutic action in the literature is the referral of these patients to psychiatrists and psychologists, which is confirmed in the following statements:

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Table 5d - Defining professional conduct

Employee Role	Time experience	Testimonial
Coordinationof CAPS Ad	*06 years in Mental Health at CAPS AD*	*I try to perform first aid, as far as possible and what I know how to do, I call a psychologist and the doctor who is in our unit to perform the necessary procedure for the moment, after the doctor is treating the patient and making the application of medication to contain, only if medication is needed, I warn the multiprofessional team, so that if this patient is stabilized and stays in the unit he will go through the team to see better referrals.*
Nurse 01	*07 years in Mental Health at CAPS AD*	*Look, I try to make a reception and in this reception try to listen, for many things to be stabilized, to try to understand the patient to establish a bond, right now I try to try to assess the level of consciousness depending on the situation I already refer him, to a psychologist or if it is a more acute case direct to the doctor and the unit doctor will take appropriate action.*

Also according to Guedes, Nogueira and Camargo Jr. (2008 apud BOARINI, 2011), the most appropriate therapy is the referral of these patients to psychiatrists and psychologists, aspects already mentioned above, was clearly evidenced in the speeches of nursing professionals in of this interviewee;

Table 5e - Defining professional conduct

Employee Role	Time experience	Testimonial
Nurse 02	04 years and 07 months in Mental Health *at CAPS AD)*	*Ah, first I try to stay calm, you know, I think we have to be calm and try to calm the patient down, then I see if there is a doctor in the sector, if not, we will call SAMU, because here we don't have any medicines , if the doctor has it there and asks for such medication there, people do it, but if not, just trigger SAMU and try to calm him as much as possible, put him in the observation room, I only do the medication with the doctor's prescription. It triggers the family too and because we can't contain him, right, the most we can do is also refer him to the psychologist to talk and try to calm the patient down, I see that the psychologist has another way to talk to these patients in outbreaks, even you interns know how to do it better than us. We try to do that makeup until SAMU arrives and send it to JPII,*

Faced with a psychotic outbreak, 05 (five) professionals presented more humane behaviors and aimed at the whole, paying attention both to biological issues and to subjective content.

Table 5f - Defining professional conduct

Employee Role	Time experience	Testimonial
NursingTechnician 02	10 years in Mental Health at CAPS AD	*I try to calm the person in the best possible way, guiding them, asking them to calm down, it is ... if they become aggressive, I will try to contain them, I immobilize, right? looks depending on the person I take by both arms, (at that moment I was asked if this professional has already received a course, training or instruction for this type of restraint) it was not in practice. Here at CAPS this is not the case, but if you have to contain it, you know, so as not to attack anyone, not to hit, not to hit anything, to become aggressive. And if you need to call for medical help, nursing, enter medication. We advise calling Samu and taking him to João Paulo II (Hospital), if you don't have a*

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		doctor here, right, even if the person freaks out here, I've seen it, I've worked in all CAPS, (Madeira Mamoré, Três Marias and here, I just didn't work at Infantil).
General Physician 01	*01 yearat CAPS AD*	*My form of assistance is to try to understand what is causing that patient to behave in that way, to try to seek the focus of the problem, and from that focus, outline the therapy, which I realize a lot, I work in an emergency; some patient arrives in an outbreak, the team is very anxious to speak, ah, make a haldol-fenergan, make a haldol. Once a young woman arrived who had attempted suicide at home, and does the haldol, does the haldol, because she is hysterical, I said no calm people, it is not like that let me talk to her, I got there I was talking to her, I talked to one and she calmed down and I didn't have to take the medication, so not the medication that ... I don't need to get rid of a problem, I need to understand what the patient's problem is, to be able to solve it and show him that together we will be able to solve.*
Psychologist 01	06 years in mental health at CAPS AD	*In my work environment it is always listening to the patient's therapy, welcoming the patient, making rapport trying to make a possible therapeutic connection. Trying to understand what he is feeling, because he is like that, and then we proceed with referrals, there are cases, for example, of people at imminent risk of suicide, or putting other people's lives at risk as well, this type of outbreak. we call SAMU, for patient removal, for emergency care, because the network here in Porto Velho is João Paulo II. My practice always in the face of the outbreak is always trying to understand and listen to the patient. Ex: A patient in the old CAPS building, which had a swimming pool, and an outdoor area, he was jumping into the pool saying he was going to kill himself and he tore his clothes and the guard said he was going to hit him, then I asked to be excused and said wait a minute let me try to talk to him and I did it, I introduced myself said looking into his eyes who I was, who was trying to help him and he didn't change me or attack me, he heard me , even in an outbreak the person has a degree of conscience, he heard me I asked him if he wanted to tell the doctor that I could describe the doctor what he told me, that patient listens, speaks, or may have altered thinking, or you may be hallucinating or that kind of behavior. A patient never attacked me because I always had a respectful attitude towards the patient, introducing myself, listening to him ask what's going on, and the doctor instructed me to do his removal for SAMU, and then I explained everything to him it would happen that he would go to the hospital, to get out of this 1 frame, I will call his family, everything I did I made him aware of everything I was going to do. If you are rude, and have no patience, you will not reach these patients.*
Psychologist 02	03 years in mental health at CAPS AD	*According to the Protocol on mental health in an outbreak: If there is an aggressive outbreak that leads to aggression, there is no way to intervene, right, so I don't know how the girls have acted on this issue, but look, I think it's very difficult to see, if this type of aggressive outbreak, usually the family that noticed it and brought it here, we can't often have an intervention didn't see it, even because of the protocol even in mental health, it wouldn't even be seen here at CAPS AD. I don't know what I've been doing here. In an outbreak the indication is that we make contact with a doctor I see the possibility of medication and whether or not there is a need to intervene, and if it is the case, together already think there about the referral so that he stabilizes and returns to the service CAPS, stabilization is usually via JPII, via the State, right, being sent to JPII, JPII, if there is a need, refer him to the psychiatry of HB, when he stabilizes and when he is discharged, HB, send here to CAPS AD, back to work, of course it's when these are serious and severe disorders, which is the demands CAPS, but when he is really in an outbreak we always have this contact and this protocol. It is very important at all times to call the family, especially when you have an outbreak, we always ask a social worker to call or get in touch with the family, they are very important at this moment, we call, tell us to come here, the patient is like this, the family you are responsible. which is the CAPS demand, but when it is really in an outbreak we always have this contact*

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		and this protocol. It is very important at all times to call the family, especially when you have an outbreak, we always ask a social worker to call or get in touch with the family, they are very important at this moment, we call, tell us to come here, the patient is like this, the family you are responsible. which is the CAPS demand, but when it is really in an outbreak we always have this contact and this protocol. It is very important at all times to call the family, especially when you have an outbreak, we always ask a social worker to call or get in touch with the family, they are very important at this moment, we call, tell us to come here, the patient is like this, the family you are responsible.
Psychologist 03	09 years in mental health at CAPS AD	*sometimes he is in a psychotic crisis with production, hallucinations, delusions, but he manages to keep his life there. It is necessary to have an intervention, but sometimes in the most severe cases in patients more resistant to medication it is more complicated.*

In view of these reports, we can see how much we still need to walk, fight and actually validate the rights and duties of people in psychological distress, these already advocated in the Psychiatric Reform Law.

Lawmakers, eager to meet the demand for Mental Health in the population, organized Law No. 10,216 / 2001, which aims to protect and guarantee the rights and duties of people with mental disorders, which reorganizes the mental health care model.

According to this law, all patients who suffer from some type of mental disorder are entitled to the best treatment in the health system, appropriate to their needs, as well as to be treated with humanity and respect, and in the exclusive interest of promoting their health, aiming to achieve their rehabilitation through insertion in the family, work and community.

Article 3 of Law 10.216 / 2001 states that it is the responsibility of the State to "develop mental health policy, assist and promote health actions for people with mental disorders, with the due participation of society and the family, the which will be provided in a mental health facility, thus understood the institutions or units that offer health care to people with mental disorders "(2001, s / p.).

Articles 4 and 6 of this Law provide that hospitalization will only occur when the other extra-hospital resources are insufficient for treatment, requiring a medical report that contains the description of the reasons for this hospitalization.

In addition, these users should be protected against any form of abuse and exploitation, with guaranteed confidentiality of the information provided regarding their clinical condition, and with the right to medical assistance, at any time, to clarify the need or not for a possible involuntary hospitalization. Patients must have free access to the available means of communication and should receive the greatest amount of information regarding their clinical condition and treatment.

It is also worth mentioning that all the rights mentioned above, as well as the others that are in force, throughout the text of Law 10.216 / 2001, must be fulfilled by the institution that manages and or organizes mental health care, so that patients can fully exercise them, under penalty of holding those who disrespect them responsible. That is why it is necessary to have prior knowledge of the legislation, both on the part of the professionals, as well as by the institution and by all who work in it, whether they deal directly with the service user or not.

3.2. The knowledge of Law 10.216 / 2001 (Law of Psychiatric Reform) by the professionals interviewed.

Having an understanding of the role and the real role of CAPS AD in the context of the reform is one of the first steps so that these professionals can measure the importance of their performance for the application of the law 10.2016 / 2001. However, the fact that a professional is inserted in the CAPS device, does not give us the guarantee that he knows the minimum of Psychiatric Reform and its law.

We were able to realize that for most of the interviewees, there is a lack of knowledge about the Law, in view of the interviewees' statements, it is possible to understand that more than half do not have satisfactory knowledge about the Psychiatric Reform Law, see:

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*Table 6a - About the **Psychiatric Reform** Law*

Employee Role	Time experience	Testimonial
Psychiatrist 01	3 years in Mental Health at CAPS AD	*I don't know much, but there are controversies: Eliminate the hospice and eliminate the beds, but there is a pharmacological evolution.*
CAPS AD Coordinator	6 years in the mental health network	*Look, I don't know the whole law, but I know about the new protocols for mental health, in fact the law only exists on paper, there is no appreciation for the work we do with patients to improve their quality of life.*
Social Worker 02	06 years in mental health, 05 in CAPS AD	*Jeez, wow! Well, what I know about the law is that it came to improve mental health, those who were once considered "crazy", are now seen with more respect and dignity by their own family and society. She confirmed that it is not just restraint, but that we can work with them on the social aspects and assistance that can help them and their families, and all this did not have before, I mean before the psychiatric reform law.*
NursingTechnician 01	01 yearat CAPS AD	*No, I don't know, do you have a new law? I would even like to know.*
NursingTechnician 02	10 years in mental health, 04 in CAPS AD	*The new law? No not yet. I heard people saying, where was it, boy? I heard it, but I think it was there at the hospital, but I can't remember what that law is. So far I haven't heard about the Psychiatric Reform law, not that I remember.*
NursingTechnician 03	05 yearsat CAPS AD	*I don't know, but I can go on the right, right? Psychiatric reform if I am not mistaken, about it, the way of leading the patient with mental illness was different, and after this reform it brought an improvement to mental health care. Before the reform, the service was less humanized than today.*
General Physician 01	01 yearat CAPS AD	*I know and what I remember was when I was in college that I saw everything, it was that in the past psychiatric patients were inmates in psychiatric hospitals. And the current understanding is that we do one more job to integrate these patients into society, than to reclose the patient.*
General Physician 02	02 yearsat CAPS AD	*It was a big reform, really big, that the assistance mode was hospitalization, they interned everything and the treatment was very inhumane and now it is more humane.*
Nurse 02	04 years and 7 months at CAPS AD	*I know more or less, I know it was deinstitutionalized ... the institutions, right? which is not to have patients institutionalized and CAPS was made for that, right.*

In this paragraph, a counterpoint was established through the speeches of the professionals who presented some knowledge about the Law, so only 04 (four) professionals from the 15 (fifteen) interviewees, brought answers that contemplated some aspects foreseen in the Reform Law. The excerpts of the interviews below demonstrate the professionals who were able to talk more about the Psychiatric Reform Law with more richness and clarity of details in their statements;

*Table 6b - About the **Psychiatric Reform** Law*

Employee Role	Time experience	Testimonial
Social Worker 01	04 yearsat CAPS AD	*Yes, I know her, the psychiatric reform, removed that hospital-centered issue, the psychiatric reform brought the deinstitutionalization of these patients, it also brought the services closer to the patients, also decreasing hospitalizations, and the families did not know how to work with this patient, it is an advance!*

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Nurse 01	07 yearsat CAPS AD	*Well, I know that the whole work should not be aimed at the hospital level, but at reinserting the patient to the activities he performed before having the psychiatric problem of not all the treatment not being aimed at the hospital level.*
Psychologist 01	06 yearsat CAPS AD	*Yes, right. It came to benefit psychiatric patients, until the 1980s, hospices were deposits of people and were also neglected by families, slept in unhealthy places, were people who suffered abuse, suffered violence, went hungry, the treatment was totally inhumane, and this violated human rights a lot even before the psychiatric reform, she came to put the patient back in his family environment and within the community, just as we left hospital care for psychosocial care.*
Psychologist 02	03 yearsat CAPS AD	*So, I see that the fight is still there today, with a lot to do with Law 11 or 12 thousand and something from Paulo Delgado, and in fact we are still fighting for it to be put into practice, that in fact the CAPS were an advance in the Psychiatric Reform, taking patients out of asylums so that they could be hospitalized only in really necessary situations, in psychiatric hospitals.*

And it happened that only 01 (one) professional demonstrated the understanding of Law 10.2016 / 2001, in a satisfactory way, as in the following statement:

Table 6c - About the Psychiatric Reform Law

Employee Role	Time experience	Testimonial
Psychologist 03	*09 yearsat CAPS AD*	*I know and study Paulo Delgado's law and also the new ones in relation to RAPS, Psychosocial Care Networks, it is in the question of the rights of patients with mental disorders, the availability of the patient to be welcomed in the environment that is not a hospital, to remain close to community, close to the family, to have the most welcoming service possible, to take a little and exclude, especially here at CAPS, this issue of marginalization, the way common sense sees chemical dependency, to really see subjects as subjects of rights, who is entitled to health treatment and whatever it is, if it is a mental disorder he has the right to have this access to health treatment, if it were an amputation, a cardiac patient, regardless of that.*

The lack of knowledge of the law may be related to the lack of information, but it was also evident in the speech of the majority the lack of interest and concern in the knowledge of the law.

3.3. The application of the Psychiatric Reform Law by other team professionals

Next, we will see the reports described in a field diary, regarding professional activities in the researched institution, which are reflected and analyzed in the light of law 10.216 / 01.

At the time of one of the visits, for active search, we witnessed not only stigmatizing words, but also, the breach of confidentiality by the professionals, about patient information, which should not be mentioned at that moment, considering that they would not be those who would receive the home visit; what goes in the opposite direction to what is in force in the Law on Psychiatric Reform, in its sole paragraph and item IV: to guarantee the confidentiality of the information provided.

While waiting for a therapeutic group, a professional from the reception brought the following comment (the name is fictitious):

> *"Maria, get ready, your group is going to rock today, the patient problem has arrived! (Laughter), good luck. "*

When referring to the user as a "problem patient", this professional acts contrary to the law of the Reformation, in his sole paragraph and item II: where he describes that the person with mental disorder must be treated with humanity and respect [.. .]

Another aspect recorded in the field diary:

> " *Right in the first weeks of the internship, which caused me disgust and discomfort, it was the speed of the assistance of a professional, showing extremely hospital practices, where each CAPS AD user, who entered his office, did not exceed 5 to 7 minutes of" service ".*

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When this attitude was questioned to another professional at the institution, the answer was:

> *"This one just renews prescription, baby, he doesn't even look at the patient's face".*

In a period that preceded the realization of the group, a CAPS AD professional was found, eating a snack and keeping in a bag to put 02 (two) other snacks in his bag, which would be offered after the group's thermos, so we asked :

> *- Hi, aren't these snacks for the group?*

This professional replied:

> *(Laughter) - First I know, for God's sake, then they, they care about that (snacks and fruit) .*

To which he obtained the following comment:

> *Do not do this, it is not certain, many of the users only have this meal that they make here.*

In this survey, of the 15 collaborators in this survey, there are only 03 (three) professionals who have their practices really in the light of the Psychiatric Reform Law, and among the three, I highlight 01 (one) case that marked in a special way, given the empathy , ethics, love and respect dedicated to the user who was attended by this professional in our presence.

When invited by a professional, in his attendance, to perform the reception and initial interview in mental health, we could see how he treated the CAPS AD user with respect and great attention when listening to him, even though he presented high agitation and anxiety, possibly because he had been abstaining for 20 days at the time, without interrupting him, because he was worried about the time or delay. At that moment, we witnessed a really welcoming approach. We realized that that user was received, treated and attended to with humanity.

In accordance with the provisions of Law 10.216 / 2001, in its sole paragraph, item II: To be treated with humanity and respect and in the exclusive interest of benefiting your health, with a view to achieving your recovery through insertion in the family, at work and in the community.

Table 7 - Representation of the subjects' opinion regarding the application of the law by the other team professionals:

Quantitative of professionals	**What they said**
04 (four)	There is application of the Psychiatric Reform Law.
10 (ten)	Some exercise the application, others do not.
01 (one)	They do not exercise the application of the Law.

At this point, we will address the perception of each employee interviewed about the application of the law 10.216 / 01, by the other members of his team, whether they see in their co-workers, a performance with the presence of the law enforcement, or not. Following are excerpts from the interviews, where each of the four employees expresses their opinions regarding the applicability of Law 10.2016 / 2001, by the other members of their team:

*Table 8a - On the application of the **Psychiatric Reform**Law*

Employee Role	**Time experience**	**Testimonial**
Psychiatrist	03 yearsat CAPS AD	*Yes, I see that there is, the patient is inserted in therapeutic actions, a multidisciplinary team and interdisciplinarity occurs.*
General Physician 02	02 yearsat CAPS AD	*Yes, there is an application that could be better if it had more resources, but with the little we have we do, we are applying it, the class here at Caps Ad is too good in front of others, you know, we have a home visit here that requires, we have night service, we have the Itinerant CAPS, we go to the interior, in those places that do not have access and we attend once a month.*
Social Worker 01	04 yearsat CAPS AD	*Yes, there is, we don't work alone. We are a multidisciplinary team. We do case studies, there is interdisciplinarity in our team. You seek to do the best for the patient within the scope of the legislation.*
Nurse 01	07 yearsat CAPS AD	*I see here in our team there is an application of the law of psychiatric reform to a reduction in the old model, the practices have been those that have improved the social, emotional and family aspects of patients. Our discussions are a lot to reduce even this old model and start applying the newer standard. My performance I see is in accordance with the law and with what every service does.*

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In this second moment, excerpts from the interviews were listed, where each of the ten employees expresses their opinions regarding the applicability of Law 10.2016 / 2001, by the other members of their team, evidencing in the statements below the fulfillment of this by only a few professionals team's;

*Table 8b - On the application of the **Psychiatric Reform** Law*

Employee Role	Time experience	Testimonial
CAPS AD Coordination	06 years	*I see that they are not all, but most professionals do not work for love, little is done based on the law, it is a superficial performance, it is not a welcome with love and commitment to that patient, they do not have that satisfaction in attending and helping the patient, go through mechanical practice. There is no service as it should be, and that understanding that it is not only the patient who gets sick, but the whole family is sick and needs to be heard, worked and helped.*
Social Worker 02	05 yearsat CAPS AD	*I realize that psychiatrists and general practitioners tend to enforce patients' rights more, trying to involve them in all the services they should have access to in CAPS AD, the other professionals do not.*
Technical 01	01 yearat CAPS AD	*As far as possible, yes, some, right, even because of the guidance they have, yes, it should all be right, but we know how it is.*
General Physician 01	01 yearat CAPS AD	*The whole team here? I think some do, some don't, so we try to work this together right, the best way to make that patient fit to live in society.*
Nurse 02	04 years and 7 months at CAPS AD	*There are countless professionals, right, here at CAPS, there are doctors who really go to the medication side, but it is not the psychiatrists, oddly enough, I see this a lot, think that medicalization is everything. There are others who know they have to wean, they have to take everything off and they look well at the reinsertion side and work more with the patient, I see that it's cool, it's cool, but it ends up not happening. I see that this reinsertion is to be desired and it ends up not happening because they stay here and there and end up falling back, you know, so I see that some do not apply and this delays the patient's treatment.*
NursingTechnician 03	05 yearsat CAPS AD	*I will be sincere here at CAPS, even because there are 3 shifts, there are professionals who do it and others do not, and most of the time they fall into the practice of knowledge, as well as doctors, some will not say that they are all, but some act in law others do not, because they think they know more than everyone, so I think that in this part we leave something to be desired because I understand that the multidisciplinary team is a set, not an individual job. Not all act according to the law, for example; the ethical issue, it doesn't happen I'm not talking about a case study that needs to be mentioned to the patient, but something outside that context and that always happens. I believe that my practice is in accordance with psychiatric reform.*
Psychologist 01	06 yearsat CAPS AD	*I see that there is not everyone, but the biggest problem is that most have no specialization, most of them who come to mental health do not have specific training to work with mental health. It comes as generalists, be it psychologists, nurses, clinicians and there must be law enforcement by the multiprofessional team, but it does not always occur by everyone on the team because the patient is not just a professional on the team, I see that there is an application in their majority by the team.*
Psychologist 02	03 yearsat CAPS AD	*They try to walk in what we understand about Psychiatric Reform yes, I don't see that they are all professionals, but in general, even our doctors I see that they try each other, right, despite the very different, totally separate view, but they try.*
Psychologist 03	09 yearsat CAPS AD).	*The professionals who work on my team, I say on my shift, I think they all have this job very clear, sometimes they don't necessarily have this reading about the law, they don't*

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		know it in depth, but it translates into their way of working, the other psychologist colleague, social worker, nurse, the doctors here we are able to discuss the cases and work hard on this perspective of the Reformation of trying to include.
Psychologist 04	05 yearsat CAPS AD	*Look at knowledge, I see that most of them have, you know, but I don't know how to apply it, because I don't know if everyone has the same understanding, you know, but I believe so, because at least with those I talk about it not so much a doctor, as the other psychologists, but I realize that for some there is application.*

And finally, the answer of a professional who said he did not see the application of the law by the other professionals of the CAPS AD team;

*Table 8c - On the application of the **Psychiatric Reform** Law*

Employee Role	Time experience	Testimonial
NursingTechnician 02	04 yearsat CAPS AD	*I don't see it, because they don't treat patients as they should, right, according to the law, we know, we see, but most are very good professionals, but if they don't comply with the law, it doesn't help the patient, but there is always one or the other that saves, you know.*

We can say that, in general, there is no application of the Psychiatric Reform law by most CAPS AD mental health professionals, some for lack of knowledge of the law, others for having their practices already plastered and based on hospital-centered and asylum models.

3.4. The methods used to reduce the stigmas suffered by users

In a search to verify how attempts are made to reduce the stigmas suffered by people in psychological distress through the work of CAPS AD professionals, we asked these "what methods are used to reduce stigma by users?".

A single professional presented his way of reducing stigmas and labels as follows:

Table 9a – On reducing stigmas

Employee Role	Time experience	Testimonial
General Physician 01	01 yearat CAPS AD	*But what I try to do for the patient is that he is not obliged to expose that part of his privacy, right, but here in our team we don't have this prejudice, I believe that this prejudice is more of society itself. We try to face the patient as he is with every set of situations that may have led him to even use drugs.*

Two professionals describe their ways of reducing stigmas as follows: Raise the user's esteem, working on their qualities and always reinforcing their potentials:

Table 9b - On reducing stigmas

Employee Role	Time experience	Testimonial
Technical 01	01 yearat CAPS AD	*I always use words of encouragement, I always give words of encouragement; man you will be fine, raise your head, you will overcome yourself, and for the more adults I say it's never too late to change, throw stones who don't have a glass roof, everyone can make mistakes and everyone sins and so on, this is my way of helping and I try to get it out of their heads, I try to pass on to them that people will not care about it, only if he gives more importance to what others say, I try to raise their self-esteem, sometimes these patients*

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		never heard a good word, a compliment or a nice opinion that will help them, I tell them that they have to fight to get rid of this problem.
Social Worker 01	04 yearsat CAPS AD)	*In our case, the first thing we try to do is make him aware, that he needs, to recover his self-esteem, we work on raising the patient's self-esteem, so that he does not label himself or allow himself to be stigmatized.*

Three professionals reported that their methods used to reduce the stigmas suffered by users, is self-care so as not to stigmatize, personal care, paying attention to how they look and especially how they treat the CAPS AD user, as they recognize that the the user feels when he is stigmatized.

Table 9c - On reducing stigmas

Employee Role	Time experience	Testimonial
NursingTechnician 02	04 yearsat CAPS AD	*If policing with emphasis on the appropriate terms, (it was asked if the professional has already acted like this) yes, I already recognize it, but I try not to do more.*
Technical 03	05 yearsat CAPS AD	*I know very well how to separate things in my appointments, I believe that the professional has to be vigilant in his words and the way he attends, even a look can make a patient feel bad, I always try to use the patient's name.*
Social Worker 02	05 yearsat CAPS AD	*The very care not to stigmatize, personal care knows, even if you don't do it, speak up, don't look with prejudice, you still have to watch yourself, because sometimes colleagues do it and it ends up taking you and them if you don't have that care you end up talking too. I believe that the concern with guaranteeing the right drives us to think of the other as a citizen in a non-stigmatizing way, that way I see the citizen, before seeing "the beggar", a homeless person, I try to look at the patient's history and see you as a person.*

When asked if they have already witnessed attitudes, speeches, looks, stigmatizing actions in general, by the professionals of the team itself, 05 (five) professionals from the 15 interviewees reported that yes, as seen in the statements below:

Table 9d - On reducing stigmas

Employee Role	Time experience	Testimonial
NursingTechnician 02	*04 yearsat CAPS AD*	*I've seen it happen a few times, but look, I treat it differently, because hey, the person is in the area, knowing that, talking among us, you know, we don't even understand a little.*
NursingTechnician 03	*05 yearsat CAPS AD*	*I have witnessed these behaviors here many times over the years and I will be very sincere, I prefer to omit myself, so as not to have problems in the work environment. Because the way you approach this person is even an offense, so I prefer to omit myself in some things.*
CAPS AD Coordination	*06 years CAPS AD*	*I always have a meeting to talk to the employees to review some attitudes that some have, but it works for everyone, you know, I speak to reinforce the attitude of looking at the patient while he speaks, I try to talk to the patient himself and make him aware that he must not give attention to these things and try to focus on his treatment, I try to solve all his demands in relation to CAPS AD).*
General Physician 02	*02 years CAPS AD*	*Ah, we always see or hear, right. Yes, I have seen it several times, but I have never seen it in front of the patient.*
Nurse 01	*07 yearsat CAPS AD*	*Yes, I have seen it, but I offer a lot of information to end these stigmas and labels. For me, one way to reduce the stigma suffered is to offer information to everyone.*

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Still 02 (two) professionals mentioned that these stigmatizing attitudes occur frequently, as we will see in the answers below:

Table 9e– On reducing stigmas

Employee Role	Time experience	Testimonial
General Physician 02	*02 years CAPS AD*	*Yes, I have seen it several times but I have never seen it in front of the patient. So I explain to the co-worker how the treatment works and then I will laugh at him and take him out for having acted like that, you know. Some people for lack of knowledge they end up putting labels and stigmas, but others do not.*
Nurse 01	*07 years CAPS AD*	*Here it is very common for us to hear employees treating patients in a pejorative way, to speak certain terms that we do not use and should not, so sometimes they do it due to lack of knowledge, right, but others are not really mean, I think this is sad .*

Still in the interview of this collaborator, she brought in her speech an example that she says is commonplace in the researched institution, and her way of acting in front of the team's stigmatizing statements;

Table 9f– On reducing stigmas

Employee Role	Time experience	Testimonial
Nurse 01	*07 years CAPS AD*	*Yesterday I was eating in the kitchen, then I heard them say: ah! He is crazy, I think the patient was giving a lot of work due to the way they spoke, at these times my posture is more to inform and say no, it is not like that and explain, and not letting them continue talking that way, guiding the person not to speak this way, I do it, sometimes they keep doing it and it only increases but I am doing my part of informing, because I believe that the lack of knowledge leads society, the family and the CAPS user to the process stigmatization, how to call by the pejorative name I try to reinforce the positive side of their life situation guide and talk about the patient the way to be called by name recognize that he is a citizen and that he needs treatment like any other citizen.*

Relating the statements mentioned above, with the field diary, we confirm these attitudes in one of the home visits made by the team. Stigmatizing speeches and attitudes can be perceived by 03 (three) professionals, and the following sentence is mentioned on the way to the visit to a patient on the street:

Table 9g - On reducing stigmas

Employee Role	Time experience	Testimonial
03 professionals	*Diverse*	*"...- This one is worse than farrowing, it is one child after another, when it wins this one, it already sucks on another one, you will see"*

Still on this visit, arriving at the place where the CAPS AD user was found, 02 (two) professionals expressed disgust at the odor presented by the user, who realized that she approached a 4th professional and hugged him sideways, as she she felt welcomed and not stigmatized.

In this question about the methods to reduce stigmas, 09 (nine) professionals reported that their methods and forms used to reduce the stigmas suffered by users; they take place through the information provided, these referring to the treatment, user profile and the CAPS AD functioning itself, information that aims to demystify some preconceptions and clarify countless doubts. These nine professionals emphasized that the first step is to inform and raise awareness among the patient; and the second is to take this information to the user's family, as they report that the more information the family receives and the more they are

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aware of the user's reality, the less they will suffer stigmas, labels and prejudices.

Some doubts arise after this verification, where 09 (nine) professionals say that the job of reducing the user's stigma is with the user and the family. Is this the only way to reduce the stigmas suffered by users? Can the ideal and described identity of CAPS AD users be able to walk hand in hand? Has the performance of the various professionals of the researched institution really managed to reduce the stigma suffered? Still on this issue, we had the proper perception: professionals who work the stigmas in isolation aiming only at the focus on the user and the family, professionals who are unaware of the services provided by the institution for the reason of not being performed at CAPS AD. A point common to all,

The rehabilitation process aims to minimize the negative effects, as well as, the stigmas and prejudices suffered.

As Pitta (2016 p.134) explains, still as goals of rehabilitation, among others:

- Prevent or reduce disabilities, loss of social skills;
- Restore potential skills in playing social roles;
- Strengthen latent skills and potential dignities;
- Facilitate social and psychological adaptation to the effects of social damage on the individual's life;
- Minimize deterioration;
- Enable optimal levels of self-determination, execution of personal and independent responsibilities, improve the person's sense of well-being.

IV. FINDINGS ON THE UNDERSTANDING OF CAPS AD PROFESSIONALS ABOUT PSYCHIC SUFFERING.

The statements described below clearly and objectively demonstrate the professionals' understanding of mental illness.

This single collaborator described his understanding of mental illness, as caused by genetic and psychological factors.

Table 10a - The professional's understanding of psychological suffering

Employee Role	Time experience	Testimonial
General Physician 01	*01 yearat CAPS AD*	*So I face how the patient has a genetic predisposition to develop that disease, the whole society in fact I think he needs psychological and psychiatric monitoring because I think we need it, we go through environmental and family situations that are triggers, which they would be by example; the abuse he suffered at the age of two, a husband who kept his wife in private prison and in an unhealthy relationship, somehow the person had an emotional dependence and somehow ended up allowing this to happen, sometimes the person gets so involved in that situation that she really freaks, we are constantly suffering various situations that can leave us a trauma or some situation of mental confusion.*

Two professionals understand that mental illness occurs due to two unique factors, the psychological and the social:

Table 10b - The professional's understanding of psychological suffering

Employee Role	Time experience	Testimonial
Coordinationo f CAPS AD	*06 years*	*As a mental disorder, as a pain that is there because of something, such as sadness, depression, anger, and all this leads to mental disorder, there are other steps and one of them is the world of drugs.*
Nurse 01	*07 yearsat CAPS AD*	*Look, I understand mental illness as something that deviates from the standard of normality, and we cannot talk about illness, right, because for me it is actually an assessment of the pattern of behavior, right, so when the person runs away from what, a mental problem, right. It is not like a physical disease that can evaluate a failure in the functioning of the body, I think it is more a failure in the functioning of how society, the*

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		population thinks that it is normal, so much so that what is considered normal for some people in some places, in others, it is considered abnormal, and then we cannot define it very well. Escape from the pattern established by that population, region at last. He is in fact an atypical patient, he is different from everything we have seen because it is difficult to deal with mental illness, we still do not understand 100% or 10% of mental illness so it is difficult to treat him.

Three professionals understand that mental illness occurs due to purely genetic factors, hereditary inheritance, complications during pregnancy or childbirth, among other factors.

Table 10c - The professional's understanding of psychological suffering

Employee Role	Time experience	Testimonial
General Physician 02	*02 yearsat CAPS AD*	*In relation to mental illness, we are light years behind, discovering what causes the disease, we only have treatment, we only treat as I would say a long shot. We know very well that pneumonia is caused by a bacterium that is installed in the lung and we know the symptoms, we know how to isolate the bacteria, but in mental illness not what caused it, lack of potassium or what.*
NursingTechnician 02	*04 yearsat CAPS AD*	*I see that the person is born with a problem in genetics, knows with some disorder and due to not treating or the family not paying attention to it early in pregnancy or when the child is born.*
NursingTechnician 03	*05 yearsat CAPS AD*	*Here at CAPS, I see it from the side of the genetic disposition even by the disorder that is caused by genetics and alcohol, by the chemical substance, crack and so on, and smokers and that there is some type of disorder and that most of the time they are chronic and requires continuous treatment and can happen to anyone in society, with me, with you.*

Four professionals understand that mental illness occurs due to purely psychological factors, such as emotional trauma and unresolved personal conflicts.

Table 10d - The professional's understanding of psychological suffering

Employee Role	Time experience	Testimonial
Social Worker 01	*04 yearsat CAPS AD*	*I see it as a very strong psychological shock, as an evil of the century, I think that all of us due to the current dynamics that we live, from stress, from the demands that are imposed on us, we are subject to certain moments of becoming patients at a mental health unit, as CAPS.*
Social Worker 02	*05 yearsat CAPS AD*	*I understand mental illness as something totally psychological, as one of the saddest evils that exists, because sometimes the person who suffers cannot say what he feels and how he feels, and we will not understand, because I really believe, who only understands who goes through or experienced it, and it is very sad not to be understood (cried), I see these people in a prison, where they are not heard and sometimes are not seen. It is as if these people were in a box, a dark square, all black at all, that you cannot see anything and it imprisons the person in a way that sometimes they have no shape and no idea how to get out of there, I understand like that and I find it very sad, because we know almost nothing about mental illness and everything we know is still very small near the universe of the human mind.*

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Nurse 02	*04 years and 7 months at CAPS AD*	*It is complex, you see, a lot of the person's emotional goes, sometimes we are so well and suddenly we start to feel sad, and sometimes we don't notice, and end up getting sick even at work, with stress, I think mental illness is very complex it is not easy to deal with, especially in relation to the person's mind, but I really like this area, I identified myself a lot, you know, and I try to do my best.*
NursingTechnician 01	*01 yearat CAPS AD*	*I see that there are people with a weak mind and a lot of work, a lot of stress and marital problems, a lot of debts, problems in the family, or a loss of a relative, I believe that all of this is what makes the person sick with the mind.*

Five professionals understand mental illness as a bio psychosocial factor, having in their speeches the justifications for the combination of the three factors: biological, psychological and social as a cause of human illness:

Table 10e - The professional's understanding of psychological suffering

Employee Role	Time experience	Testimonial
Psychiatrist 01	*03 at CAPS AD*	*I understand it from the bio-psycho-social point of view, with the mental and emotional aspects and the social point of view that covers the economic, being employed or not, family conflicts and others.*
Psychologist 01	*06 at CAPS AD*	*I do understand that the psychic disorder has a bio-psycho-social, biological, genetic, environmental, social basis, psychological factors of the patient's personality structure that favor the appearance of these mental disorders.*
Psychologist 02	*03 at CAPS AD*	*I understand that it is a biopsychosocial process, it has a whole and in our case it has and most of the time it comes as a comorbidity associated with the drug issue. Sometimes mental illness comes before, then comes the use of drugs, we have this particularity, right here at CAPS AD, in relation to mental illness. It is not the same to talk about the other CAPS, we have an association, sometimes there is the illness, there is already a biological inheritance, and then the drug comes together and brings this mental illness of the user, who already has this issue of several conflicts social systems installed and then the junction of it all ends up making this patient sick, I see this a lot.*
Psychologist 03	*09 at CAPS AD*	*Complex saw, for being formed by several factors, it is a very biopsychosocial process, my view on mental illness is a psychodynamic look, it is a look that comes from psychoanalysis, thinking about this personality structure, how this patient was formed, from these bases these environmental experiences that this patient had, so I think about mental health structured in this way. The person has a personality structure and she got sick and it got more exacerbated and there was, for example, the psychotic crisis, panic attacks, anxiety crises triggered by the use of the drug, this bias of drug addiction, drug addiction, all of that, I I see it as a consequence of a personality structure.*
Psychologist 04	*05 at CAPS AD*	*I consider the disease to be more serious, I see it as a series of factors that make that person get sick, in fact for me I understand it as the result of our three bases; bio-psycho-social, I believe that it is very difficult to deal with questions of the mind, and suddenly you tell this to other people and know that they do not believe, or even that they believe, do not understand and do not know how to help you, or you yourself without any guidance before, start to hear voices and give you orders telling you, where you are going or coming from, and you have to fight against it without even knowing where it came from. I consider the most difficult of the diseases that we know, and the one that causes the most suffering for the person the most that is possible to be treated.*

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The employees present a vision of what the mental disorder would be, based on the idea of mental "disease", sometimes for biological, sometimes psychological, or social issues.

V. KNOWLEDGE OF CAPS AD PROFESSIONALS ABOUT NATIONAL CONFERENCES ON MENTAL HEALTH

The only professional who participated in national conferences is also the only one who has satisfactory knowledge on the subject:

Table 11a - Professional's knowledge of national mental health conferences

Employee Role	Time experience	Testimonial
Psychologist 03	*09 at CAPS AD*	*I have already participated, I was at a conference in Rio de Janeiro in 2011, it takes place every 2 years, since then I have not been able to attend national conferences since then, but I try to follow the published articles regardless of my availability to be over there. I read a lot of what they produce there, I think it's important, it is the professionals bringing their practices, what they have done and what has worked, how some things have worked, what I like most to see are these reports of the professionals from different areas work and improve their performance in the challenges of working with mental health, that we can learn a little and put into our practice.*

Five out of fifteen employees have no knowledge of national mental health conferences:

Table 11b - Professional's knowledge of national mental health conferences

Employee Role	Time experience	Testimonial
CAPS Coordination	*06 yearsat CAPS AD*	*I did not participate in any national conference and I confess that I know nothing about them, I only participated in seminars, courses in mental health, suicidal ideation, people in street situations, and emergency care for psychiatric patients.*
NursingTechnician	*01 yearat CAPS AD*	*No lady, I never participated and never heard about her here either.*
General Physician 01	*01 yearat CAPS AD*	*I have no knowledge. I also did not participate in any conference, I believe that there must be every year in some state in the country.*
Nurse 01	*07 yearsat CAPS AD*	*I have never participated in any, I know they exist but I have never heard anything so profound.*
Psychologist 04	*05 yearsat CAPS AD*	*I didn't participate in any and I don't know anything about them.*

Nine professionals have a superficial knowledge of national mental health conferences, they also did not participate in any of them:

Table 11c - Professional knowledge about national mental health conferences

Employee Role	Time experience	Testimonial
Psychiatrist 01	*03 yearsat CAPS AD*	*I did not participate in national conferences, only from 01 state, which I was the organizer of and brought some colleagues and other professionals to discuss mental health, public health and seek new opinions about mental health and be open to talking about issues of great importance in this context, but I have already participated in several mental health workshops, mini courses and mini conferences to set up mental health action plans.*

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Social Worker 02	*03 yearsat CAPS AD*	*I have never participated, I have already participated in two mental health courses, the knowledge I acquired there that talked about mental health conferences is that there are several cycles of lectures and rounds of conversations, to discuss mental health in Brazil, how is the change going? and adaptation of CAPS, NAPS and Therapeutic Communities. What I also see is that even the little we know, we must put into practice, these conferences serve to empower the team, but no one on the team ever goes, because if only one could go, they could pass on the knowledge to the others, but not even this happens, if there was a team, it would be better to assist the patient, and it would improve the functioning of the network and the patient would be better assisted.*
NursingTechnician 02	*04 yearsat CAPS AD*	*I have already participated in several here in the city: I saw the psychiatric approach as to how to treat the patient, there are several specialists, doctors spoke about the new techniques of the new medications he is taking.*
General Physician 02	*02 yearsat CAPS AD*	*I didn't participate in any. They always try to improve the treatment of the psychiatric patient so that they can treat the psychiatric patient well.*
Social Worker 01	*04 yearsat CAPS AD*	*I didn't participate in any national, but I already participated in the last one that happened in the state. And I've heard of the national ones, yes, the last one in 2010. It regulates and regulates everything we've already said and followed up to here.*
Nurse 02	*04 years and 7 months at CAPS AD*	*I didn't participate in any. Has knowledge of harm reduction (alcohol and drugs). Smoking Seminar, Emergency Seminars for Psychiatric Patients and Coping with Alcohol and Drugs.*
NursingTechnician 03	*05 yearsat CAPS AD*	*I never participated, but as far as I know it is the conferences that take place anywhere in Brazil where professionals working in mental health will discuss or address some topic for the betterment of mental health patients, that's about right, looking for solutions, means for the patient.*
Psychologist 01	*01 yearat CAPS AD*	*I did not participate in any, but I have already read about the mental health conferences and from them emerged the anti-asylum movement, the laws and the very reports of experiences of mental health professionals.*
Psychologist 02	*03 yearsat CAPS AD*	*I did not participate in any, I do not know much about the subject, but I have read and participated in several courses and seminars in mental health.*

It is up to the professionals who deal with mental disorders on a daily basis, the function of seeking to study, analyze and understand this universe, which is so complex that it is psychological suffering, but this is not what we identified in this researched institution.

VI. FINAL CONSIDERATIONS

The main objective of the research was to understand how the Psychiatric Reform Law is being experienced through the practices of mental health professionals at CAPS AD in the city of Porto Velho. For this reason, through a field diary and interviews, we seek to get to know the institution, all the professionals who make up the team and its users, for a better view of this complex context, so that in fact the themes represented in this research are assimilated in more depth and the practices of mental health professionals are more efficient in terms of the Psychiatric Reform model.

Checking the performance of professionals in this area of mental health, whether it is in accordance with the Psychiatric Reform Law in force, whether the services and resources used have been sufficient to comply with the said Law in relation to its users. We seek to know the performance and resources used by these professionals to reduce the stigmas suffered or faced by CAPS AD users.

Regarding knowledge about the Psychiatric Reform Law, the vast majority of professionals interviewed do not have a satisfactory knowledge of the law. Thus, these professionals do not seem to be concerned with knowing the Law and applying it in their practices.

Most CAPS AD professionals work at the institution for an average of 5 to 9 years, but even before that time, they brought in their speeches that they did not have a specific training to work in mental health, with the exception of the psychiatrist, who reported in your interview has a specialization in mental health and drug addiction. It was

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found that the fact that they have no training does not cause dissatisfaction with their performance.

Given the facts, the importance of a course, training or qualification is emphasized for these professionals, aiming at a modification that will surpass the current and predominant model in most professional activities of this institution, aiming at a resumption of ethical conduct, in the models of listening and looking at the CAPS AD user, who are externalized in the daily interpersonal relationships that occurred in each service.

A point that deserves attention is when most of them, when describing their activities and functions in mental health, demonstrated to work in a team, leaving aside the individualized performance that reflects the hospital model restricted to medical records, patients and users. However, all of them presented in their speeches the importance given to the multidisciplinary work that the Psychiatric Reform proposes.

When asked about their understanding of mental illness, the interviewed employees, in their answers, delineated the possible causes of these diseases, biological, psychological and social factors.

In view of all the literature used as the basis for the theoretical framework and various materials, with regard to the Psychiatric Reform law, which was collected via granted interviews, descriptions in a field diary and the experiences during the period we were at the institution, we realize that many times the changes in the mental health area have been restricted to assistance changes, although mental health is an area that cannot and should not be limited only to the treatment of mental "problems", such as biological disease, this is not what we see in the practice of institution. So that this restriction does not occur, it may be necessary to rethink the mental health field in a different way than the current one.

Probably, given the need to point out that it was possible to overcome the asylum model, some changes made in the name of the Psychiatric Reform Law ended up being reduced to a mere reformulation of care services, that is, these changes were restricted to changing addresses, because asylum practices still permeate and supplant psychosocial practices in the institution.

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