## Articles

# "There is space, but at the same time there isn't": the care process analysis in psychopharmacological treatment in mental health

"Existe o espaço, mas ao mesmo tempo não existe": análise do processo de cuidado no tratamento psicofarmacológico na saúde mental (resumo: p. 19)

"Existe el espacio, pero al mismo tiempo no existe": análisis del proceso de cuidado en el tratamiento psicofarmacéutico en la salud mental (resumen: p. 19)

Roberto Carlos Pires Júnior[a]
<robertocarlospjunior@gmail.com> iD

Fabrine Costa Marques[b]
<fabrinecmarques@gmail.com> iD

Lêda Antunes Rocha[c]
<ledaantunesr@gmail.com> iD

Bárbara Soares Fonseca[d]
<basoaresf@gmail.com> iD

[a] Pós-graduando do Programa de Pós-Graduação em Ciências da Saúde (mestrado), Centro de Ciências Biológicas e da Saúde (CCBS), Universidade Estadual de Montes Claros (Unimontes). Avenida Cula Mangabeira, 562, Cândida Câmara. Montes Claros, MG, Brasil. 39401-696.

[b, c, d, e] Programa de Pós-Graduação em Ciências da Saúde, CCBS, Unimontes. Montes Claros, MG, Brasil.

[f] Departamento de Saúde Mental e Saúde Coletiva, Programa de Pós-Graduação em Ciências da Saúde, CCBS, Unimontes. Montes Claros, MG, Brasil.

Considering the challenges to psychosocial rehabilitation, this study was aimed at understanding the perspective of users and workers regarding psychopharmacological treatment. This is a qualitative study, which interviewed six providers and ten users of the Psychosocial Care Center of a municipality in the north of Minas Gerais. The transcripts were treated in Coding Cycles and examined by Discourse Analysis. Three categories related to the micropolitical dimension of care were defined: the institutional flowchart; the intercessory spaces; and the subjective production of the agents. Dissonances were revealed between statements alluding to the psychosocial care policy, with the competition of emancipatory and restrictive conceptions and technologies of care. The importance of the micropolitical analysis of care in psychopharmacological treatment was verified, favoring the processes of contractuality, protagonism, and user autonomy.

Keywords: Psychotropic drugs. Mental health. Professional-patient relations. Decision making, shared. Relational autonomy.

## Introduction

In recent decades, there has been a macro-structural transition in the policy and management of health practices in Brazil, through the consolidation of the Brazilian National Health System (SUS). While health was being restructured and democratized in the 1970s and 1980s, at the same time, the Psychiatric Reform boosted the transformation of the care model for people with psychological distress, by defending their rights and improving their living conditions[1].

The Law No. 10.216/2001[2] was a milestone for the Psychiatric Reform, providing for the protection and rights of individuals with mental disorders, recommending humanized health care. Psychosocial rehabilitation, expressed in law as the permanent purpose of the services included in the Mental Health Services (RAPs)[1], is currently considered the main purpose of this new policy. It is described as a set of initiatives and procedures aimed at reducing the chronicity and debilitating power of mental illness and enhancing opportunities for recovery and autonomy in the socio-community environment[3].

The Psychosocial Care Center (CAPS) aims to be one of the main expressions of this principle, by proposing assistance to people with psychological distress in an open and community health service[1]. Among the attributions, it provides for psychosocial rehabilitation actions that encourage the user to the right to citizenship and the exercise of contractuality in the various spheres of existence, including the treatment itself[3].

However, there are challenges to be overcome with the current paradigm, since the new references come with retrograde perspectives remaining from the asylum and hospital-centered models[4-6]. Considering that psychosocial rehabilitation is foreseen in the scope of public policies, it is in the microcosm of its devices and the relationships between workers and users that contradictions are evident, especially in the conjunctures that involve the negotiation and decision of the user about their treatment. The full process of contractuality and shared decision-making with users of mental health services is still one of the controversial issues identified in national and international studies[7-17], as even if desired, the workers can inhibit and hinder it. Pharmacological treatment, in particular, reinforces this paradox and is currently considered one of the main challenges in mental health.

Therefore, it is important to advance in the investigation of the scope of the constitution of psychosocial care in relation to its devices. According to Merhy[18], macro-structural reforms of health systems are not sufficient for an effective shift in attention. This transition can only be achieved through a policy conceived in the routine of services, which is based on the relationships and representations built among its actors. At the micropolitical level of health work processes, the production of care and the processes of adjunct subjectivation are materialized[19].

Health production depends on the intentionality of the worker concerning the user, the result of which is shown by their action, which is called by Merhy[18,20] as "Living Labor". Therefore, it is different from "Dead Labor", related to the production once achieved and incorporated into the work instruments. The analysis of the technologies

involved in the health work process makes it possible to understand the competition between Living Labor and Dead Labor in technical assistance models, in technological arrangements of health processes, and modes of care production[21,22].

Considering the dissensions of pharmacological treatment during the Psychiatric Reform[10,23], it can be used as an indicator of evaluation of the technological transition[21] in psychosocial care. Therefore, we wanted to understand the perspective of users and workers of the care process related to psychopharmacological treatment in CAPS.

## Methodology

This is a qualitative study, with participatory intervention research[24-26], which involved the creation of the first group of Autonomous Medication Management (GAM)[9,10] in the north of Minas Gerais, carried out in a CAPS of a municipality in this region.

Before the GAM implementation stage, semi-structured interviews were conducted with six providers and ten users, whose transcript was translated and adapted from a study in Catalonia, Spain[12]. The perception about the treatment, the drug management process and the care relationship were addressed. Data collection involved the recording and full transcription of the interviews. The providers were tagged as "P", and the users were tagged as "U", followed by a number related to the collection sequence. Data was collected between May 2021 and April 2022. The average duration of the interviews was 54 minutes (between 30min and 1hr33min).

The inclusion criteria of the providers were: 1) working at CAPS; 2) having experience with the psychopharmacological treatment of users; and 3) interest in participating in the research. The inclusion criteria for users were: 1) being inserted in the CAPS; 2) being on psychiatric medication for at least one year; 3) agreeing to participate in the research; and 4) not having severe cognitive impairment that could prevent participation. The service team selected the users and was advised to maintain the heterogeneity representative of the public. The sample size was defined by exhaustion for the providers by saturation for the users[27].

The transcripts were divided into two sets: "providers" and "users"; and gathered in the qualitative data analysis software *ATLAS.ti*. Data extraction, organization, and preliminary analysis were carried out using the Coding Cycle technique[28], in the following steps: 1) pre-coding: preliminary analysis of the *corpus* in the identification of the spare elements in the investigation; 2) first cycle: primary classification of the data in descriptive encodings, terms that allowed to summarize, capture the essence and/or evoke the contained data; 3) intermediate cycle: reassessment of the material and codes in the identification and systematization of the patterns of similarity, difference, frequency, sequence, correspondence, and causality between the codes; 4) second cycle: in-depth analysis and refinement of the codes, aiming at greater accuracy of their network; and 5) post-coding: organization and grouping of the codes into categories, allowing to transcend the analysis in the identification of latent structures in the linguistic material.

Discourse Analysis[29] was adopted for data analysis. By organizing the *corpus* into categories, the "linguistic surface" was outlined, explaining how the enunciated textual material and its operation features were structured and framed. Then, the data was treated again, evidencing the "discourse object", the relationship between the product with the different layers and discursive formations. Finally, the analysis of the "discourse process" and the effects of meaning on the structure and regulation of social relations among the participants were developed.

The analysis was theoretically instrumentalized by the studies of the Micropolitics of the Healthcare Work Process[18] and the qualitative examination of its technologies of care[21]. For validation, the materials were subjected to data triangulation[30], and the analyses were shared and confronted by three independent researchers, making it possible to synthesize the interpretative variability of the data and minimize the subjective inclinations of the researchers.

The study followed the prerogatives of the Resolution of the National Health Council No.466/2013[31], including the Informed Consent Form agreed to and signed by the participants, and the approval of this research by the Ethics Committee: CEP/UNIMONTES No. 4.034.265/2020, Amendment No. 4.332.549/2020.

## Results and Discussion

In total, 16 interviews were conducted. Of the workers, three psychologists, two nursing technicians and one physician participated in the research. The average time of professional experience in CAPS was eight years:

**Frame 1.** Characterization of the providers interviewed.

| Identification | Gender | Academic Background | Age (years) | Employment service (length in years) |
|---|---|---|---|---|
| P1 | Female | Psychology | 63 | 5 |
| P2 | Female | Psychology | 42 | 9 |
| P3 | Female | Nursing technician | 58 | 13 |
| P4 | Male | Nursing technician | 22 | 2 |
| P5 | Female | Psychology | 37 | 10 |
| P6 | Female | Medicine | 41 | 6 |

Source: Prepared by the authors.

Of the users, seven men and three women participated in the study. The mean age was 45 years old, and the mean treatment time was 12 years. During the research period, the participants were in different stages of psychological distress and stay at the CAPS.

**Frame 2.** Characterization of the interviewed users.

| Identification | Gender | Age (years) | Treatment time (years) |
|---|---|---|---|
| U1 | Female | 46 | 10 |
| U2 | Male | 28 | 16 |
| U3 | Female | 46 | 2 |
| U4 | Male | 37 | 5 |
| U5 | Male | 33 | 13 |
| U6 | Male | 52 | 32 |
| U7 | Male | 70 | 8 |
| U8 | Male | 53 | 16 |
| U9 | Male | 34 | 3 |
| U10 | Female | 46 | 11 |

Source: Prepared by the authors.

The analysis was divided into three categories related to the different analytical plans of the micropolitical dimension of care in the view of the participants: the first maps the work process from the description of the institutional routine; the second refers to the intercessory spaces arising from the relational dynamics between workers and between them and the users; the last category explores the subjective production of agents, related to meanings and actions in health practices.

Despite the segmentation, the plans are inseparable and reveal dissonances between the manifest discourse – referred to the macropolitics of psychosocial care – and latent perceptions that shelter a microcosmic spectrum of paradoxes, tensions, and ambivalence, with references to psychopharmacological treatment.

**Flowchart of the Care Production Process: Paradoxes at the Institutional Level**

In general, workers showed knowledge of the guidelines of psychosocial care, characterizing the routine of the service in accordance with the policy. CAPS' purpose was the recovery of autonomy and the reinsertion of the user in the socio-family environment, and medication treatment was considered important, but not exclusive.

However, most participants pointed out trends to psychiatric treatment instituted in the CAPS, with a certain inclination of the "team" to pharmacological conducts that can lead to overmedicate and the "silence" the user. Likewise, it is believed that the public reinforces in its demands the urgency of psychiatric intervention on distress. In contrast, the interviewees postpone medical assessment, aiming to buy time to establish bonds with the other devices and with non-medical providers:

In the service, in the past, the individual would come in, there would be a reception process, and their first medical appointment would be scheduled. It turns out that the user adheres more to the physician's figure and does not continue the reception process; in fact, there is not even a reception. Or, in the first reception, the individual schedules the medical appointment, but does not attend it later, because the individual has already been silenced and did not have a space to be able to work on these symptoms, these issues, this anguish, which ends up being solved with medication. (P2)

Despite the manifest criticism, the excerpt implies the convergence of care in the CAPS around medical assessment, encompassing relational devices. The reception is associated with "forwarding the case" to the psychiatrist, who will ratify the non-medical assessment. In the definition of the therapeutic project, the interests of the user are appreciated as long as they are subject to the "control" of the prescription. Therapeutic workshops can instruct about the use of medication through "awareness". Mentions of active search are related to the rescue of users who diverge from the treatment. "Discharge" is a possibility for those with the potential to continue the medical prescription. Family participation is related to the extent of surveillance regarding the administration of psychotropic drugs:

Patients go through reception, to check if they are already a CAPS patient, or not, because it is a place of crisis care, right? Of severe cases. Then, they go through the reception. Whoever is on duty will evaluate and see if the patient should be at CAPS, or if they should be referred to the psychiatrist. In this case, the psychologist continues following up on the patient, who begins to see the psychiatrist, who will prescribe the medications to control the patient's symptoms. (P3)

The pharmacological indispensability was more accentuated when the crisis care was mentioned. Even if some participants bet on the negotiation with the user, most understand that only drug intervention is effective. However, the clinical and legal limits of the intervention seem undefined, especially for non-medical providers:

There were several providers there to approach the crisis and some were like: "Oh, but she won't take it, why don't you tie her up and give it to her?" Others would say: "No! Let's talk a little bit more, let's see what can we can do." People... some providers were in such a hurry, had a sense of urgency, and were trying to negotiate: "Let's still try it again". So, there is this urgency to administer medication as soon as possible, to silence the patient as soon as possible, which means less work. (P2)

The emphasis on medical assessment assumed in the workers' discourses seems to correspond to the users' perception. Unlike other CAPS features, users reported regulations on access to medical appointment. On the other hand, its indispensability extends in articulation with RAPs, hindering the flow of care. Together, ruptures, bureaucratization, and unpleasant experiences involving involuntary or excessive pharmacological interventions were identified. Users pointed out that they preferred staying in the CAPS, fearing the care they would receive outside:

> I'm afraid of being discharged from CAPS because of this too. I think about being discharged one day, but only when I'm much better. When I won't need medication anymore. (U2)

The presence of divergent lines of care at the institutional level is visible, and they are entangled, especially in spaces of micro decisions[21] regarding pharmacological treatment and crisis care. The interviewees mentioned deliberations to curb the tendency to prescribe medication[32-34]; however, indirectly, the devices are subjected to the technicist logic of the medical perspective. These crossings are experienced by users in the form of obstructions in care, contradicting the expectation of the providers in the rearrangement of the service flowchart.
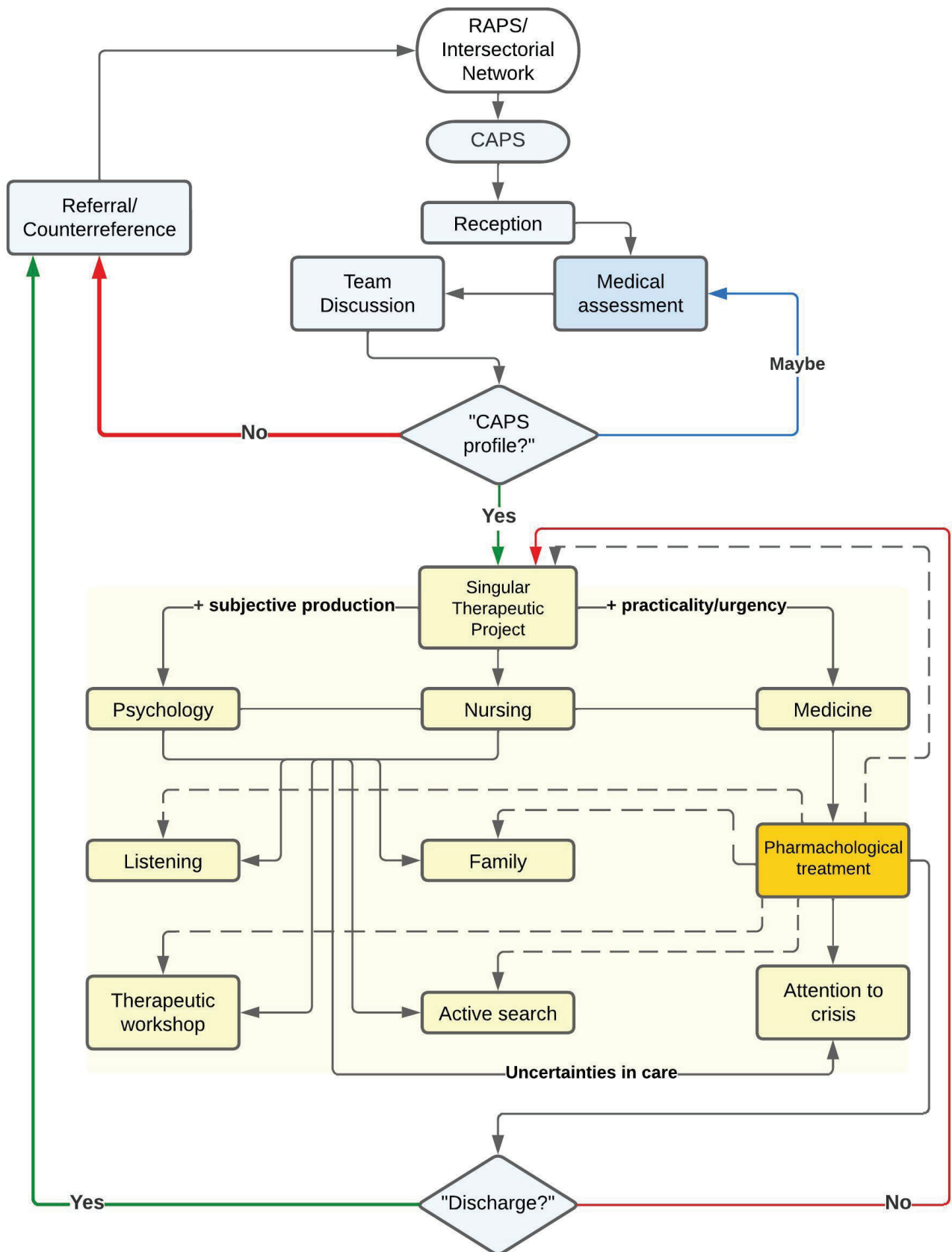
**Figure 1.** Flowchart of care in the CAPS according to the description of the participants.
Source: Prepared by the authors.

Analogous to the observations, a study conducted in three Brazilian locations[9] revealed disagreements among the CAPS providers regarding pharmacological primacy in crisis care. In another investigation, which analyzed mental health practices through the implementation of GAM[10], physicians stated that the decision-making monopoly does not come from their category, but from the organizational structure of the service. The study also showed the mismatch between technical and political guidelines regarding the experience of the users.

There is an emphasis on the instrumentalization of care based on hard and light-hard technologies from the hegemony of the Flexner's biomedical model[18]. In this context, medicalization plays a significant role in social control by redefining social, behavioral, and cultural issues as medical issues. The agents can foster this process themselves, including physicians and users[33]. As a result, the use of medication in contexts that are not previously considered medical is expanding, in addition to overmedication for already established conditions[34].

Therefore, the effective technological transition rises from the collective agreement of the agents in the inversion of the technological core, aspiring a new standard for care practices structured in the predominance of relational technologies, centered on the user and based on Living Labor[4,5,22]. The bet of the workers in the intervals of the medical consultation can be a way to open fissures in the instituted processes, allowing for new agencies.

## Intercessory Spaces in Health Production: Tensions in Care Relationships

Faced with the dispute between the lines of care at the institutional level, the practices that workers consider auspicious were often said to be isolated and, characteristically, referred to the interviewees themselves, disassociating them from the "team". This disjunction was more pronounced when mentioning the management of pharmacological treatment and the approach to the crisis:

> I have seen many patients being heavily medicated and this leads to anguish [...]
> As much as we work with a "multi" team, we do not have the domain and the
> power to deter someone. Each one has its autonomy, its professional ethics, and
> some guidelines. (P5)

In addition to perceiving the lack of assistance, the workers stated that they had no command over the decisions of the therapeutic projects, due to crossings of other categories. Although they demonstrated knowledge about interdisciplinarity[1], the speeches revealed sectorial and hierarchical actions. The politeness of the interviewees was evidenced when they were not being "invasive" regarding other people's conduct. Their responses seem to moderate a latent tension in the team, especially from non-medical providers in relation to doctors:

I sit and discuss, without being, without being invasive, without interfering in a medical conduct [...] And as we are a team that works horizontally, everyone sits, talks, and discusses. It is not only the figure of the vertical doctor, the one who just determines. Because, sometimes, we know more about the patient than the doctor does, for sure. What I try to do is be polite and position myself in a way as I was not giving an order to the doctor, as if I was not intervening in their conduct. (P1)

Despite this, the implicit agreement among workers was evidenced, with physicians having knowledge, performance, and decision-making power over pharmacology, while other providers are in charge of the subjective particularities of the user. Even if they hesitate to have their "power of voice" over medication treatment, the reports have indicated co-participation in the process. They are the ones who first identify delays in medical assessments, divergent uses of the prescription, adverse effects and to whom users turn for guidance. Psychologists, specifically, mediate the decision-making regarding the prescription, including or translating the idiosyncrasies of the case to the physician:

Like, I talk to the psychologist. I explain to her the situation that the patient is asking me. Then, only the psychologist to decide. But this power, which you're talking about, of me intervening, I don't have, no [...] I don't have that voice power! Only the physician and the psychologist can decide. (P4)

Although the interviewees expressed their opposition to medicalization[32-34], it was possible to see that the physicians increased their interest in other providers, using the bond itself as a tactic to favor the user's adherence to medication. Listening, considered a fundamental non-medicalizing resource, is also used to discipline the user about prescription. Thus, the perception of workers about "non-adherence" or "resistance" to treatment was mainly related to users who do not agree with the use of medicines:

There are many patients who at first do not accept, do not accept any medication. They don't even want to know, they don't even want to know what it is, they just say, "I'm fine" and that they don't accept it [...] So, they are really resistant to medications. At first, they do not accept it. Then, we start working to convince them and talk about their needs. Then they start to accept it. (P3)

The predominance of the physicians' speech and tensions arising from power relations observed between providers can be observed in the user-worker interaction. In general, users reported distancing and difficulty talking openly with the doctors. On the other hand, they search for non-medical providers to address issues of pharmacological treatment. The physician's knowledge is seen as superior, correct, and unquestionable, inhibiting the manifestation of users in care:

> I don't even ask [the doctor]. They don't have time either. The only one who can tell is the psychiatrist. The psychiatrist prescribes the medication in a hurry. And she is quiet, she does not explain it to me. (U8).

> I think I need a psychologist, because sometimes the doctors, you just say a little thing, they already understand that you, they think they already understand. And psychologists listen to you, to the whole story. So, sometimes, the person needs to have someone to tell what really happened. I need it. (U1)

On the other hand, users reported a perception of improvement when they started follow-up at CAPS. In this service, the interviewees stated that they had greater access, recognition, and support from the workers, which was crucial in the recovery and in coping with the illness. The contact with other users favored self-perception and acceptance of care. They believe that talking about the treatment facilitated the understanding of the malaise, improved bonding, and commitment to self-care:

> At CAPS, I was able to stabilize mentally, to live more with the disease in a more flexible way. Without being so hard on myself, as I was before, because I used to ask myself why I was like that. So, now I am not that hard on myself. Today, I know that it's a process that anyone would go through, it is not just me who goes through it. So, I can take the disease more lightly, and I think that's why I can get out of the psychotic trance, and I can get out every time. (U10)

Similarly, workers believe that the effectiveness of care is associated with practices involving relational technologies. Welcoming, bonding, listening, shared decision-making and the expansion of the social network appear as strategies to avoid overmedication. The discussion of cases as a team may include the need for immediate drug intervention.

Despite this, there was no unanimity among workers and users regarding the existence of dialogic spaces in care. Part of the workers believe that there is little communication with the users and recognize that the weakening of the bond can result in the omission of the users about the inadequacy or interruption of the use of psychotropic drugs and in the concealment of symptoms of mental distress or side effects. Users confirmed this perception in their current experiences, indicating the need for the co-participatory creation of these spaces:

> It's important to talk about it. Because not all of them [providers] talk. Because there are some who mention the medication, give the prescription and say: "take these little pills, and you will be fine". They just waffle about, but they don't talk about the effects. I would like them to tell me the effects of each one of them. (U8)

It's a new thing that the patient talks about the medication in such a way. There is space, but at the same time there isn't! Because people are not used to it. Nor the healthcare providers, and I think much less the patient. So, you have to implement a way to have this conversation. (U6)

Brazilian investigations[9,10] also identified the existence of a hierarchy in the treatment decision-making process, a lack of team support, and conflicts between non-medical providers and prescribers, according to the workers' perspective. The physician's knowledge mastery coexists with the absence of dialog on pharmacological treatment. In addition, non-medical providers report low technical qualifications and fear of being exclusively responsible for clinical decisions, preferring to refer them to prescribers.

The same studies identified relational difficulties of users with physicians when perceiving them as authorities in the decision-making process of treatment[9,10]. An ethnographic research in Catalonia[12], which explored the challenges in collaborative management of antipsychotics, highlighted disparities in clinical communication. While the providers emphasized the unilateral management of psychotherapeutic and medical treatments, the users emphasized the importance of interpersonal relationships and collaborative care processes, transcending the exclusively pharmacological approach.

Thus, the relevance of the technologies developed in the encounter between subjects, the so-called "intercessory spaces"[18], is verified, considering that, in its process, it captures the unique arrangements of the concrete and symbolic experience of the users in the treatment[20]. As indicated by the participants, the pharmacological domain itself, predisposed to instrumental and prescriptive strictness, can be the stage of the technological transition from which light technologies stand out, providing more realistic, powerful, and effective care practices[4,7,11,21,23].

### Subjective Production in Care: Ambivalences in The Ways of Signifying And Acting in Health

In general, the workers declared that they understood the user's right to access information on the treatment. Thus, they can have more security and autonomy in self-care; identify and prevent crises; discriminate the adverse effects of medication; endure the difficulties of treatment; make appropriate use of medications; have greater participation in care.

However, some respondents acknowledged that users have little or no access to information on treatment. It is believed that not everyone should be aware of the treatment, since knowledge about medication can make them "resistant" to it. They also pointed out that the professional clarification of the package insert is important, but this is not always done in the service, or it is strictly associated with medicine:

There are patients that we do not even mention that, otherwise it is dangerous for them not to take the medication. And there are others with whom we talk about it, we clarify [...] I usually refer them to the doctor. Because she is the only one who can explain this medication issue, in case the patient has lots of doubts, even about side effects. (P4)

The workers stated that the support offered by the service is important for the emancipatory process of the users. However, in a contradictory way, they reproduce "precautions" aimed at protection, but limit their autonomy, as they understand that not everyone has conditions for self-government. In the statements, restrictive practices in care are intertwined with clinical conceptions that result in tactics of subjecting users to the defined treatment. There are paradoxical understandings about contractuality, in which agreements with the users are considered, as long as they have "criticism" and are not "wrong" from the team's point of view:

Because if psychotics are totally without medications, they can't handle it. And any deviation, anything strange that happens in their lives, or any occurrence, family or even some crisis with someone triggers a new crisis. (P3)

If something is against [the user], it won't work! If there is criticism, if there is something against the user, it won't work, then they have to feel comfortable in our proposal, too. We try to make them feel at ease, too. Tell them what is better. Most of them, for sure, end up agreeing and this has a good effect. When there is agreement between both parties in the treatment process, therapy and everything, certainly the effect, remission, is better. (P6)

Restrictions in care seem to influence users' self-perception, considering that few declared having decision-making power in treatment. Some of the users believe that the person with mental distress is not able to make decisions and consider that the demands from healthcare providers to those who are "resistant" are positive. In addition, some interviewees stated that they were against the user's participation in treatment decisions. From the experiences of instabilities with psychic suffering, losses with self-medication and conflict with healthcare providers, some users stated that they had no interest in giving opinions regarding prescription, "accepting" and obeying the decisions of the providers, even if contrary to their will:

I have no strength; I already take medication. I can't change it, only the doctor [...] I think it is the doctor who has to decide, not the patient. (U1)

I am not able to define anything. When I talk to her [the doctor], she already knows what I have. What she can change. I can't change something she's already prescribed, besides not feeling bad. Even when I'm a little depressed, but even so, I'm better than I was. (U9)

Despite the self-reported restrictions, users stated that, when stable, they can participate in self-care maintenance with the collaboration of the team and family. In the interviews, they presented insights on protective factors for mental health, experiential knowledge of drugs, and resilience to dosage adjustments at different stages of psychological distress. In addition, they understand that, in the crisis, care management can be shared, and stated that they feel safer with this support:

> I accepted [the psychiatric medications] naturally because I knew myself, I know myself from the inside. I felt like I wasn't well. So much so that I sought the service by myself. No one guided me. I sought a mental health facility before going to the hospital. (U7)

> Today I feel much better, I feel great! As long as I take the right medicine, at the right time. It also depends on the effort of many people. You can't just get carried away by the medicine! Sometimes it makes you sleep all day; will you sleep all day? No! You will try to keep your mind busy, go for a walk. (U3)

As barriers to co-participation and autonomy in treatment, respondents reported difficulties in negotiating with prescribers, especially in reducing medication. Difficulties in the relationship with physicians generate the extension of resolvability, requiring the mediation of non-medical providers to validate their needs.

Users' lack of knowledge of rights can lead them to understand the workers' practices as exclusively altruistic, intimidating divergent manifestations. Finally, they feel socially stigmatized, and CAPS is considered the only protective space against violence, inhibiting the desire of some participants to enter social life and work:

> People also used to... they still say that we are "crazy". If we go to CAPS, they think we are "crazy". But I don't care anymore. Now I can talk, because CAPS has helped me. If it weren't for CAPS in my life, I don't know what the outcome would be. (P2)

In other studies, challenges were identified in the control of services over users, resulting in barriers to access to rights and citizenship. Workers showed reluctance to share treatment information, revealing uncertainty in promoting co-responsibility in care. This attitude was accompanied by inflexibility with users who disagree with pharmacological treatment[10]. Although CAPS are recognized for their support, paradoxically, they perpetuate stigmas and guardianship approaches based on users' supposed "lack of rationality"[9]. The voice of users is often underestimated in therapeutic decisions, contributing to a process of desubjectivation and reduction of their subjectivities to the pathological condition [12].

Research that used the GAM strategy identified the increased interest of users in participating in care. This improved relationships with workers, optimizing clinical strategies that effectively contributed to the well-being of users. This dynamic strengthened the collective processes of autonomy and co-management[9-11]. In addition, the appreciation of the knowledge produced in the unique experience of users, integrated with technical knowledge, could provide knowledge development in mental health[25,26].

However, according to Brazilian investigations[9,10], the effectiveness of GAM was attenuated by the institutional and relational factors of workers, as well as their attitudes. As indicated by the participants, ensuring spaces for reflection and shared decision-making can allow users and workers to have new experiences of care, critically evaluating the ways of acting in health, guiding themselves to more emancipatory practices[4,7,20,21].

## Final considerations

The study showed the dissonance between the literality of the macropolitical discourse of psychosocial care and the heterogeneity of conceptions within its devices. In the institutional flowchart, in the intercessory spaces and in the subjective production of the agents, a field of disputes between innovative and retrograde perspectives and emancipatory and restrictive work technologies was revealed, especially in the micro-decision spaces of psychopharmacological treatment, in which mechanisms that curb the power of contractuality, protagonism, and autonomy of the user are predominant.

In this research, limitations arose in the representative selection of providers, considering that their participation was motivated by their identification with the project, so some members of team the that were invited were not included. Thus, there was an insufficient number of participants to reach saturation, especially in understanding more the side of the prescribers. In addition, the selection of users was screened by the team, which, even under the guidance of the researchers, may have been based on subjective biases.

Amid the highlighted challenges, it is relevant to note that, in the current Brazilian context, initiatives are underway aimed at combating medicalization by adopting innovative technologies. Among these, GAM practices stand out, whose experiences are promising in promoting emancipatory and non-medicalizing approaches. Given this scenario, it is appropriate to consider the expansion and improvement of dialogic, participatory, and collaborative care practices in mental health.

Therefore, deepening the micropolitical analysis of the care process in psychopharmacological treatment and the scrutiny of the polysemy of the voices of subjects, fundamental for the technological transition in psychosocial care, are suggested. These studies can become consistent strategies that support workers in the exercise of self-analysis, self-government, and resignification of their act, supported collaboratively by the experiential knowledge and decision-making power of the user.

## Authors

Jayne Duarte Martins(e)
<jayneduartmartins@hotmail.com> iD

Cristina Andrade Sampaio(f)
<cristina.sampaio@unimontes.br> iD

## Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

## Conflict of interest

The authors have no conflict of interest to declare.

## Copyright

# References

1. Amarante P. Saúde mental e atenção psicossocial. Rio de Janeiro: Fiocruz; 2007.

2. Brasil. Presidência da República. Lei n° 10.216, de 6 de Abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Diário Oficial da União. 9 Abr 2001.

3. Pitta AMF. Reabilitação Psicossocial no Brasil. 2a ed. São Paulo: Hucitec; 2001. O que é a reabilitação psicossocial no Brasil, hoje?; p. 19-26.

4. Merhy EE. Os CAPS e seus trabalhadores: no olho do furacão antimanicomial. In: Merhy EE, Franco TB. Trabalho, produção do cuidado e subjetividade em saúde: textos reunidos. São Paulo: Hucitec; 2013. p. 213-25.

5. Almeida SA, Merhy EE. Micropolítica do trabalho vivo em saúde mental: composição por uma ética antimanicomial em ato. Rev Psicol Polit. 2020; 20(47):65-75.

6. Yasui S, Costa-Rosa A. A estratégia atenção psicossocial: desafio na prática dos novos dispositivos de saúde mental. Saude Debate. 2008; 32(78/80):27-37.

7. Deegan PE, Drake RE. Shared decision making and medication management in the recovery process. Psychiatr Serv. 2006; 57(11):1636-9.

8. Jardim VMR, Cartana MHF, Kantorski LP, Quevedo ALA. Avaliação da política de saúde mental a partir dos projetos terapêuticos de Centros de Atenção Psicossocial. Texto Contexto Enferm. 2009; 18(2):241-8.

9. Onocko-Campos RT, Palombini AL, Silva AE, Passos E, Leal EM, Serpa OD Jr, et al. Adaptação multicêntrica do guia para a gestão autônoma da medicação. Interface (Botucatu). 2012; 16(43):967-80. doi: 10.1590/S1414-32832012005000040.

10. Onocko-Campos RT, Passos E, Palombini AL, Santos DVD, Stefanello S, Gonçalves LLM, et al. A gestão autônoma da medicação: uma intervenção analisadora de serviços em saúde mental. Cienc Saude Colet. 2013; 18(10):2889-98.

11. Barrio LR, Cyr C, Benisty L, Richard P. Gaining Autonomy & Medication Management (GAM): new perspectives on well-being, quality of life and psychiatric medication. Cienc Saude Colet. 2013; 18(10):2879-87.

12. Martínez-Hernáez Á, Pié-Balaguer A, Serrano-Miguel M, Morales-Sáez N, García-Santesmases A, Bekele D, et al. The collaborative management of antipsychotic medication and its obstacles: a qualitative study. Soc Sci Med. 2020; 247:112811.

13. Calcedo-Barba A, Fructuoso U, Martinez-Raga J, Paz S, Carmona MS, Vicens E. A meta-review of literature reviews assessing the capacity of patients with severe mental disorders to make decisions about their healthcare. BMC Pychiatry. 2020; 20(1):339.

14. Haugom EW, Stensrud B, Beston G, Ruud T, Landheim AS. Mental health professionals' experiences with shared decision-making for patients with psychotic disorders: a qualitative study. BMC Health Serv Res. 2020; 20(1):1093.

15. Becher S, Holzhüter F, Heres S, Hamann J. Barriers and facilitators of shared decision making in acutely ill inpatients with schizophrenia: qualitative findings from the intervention group of a randomised-controlled trial. Health Expect. 2021; 24(5):1737-46.

16. Kaminskiy E, Zisman-Ilani Y, Morant N, Ramon S. Barriers and enablers to shared decision making in psychiatric medication management: a qualitative investigation of clinician and service users' views. Front Psychiatry. 2021; 12:678005.

17. Andrade APM, Maluf SW. Sujeitos e(m) experiências: estratégias micropolíticas no contexto da reforma psiquiátrica no Brasil. Physis. 2016; 26(1):251-70.

18. Merhy EE. Saúde: a cartografia do trabalho vivo. 4a ed. São Paulo: Hucitec; 2014.

19. Franco TB, Merhy EE. Trabalho, produção do cuidado e subjetividade em saúde: textos reunidos. São Paulo: Hucitec; 2013. O reconhecimento de uma produção subjetiva no cuidado; p. 230-49.

20. Merhy EE, Franco TB. Por uma composição técnica do trabalho centrada no campo relacional e nas tecnologias leves. Saude Debate. 2003; 27(65):316-23.

21. Franco TB, Merhy EE. Trabalho, produção do cuidado e subjetividade em saúde: textos reunidos. São Paulo: Hucitec; 2013. Reestruturação produtiva e transição tecnológica na saúde; p. 151-70.

22. Franco TB, Merhy EE. Cartografias do trabalho e cuidado em saúde. Tempus. 2012; 6(2):151-63.

23. Nascimento ML. Em defesa de uma gestão compartilhada da medicação em psiquiatria. Physis. 2012; 22(1):275-90.

24. Mendes R, Pezzato LM, Sacardo DP. Pesquisa-intervenção em promoção da saúde: desafios metodológicos de pesquisar "com". Cienc Saude Colet. 2016; 21(6):1737-45.

25. Passos E, Otanari TMC, Emerich BF, Guerini L. O Comitê Cidadão como estratégia cogestiva em uma pesquisa participativa no campo da saúde mental. Cienc Saude Colet. 2013; 18(10):2919-28.

26. Passos E, Palombini AL, Onocko-Campos R. Estratégia cogestiva na pesquisa e na clínica em saúde mental. ECOS Estud Contemp Subjetiv. 2013; 3(1):4-17.

27. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saude Publica. 2008; 24(1):17-27.

28. Saldaña J. The coding manual for qualitative researchers. 2nd ed. Los Angeles: Sage; 2013.

29. Orlandi ELP. Análise de discurso: princípios e procedimentos. Campinas: Pontes; 2005.

30. Santos KS, Ribeiro MC, Queiroga DEU, Silva IAP, Ferreira SMS. O uso de triangulação múltipla como estratégia de validação em um estudo qualitativo. Cienc Saude Colet. 2020; 25(2):655-64.

31. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução CNS n° 466 de 12 de Dezembro de 2012. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União. 13 Jun 2013.

32. Camargo KR Jr. Medicalização, farmacologização e imperialismo sanitário. Cad Saude Publica. 2013; 29(5):844-6.

33. Conrad P, Leiter V. Medicalization, markets and consumers. J Health Soc Behav. 2004; 45 Suppl:158-76.

34. Bell SE, Figert AE. Medicalization and pharmaceuticalization at the intersections: looking backward, sideways and forward. Soc Sci Med. 2012; 75(5):775-83.

Considerando os desafios à reabilitação psicossocial, objetivou-se compreender a perspectiva de usuários e trabalhadores no tratamento psicofarmacológico. Trata-se de um estudo qualitativo que entrevistou seis profissionais e dez usuários do Centro de Atenção Psicossocial de um município da região norte de Minas Gerais. As transcrições foram tratadas em Ciclos de Codificação e examinadas pela Análise de Discurso. Definiram-se três categorias relativas à dimensão micropolítica do cuidado: o fluxograma institucional, os espaços intercessores e a produção subjetiva dos agentes. Revelaram-se dissonâncias entre enunciados alusivos à política da atenção psicossocial, com a concorrência de concepções e tecnologias de cuidado emancipatórias e restritivas. Constatou-se a importância da análise micropolítica do cuidado no tratamento psicofarmacológico, favorecendo os processos de contratualidade, protagonismo e autonomia do usuário.

**Palavras-chave:** Psicotrópicos. Saúde mental. Relação profissional-paciente. Tomada de decisão compartilhada. Autonomia relacional.

Considerando los desafíos para la rehabilitación psicosocial, el objetivo fue comprender la perspectiva de usuarios y trabajadores en el tratamiento psicofarmacéutico. Se trata de un estudio cualitativo que entrevistó a seis profesionales y a diez usuarios del Centro de Atención Psicosocial de un municipio de la región norte de Minas Gerais. Las transcripciones fueron tratadas en Ciclos de Codificación y examinadas por el Análisis del Discurso. Se definieron tres categorías relativas a la dimensión micropolítica del cuidado: el diagrama de flujo institucional, los espacios intercesores y la producción subjetiva de los agentes. Se revelaron disonancias entre enunciados alusivos a la política de la atención psicosocial, con la concurrencia de concepciones y tecnologías de cuidado emancipatorias y restrictivas. Se constató la importancia del análisis micropolítico del cuidado en el tratamiento psicofarmacéutico, favoreciendo los procesos de contractualidad, protagonismo y autonomía del usuario.

**Palabras clave:** Psicotrópicos. Salud mental. Relación profesional-paciente. Toma de decisión compartida. Autonomía relacional.