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HUMAN RIGHTS, SOCIAL VULNERABILITY, AND FREEDOM-BASED CARE IN MENTAL HEALTH[1]

Direitos humanos, vulnerabilidade social e cuidado em liberdade na saúde mental

Derechos humanos, vulnerabilidad social y atención en libertad en salud mental

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1 Part of the initial structuring of this text relied on **artificial intelligence** tools for text organization, which were revised, adapted, and validated by the authors.

Abstract

This article presents a systematic review that articulates human rights, social vulnerability, and mental health, with emphasis on the Brazilian Psychiatric Reform and the Psychosocial Care Network (RAPS). The objective is to analyze how vulnerability conditions impact access to the right to mental health and how care in freedom operates as either a realization or denial of fundamental rights. Fifty-two publications were selected from SciELO, LILACS, PubMed, and CAPES Journals databases (2010–2025). Results indicate that socioeconomic inequalities, structural racism, sexism, and LGBTQIA+phobia constitute barriers to service access and produce psychological suffering. Care in freedom, sustained by interdisciplinary teams and territorial practices, proves more effective when guided by human rights principles, although challenges persist regarding financing, professional training, and resistance to asylum-based models. The study concludes that intersectoral policies, strengthening of the RAPS, and confrontation of structural vulnerabilities are necessary.
Keywords: Human rights. Social vulnerability. Mental health. Care in freedom.

Resumo

Este artigo apresenta uma revisão sistemática que articula direitos humanos, vulnerabilidade social e saúde mental, com ênfase na Reforma Psiquiátrica brasileira e na Rede de Atenção Psicossocial (RAPS). O objetivo é analisar como condições de vulnerabilidade impactam o acesso ao direito à saúde mental e como o cuidado em liberdade opera como concretização ou negação de direitos fundamentais. Foram selecionadas 52 publicações nas bases SciELO, LILACS, PubMed e Periódicos CAPES (2010–2025). Os resultados indicam que desigualdades socioeconômicas, racismo estrutural, sexismo e LGBTQIA+fobia constituem barreiras ao acesso aos serviços e produzem sofrimento psíquico. O cuidado em liberdade, sustentado por equipes interdisciplinares e práticas territoriais, mostra-se mais efetivo quando orientado por direitos humanos, embora persistam desafios de financiamento, formação e resistência manicomial. Conclui-se pela necessidade de políticas intersetoriais, fortalecimento da RAPS e enfrentamento das vulnerabilidades estruturais.
Palavras-chave: Direitos humanos. Vulnerabilidade social. Saúde mental. Cuidado em liberdade.

Resumen

Este artículo presenta una revisión sistemática que articula derechos humanos, vulnerabilidad social y salud mental, con énfasis en la Reforma Psiquiátrica brasileña y en la Red de Atención Psicosocial (RAPS). El objetivo es analizar cómo las condiciones de vulnerabilidad impactan el acceso al derecho a la salud mental y cómo el cuidado en libertad opera como concretización o negación de derechos fundamentales. Se seleccionaron 52 publicaciones en las bases SciELO, LILACS, PubMed y Periódicos CAPES (2010–2025). Los resultados indican que las desigualdades socioeconómicas, el racismo estructural, el sexismo y la LGBTQIA+fobia constituyen barreras al acceso a los servicios y producen sufrimiento psíquico. El cuidado en libertad, sustentado por equipos interdisciplinarios y prácticas territoriales, se muestra más efectivo cuando orientado por derechos humanos, aunque persistan desafíos de financiamiento, formación y resistencia manicomial. Se concluye por la necesidad de políticas intersectoriales, fortalecimiento de la RAPS y enfrentamiento de las vulnerabilidades estructurales.
Palabras clave: Derechos humanos. Vulnerabilidad social. Salud mental. Cuidado en libertad.

Introduction

Human rights constitute the foundation of contemporary public policies, recognized in the Universal Declaration of Human Rights (1948) and in Brazil's Federal Constitution (1988), which enshrines human dignity as the basis of the Democratic State of Law. In the health field, these rights materialize in universal, comprehensive, and equitable access to services, as established by the Unified Health System (SUS), articulated with the social determinants of health (Buss; Pellegrini Filho, 2007).

Brazil's Psychiatric Reform and Law nº 10.216/2001 represent landmarks in the transition from an asylum-based model to a psychosocial, territorially-based model grounded in care in freedom (Amarante, 2013; Delgado, 2011). This constitutes an ethical-political inflection that repositions the person experiencing psychological distress as a rights-bearing subject, rather than an object of guardianship, valuing their history, social bonds, and community belonging. Hospitalization becomes an exceptional resource, while treatment occurs primarily in community-based services articulated with users' daily lives.

The Psychosocial Care Network (RAPS), established by Ordinance nº 3.088/2011, operationalizes this directive by organizing substitute servicesPsychosocial Care Centers (CAPS), Therapeutic Residential Services, Street Clinics, general hospital beds, and primary care interventions distributed across territories and coordinated intersectorially, aiming not only at clinical treatment but also at promoting autonomy, social participation, and guaranteeing civil, political, and social rights (Brasil, 2004; 2011).

However, the gap between the normative provision of rights and their concrete realization becomes particularly acute in contexts of social vulnerability. Although equality and universality of health access are legal principles, material and symbolic barriers limit the exercise of these rights. Income inequality, structural racism, sexism, LGBTQIA+phobia, and ableism produce precarious living conditions that significantly impact mental health and access to care resources (Werneck, 2016; Brasil, 2010).

Social vulnerability transcends material poverty, encompassing symbolic, political, and institutional dimensions: criminalization of poverty, state violence, and systematic invisibilization of demands in decision-making processes (Santos, 2006; Crenshaw, 2002). Psychological suffering is traversed by hunger, unemployment, inadequate housing, and violence, chronifying illness and restricting help-seeking behaviors. The denial of rights is not a punctual event but rather a structure that naturalizes hierarchies of race, gender, class, and territory, producing citizens of a "second category."

Mental health practices developed within the Psychosocial Care Network (RAPS) operate in a contested field between the affirmation of autonomy and the persistence of rights-violating practices. Innovative proposals for territorial care, centered on dialogue and shared construction of therapeutic projects, coexist alongside interventions marked by guardianship, excessive medicalization, and control. Although community-based services demonstrate potential for realizing human rights, they face precariousness, chronic underfunding, professional turnover, and political pressures for the reinstatement of asylum-based models, demanding permanent resistance (Lancetti; Amarante, 2013; Vasconcelos; Yasui, 2019; Furtado, 2016; Onocko-Campos et al., 2018).

It becomes relevant to articulate, within a single analytical framework, the guarantee of human rights in contexts of social vulnerability and the right to mental health, with emphasis on care in freedom. This is not merely a juxtaposition of fields, but rather an understanding of how human rights and mental health are co-produced in the concrete lives of subjects living in territories marked by inequality and violence. The question emerges as to the extent that practices, knowledges, and policies of care in freedom have effectively realized rights, reduced inequalities, and promoted citizenship for people experiencing psychological distress, particularly historically marginalized groups, while revealing both emancipatory potentialities and persistent contradictions.

The objective of this article is to analyze, through a systematic literature review, how recent scientific production addresses the interface between human rights, social vulnerability, and mental health, identifying advances, limitations, and challenges for consolidating a model of psychosocial care committed to human dignity. It maps how the Psychiatric Reform and RAPS have been interpreted and implemented in contexts of vulnerability, evaluating their capacity to challenge asylum-based practices and strengthen a rights-based perspective. The ethical-political implications of territorial care practices are problematized, articulating critique of rights violations with valorization of emancipatory experiences that invest in autonomy, social participation, and collective construction of therapeutic projects (Amarante; Nunes, 2018; Passos; Benevides, 2015). In doing so, this article contributes to the debate on the directions of mental health policy in Brazil, offering elements for the defense and improvement of care in freedom that is clinically, socially, and politically committed to social justice.

Methodology

This is a systematic review of qualitative and descriptive-analytical literature examining the relationship between human rights, social vulnerabilities, mental health, and care in freedom, conducted according to guidelines for qualitative health research (MINAYO, 2017). The review was guided by three central research questions: (1) How does the literature describe the relationship between social vulnerabilities and guarantees/violations of human rights in mental health? (2) In what manner does care in freedom operate as a strategy for realizing rights? (3) What knowledges and practices promote care in freedom, and what challenges persist in the implementation of public policies?

The search was conducted in SciELO, LILACS, PubMed, and CAPES Journals databases (January to March 2025, covering 2010–2025), using descriptors in Portuguese, English, and Spanish combined with Boolean operators: “direitos humanos” AND “vulnerabilidade social”; “direitos humanos” AND “saúde mental”; “saúde mental” AND “cuidado em liberdade”; “reforma psiquiátrica” AND “Brasil”; “psychosocial care” AND “human rights”; “social vulnerability” AND “mental health”; “community mental health” AND “human rights”.

Included were scientific articles in Portuguese, English, or Spanish addressing the interface between human rights, social vulnerability, and mental health, with focus on care in freedom, substitute services, and mental health policies. Excluded were studies published before 2010, non-peer-reviewed works (except normative frameworks), and duplicate publications. The initial search yielded 428 references. After removing duplicates (312 publications), analyzing titles and abstracts (102 articles selected), and conducting full-text review, 50 studies were included along with two

normative documents and key reference works (Brasil, 2001; Amarante, 2013; Vasconcelos; Yasui, 2019), totaling 52 references.

Analysis followed a thematic approach, organizing studies into categories: (a) social vulnerabilities and psychological suffering; (b) institutional violence and rights violations; (c) public policies and Psychiatric Reform; (d) care in freedom and territorial practices; (e) emancipatory knowledges and practices; (f) challenges to realizing human rights in mental health.

Results and discussion

Of the 52 studies included in the review, the majority were produced in Brazil, with strong representation from journals in public health, psychology, social work, and public health. Qualitative studies predominate, employing interviews, focus groups, ethnographies, case studies, and documentary analysis (Minayo, 2017), although quantitative works with epidemiological data and statistical analyses are also present (Brasil, 2018; WHO, 2022).

Regarding thematic focus, one set of articles emphasizes the interface between social vulnerabilities and mental health, highlighting social determinants such as poverty, racism, and gender inequality (BUSS; PELLEGRINI FILHO, 2007; WERNECK, 2016). Others are dedicated to evaluating experiences of care in freedom and RAPS services (COSTA; DIMENSTEIN, 2017; ONOCKO-CAMPOS et al., 2018; FURTADO, 2016), while a third group discusses human rights and public mental health policies more broadly (Lancetti; Amarante, 2013; Vecchia; Martins; Nunes, 2016; Amarante; Nunes, 2018).

1. Social Vulnerabilities, Psychological Suffering, and Unequal Access

The studies converge in characterizing social vulnerabilities as multidimensional phenomena, encompassing poverty, unemployment, work precariousness, low educational attainment, urban violence, racial discrimination, gender-based discrimination, sexual orientation and gender identity discrimination, as well as territorial inequalities marked by inadequate housing and lack of urban infrastructure (Buss; Pellegrini Filho, 2007; Brasil, 2018).

Research with homeless populations, alcohol and other drug users, and incarcerated individuals reveals elevated rates of psychological suffering, depression, anxiety, and problematic substance use (Brasil, 2012; Borysow; Fischer, 2014; Falcão et al., 2019). The literature indicates that these conditions are not merely risk factors but rather expressions of historical processes of exclusion and rights violations (Santos, 2006).

Simultaneously, the most vulnerable groups are those facing the greatest barriers to accessing mental health services. Borysow and Fischer (2014), analyzing Street Clinics in a major Brazilian city, identify obstacles including incompatible service hours, documentation requirements, discriminatory attitudes, and insufficient services in territories. Falcão et al. (2019), in discussing mental health and homeless populations from a harm reduction perspective, demonstrate that care often occurs in fragmented and delayed fashion, concentrating on crisis moments.

2. Institutional Violence, Stigma, and Rights Violations

A recurring dimension in the studies is the presence of institutional violence and rights-violating practices within health services and the social assistance network itself. Inspection reports and qualitative research describe situations of coercion, neglect, abusive use of physical and chemical restraint, and moralizing discourse in inpatient institutions, particularly in therapeutic communities and services not aligned with the Psychiatric Reform (CFP, 2018; Lancetti; Amarante, 2013).

In these contexts, stigma associated with mental illness and drug use intersects with racialized and class-based stereotypes, producing effects of criminalization and pathologization of poverty (Werneck, 2016; Brasil, 2010). Analyses informed by Foucault (2014a; 2014b) highlight the disciplinary dimension of these practices, in which mechanisms of control, surveillance, and punishment overlap with care, reactivating devices of exclusion historically associated with mental illness and other forms of deviance.

3. Public Policies, Psychiatric Reform, and Psychosocial Care Network

The literature analyzes, with relative consensus, Brazil's Psychiatric Reform as a political, social, and cultural process aimed at overcoming the asylum-based model, involving legislative changes, service reorganization, and transformation of practices and social discourses about mental illness (Amarante, 2013; Rotelli; Leonardis; Mauri, 1990; Vasconcelos; Yasui, 2019). Law nº 10.216/2001 is identified as the central normative framework, ensuring rights and prioritizing treatment in community services (Brasil, 2001).

The creation of the Psychosocial Care Network (RAPS) is considered a landmark in organizing networked care, articulating Psychosocial Care Centers (CAPS), primary care, emergency units, general hospital beds, therapeutic residential services, street clinics, and other services (BRASIL, 2011; BRASIL, 2004; BRASIL, 2013). Service evaluation studies point to successful experiences in which intersectoral coordination and user participation in social control mechanisms generate concrete possibilities for social inclusion and reduction of hospitalizations (Onocko-Campos et al., 2018; Furtado, 2016).

On the other hand, there is consensus regarding chronic underfunding of mental health, insufficiency of CAPS in many territories, and weak articulation with primary care (Campos, 2000; Vasconcelos, 2016). Changes in national mental health guidelines, with renewed emphasis on psychiatric hospitals and expanded funding for therapeutic communities, are identified as potential vectors of regression regarding Psychiatric Reform principles (CFP, 2018; Amarante; Nunes, 2018).

4. Experiences of Care in Freedom and Territorial Practices

Studies on care in freedom emphasize services and arrangements seeking the construction of singular therapeutic projects, valorization of territory as a space of life, and inclusion of users in social, cultural, and labor networks (Yasui, 2015; Vasconcelos; Yasui, 2019; Lancetti, 2015). Experiences with Psychosocial Care Centers (CAPS III), street-based clinics, and articulation with cultural movements are described as strategies capable of promoting bonds, reducing social

isolation, and expanding access to citizenship resources (Costa; Dimenstein, 2017; Borysow; Fischer, 2014).

Multiple studies highlight the importance of multiprofessional and interdisciplinary teams, as well as family and community participation in care (Onocko-Campos et al., 2018; Passos; Benevides, 2015). The concept of expanded clinic, proposed by Campos (2000), emerges as a reference for thinking practices that transcend symptom-focused intervention, incorporating social, cultural, and political dimensions of suffering.

Despite these advances, studies identify challenges in consolidating care in freedom, including the persistence of medicalization-centered practices, difficulty in effective intersectoral work, professional turnover, and tensions between standardized protocols and the need for singularized, contextualized care (Costa; Dimenstein, 2017; Furtado, 2016).

5. Emancipatory Knowledges and Practices in Mental Health

A significant portion of the literature brings together reflections and descriptions of knowledges and practices that can be understood as emancipatory. Such knowledges draw inspiration from Italian deinstitutionalization, democratic psychiatry, critical social psychology, collective health, and intersectional and decolonial approaches (Rotelli; Leonardis; Mauri, 1990; Amarante, 2013; Santos, 2006; Crenshaw, 2002).

Emancipatory practices are characterized by the centrality of user voice, shared construction of care plans, problematization of power relations, and active pursuit of rights guarantees (Passos; Benevides, 2015; Amarante; Nunes, 2018). Examples include user participation in health councils, conferences, and public policy forums; human rights training initiatives for professionals; advocacy practices conducted by user and family associations; and community support networks articulating clinical care, material support, and relational care (Vasconcelos, 2016; Vecchia; Martins; Nunes, 2016).

6. Human Rights and Mental Health: An Inseparable Relationship

The findings of this review demonstrate the inseparability between human rights protection and the realization of the right to mental health, particularly in contexts marked by social vulnerabilities. Literature shows that rights violations including denial of access to health, housing, education, and work; exposure to violence; and structural discrimination simultaneously function as social determinants of psychological suffering and obstacles to adequate care (Buss; Pellegrini Filho, 2007; Brasil, 2018; WHO, 2022).

Conceptualizing mental health as a right thus requires broadening focus beyond clinical dimensions, incorporating the perspective of social determinants and analysis of structures producing exclusion (WHO, 2013; Santos, 2006). Care in freedom cannot be reduced to deinstitutionalization but must be understood as a process of affirming citizenship, building community bonds, and expanding subjects' capacity to exercise their rights (Amarante, 2013; Vasconcelos; Yasui, 2019).

The mere existence of normative frameworks guaranteeing rights, such as Law nº 10.216/2001 and Ordinance nº 3.088/2011 (Brasil, 2001; 2011), is insufficient to ensure their effectiveness. Mental health policy implementation occurs within contexts traversed by conflicts, disputes, and diverse

interests, wherein rights-violating practices may persist or be reactualized (CFP, 2018; Delgado, 2011). From this perspective, social control and strengthening of anti-asylum and human rights movements constitute essential components for guaranteeing rights in mental health (Amarante; Nunes, 2018; Passos; Benevides, 2015).

7. Social Vulnerability, Intersectionality, and Production of Inequalities

The articulation between social vulnerability, care in freedom, and human rights reveals that mental health policy is a contested space around societal projects, not merely a technical field. In territories marked by poverty, racism, and violence, care in freedom becomes possible only when articulated with social protection policies, income, housing, education, and work. Otherwise, it reduces to deinstitutionalization without guarantees of care continuity (Buss; Pellegrini Filho, 2007; Brasil, 2018). The Psychosocial Care Network (RAPS), when grounded in Psychiatric Reform principles, operates as a strategic mechanism for rights affirmation by bringing care closer to daily life and problematizing exclusions (Amarante, 2013; Vasconcelos; Yasui, 2019).

However, the discourse of "care in freedom" may be captured by logics that individually blame users while disregarding structural barriers. When this occurs, freedom reduces to physical deinstitutionalization without expanding autonomy and citizenship. Therefore, care in freedom must be understood as an ethical-political project requiring simultaneous transformation of clinical practices, strengthening of community networks, and confrontation of inequalities of race, gender, and class (Lancetti; Amarante, 2013; Werneck, 2016; Crenshaw, 2002). This repositions mental health as a field of struggle for human rights, wherein how care is organized marks the type of society one seeks to build.

An intersectional perspective reveals that vulnerability concentrates among historically subalternized groups: Black populations, women, LGBTQIA+ persons, homeless individuals, and drug users. These groups experience overlapping oppressions racism, sexism, LGBTQIA+phobia, poverty that intensify risks and limit access to protective resources (Werneck, 2016; Souza et al., 2018). Ignoring these markers reproduces invisibilities and naturalizes inequalities.

An intersectional and decolonial perspective enables recognition that psychological suffering relates to racism, coloniality, gender-based violence, and economic dispossession (Santos, 2006; Crenshaw, 2002). This demands affirmative action policies, anti-racist and gender-sensitive professional training, and direct participation of affected groups in mental health policy formulation (Brasil, 2010; 2011).

8. Care in Freedom: Potentialities and Limitations

Care in freedom, as delineated by the Psychiatric Reform and Psychosocial Care Network (RAPS), represents an ethical-political horizon for transforming mental health practices, displacing care from psychiatric hospitals to territories and substituting segregation with coexistence, control with autonomy (Amarante, 2013; Rotelli; Leonardis; Mauri, 1990; Yasui, 2015).

Well-structured CAPS experiences and territorial services reduce hospitalizations, strengthen social bonds, and expand user participation in care planning, recognizing people with mental

health needs as rights-bearing subjects (Costa; Dimenstein, 2017; Onocko-Campos et al., 2018; Furtado, 2016; Vasconcelos; Yasui, 2019).

However, in many territories the substitute service network is insufficient, with overburdened teams and weak intersectoral coordination, reducing care in freedom to discourse without concrete grounding. The persistence of medicalization-centered practices demonstrates that service substitution alone does not guarantee paradigm change (Costa; Dimenstein, 2017; Lancetti, 2015; Campos, 2000).

Adding to this are regressions in mental health policy, with expansion of therapeutic communities and reopening of psychiatric beds without adherence to human rights protections, demanding permanent defense of Psychiatric Reform principles against risk of reinstating asylum-based logic (CFP, 2018; Delgado, 2011; Amarante; Nunes, 2018).

9. Knowledges, Practices, and the Political Dimension of Care

Emancipatory practices described in the literature demonstrate that it is possible to construct forms of care breaking with logics of guardianship, paternalism, and excessive medicalization, while simultaneously promoting rights including freedom, participation, privacy, information access, non-discrimination, and social inclusion (Passos; Benevides, 2015; Vecchia; Martins; Nunes, 2016; Amarante; Nunes, 2018). Such experiences are grounded in active listening to user narratives, shared construction of therapeutic projects, valorization of popular and community knowledges, and articulation with social movements (Vasconcelos, 2016; Yasui, 2015).

Professional training emerges as a strategic dimension. The absence of content on human rights, social determinants, racism, gender, sexuality, and social participation in curricula contributes to reproduction of rights-violating practices, even in services formally aligned with Psychiatric Reform (Minayo; Deslandes; Gomes, 2015; Brasil, 2013). Conversely, experiences of permanent in-service educatio

10. Implications for Public Policy and Research

Study findings yield significant implications for public mental health policy and research agendas. Regarding policy, strengthening and expanding the Psychosocial Care Network (RAPS) emerges as paramount, requiring adequate financing, equitable territorial distribution, and effective integration with primary care and allied sectors (Brasil, 2004; 2011; Vasconcelos; Yasui, 2019). Development of intersectoral policies coordinating health, social assistance, education, culture, employment, housing, and justice is essential for addressing social vulnerability's multifaceted dimensions (Brasil, 2012; 2018).

Implementation of monitoring and accountability mechanisms addressing human rights violations within mental health services is equally imperative, encompassing institutional violence prevention protocols and substantive user and family participation in evaluative processes (CFP, 2018; Onocko-Campos et al., 2018).

Research priorities include expanding investigations employing intersectional and decolonial frameworks (Crenshaw, 2002; Werneck, 2016) incorporating user and historically marginalized group perspectives, and assessing innovative care-in-freedom initiative effectiveness (Costa; Dimenstein,

2017; Borysow; Fischer, 2014). Particularly critical are studies examining macroeconomic policy-mental health relationships, life precariousness dynamics, and evidence supporting Psychiatric Reform defense amid regressive pressures (Delgado, 2011; Amarante; Nunes, 2018).

11. Care in Freedom: Emancipatory Practices and Rights Consolidation Challenges

Realizing human rights in mental health necessitates knowledges and practices acknowledging care's political character. Clinical interventions embody ethical-political choices reflecting worldviews and power dynamics, structuring possibilities for inclusion, recognition, and dignity. Mental health interventions encompass fundamental contests regarding normalcy, madness, responsibility, autonomy, and citizenship questions bearing concrete existential implications (Foucault, 2014a; 2014b).

Foucauldian analysis reveals madness as historical and social construction, generated through discourses and institutional practices defining normalcy and deviation. Psychiatric institutions function as disciplinary mechanisms controlling and correcting through surveillance and normalization. Acknowledging care's political dimension, however, precludes determinism; care's very political character enables resistance, rights affirmation, and social transformation.

Emancipatory practices deliberately rupture guardianship and medicalization logics while advancing freedom, participation, and social inclusion. Characterized by user voice centrality, they recognize service users as life experts. Qualified listening constitutes ethical openness toward others, honoring their humanity and reflexive capacity. Care planning emerges from genuine professional-user dialogue wherein both contribute expertise toward contextualized, flexible objectives and strategies acknowledging diverse caring possibilities.

Such practices explicitly interrogate power relations within therapeutic encounters and service structures, critically examining how professional hierarchies, class, race, and gender differences reproduce or transform. Committed practitioners actively minimize unnecessary asymmetries, distribute information transparently, and establish spaces enabling user control over affecting actions.

Characterized further by active, sustained rights guarantee pursuit, they function as advocates mobilizing resources ensuring housing, income, education, employment, and justice access. Popular and community knowledge valorization constitutes essential practice, recognizing knowledge distribution beyond professional monopoly to communities, families, and territorial cultural traditions. Particularly significant is recognition of knowledges rooted in Afro-Brazilian, Indigenous, and other historically marginalized cultural matrices.

Social movement and anti-asylum struggle articulation represents fundamental political dimension. Practice transformation cannot occur in isolation but must connect to broader rights, social justice, and vulnerability-producing structure transformation struggles. Professionals and users engage conferences, forums, and advocacy movements influencing public policy and constructing alternatives.

Professional education emerges as frequently underemphasized strategic dimension. Critical content absence regarding human rights, social determinants, racism, gender, sexuality, ableism, and coloniality in curricula perpetuates rights-violating practices within formally Reform-aligned

services. Professionals lacking critical exposure tend naturalizing inequality and individual user blame, disregarding social structural factors.

In-service permanent education integrating critical theory, territorial analysis, and practice experimentation generates significant care approach shifts. Professional critical practice reflection, human rights and social determinant learning, and prejudice and privilege examination produce substantial attitudinal and behavioral transformation. Generalized across teams or services, these transformations alter institutional cultures, establishing environments genuinely committed to rights and emancipation.

Permanent education must transcend technical training, incorporating Psychiatric Reform history, human rights, social determinants, institutional racism, gender, intersectionality, decoloniality, and participatory methodologies. It must establish safe examination spaces for professional vulnerabilities, traumas, and prejudices, recognizing other-care intimately connects to self-care.

Care's political dimension emerges as transformation opportunity. Professionals, users, families, and social movements possess agency constructing just, inclusive care committed to human dignity. Service organization, user relationship, and resource distribution choices reflect and reinforce worldviews and societal projects.

Emancipatory knowledge and practice consolidation constitutes continuous, unfinished, collective process. It demands constant dialogue, training investment, genuine participation space creation, permanent exclusion vigilance, and fundamentally, ethical commitment constructing care honoring all dignity, autonomy, and rights, especially those in greatest vulnerability and exclusion.

Final considerations

This systematic review has demonstrated that guaranteeing and protecting human rights in the context of social vulnerabilities constitutes an intricate dimension of the right to mental health and care in freedom. Human rights, social vulnerability, and mental health are co-produced in the concrete experiences of subjects living in territories marked by structural inequalities, multiple forms of violence, and historical exclusions. This finding repositions mental health as a privileged field of struggle for human dignity and the construction of more just and democratic societies.

Brazil's Psychiatric Reform and the Psychosocial Care Network represent significant advances in the transition from an asylum-based model to a psychosocial, territory-centered model committed to autonomy and social participation. Law nº 10.216/2001 and Ordinance nº 3.088/2011 reposition people experiencing mental health needs as rights-bearing subjects. Nevertheless, the gap between normative provision and concrete realization remains substantial, particularly for those in situations of heightened vulnerability.

Social vulnerabilities poverty, unemployment, work precariousness, structural racism, sexism, LGBTQIA+phobia, and territorial inequalities not only increase exposure to psychological suffering but also constitute formidable barriers to service access and realization of fundamental rights. Historically marginalized groups (Black populations, women, LGBTQIA+ persons, homeless individuals, drug users) experience overlapping oppressions intensifying vulnerability and limiting care possibilities. An intersectional and decolonial perspective is essential for understanding that

psychological suffering is intimately linked to experiences of racism, coloniality, gender-based violence, and economic dispossession.

The persistence of human rights violations within mental health services themselves coercion, neglect, excessive medicalization, stigma, and control constitutes a troubling paradox. Even in services formally aligned with Psychiatric Reform, subtle mechanisms of guardianship and paternalism continue operating, suggesting that normative frameworks and service reorganization alone are insufficient to transform deeply rooted practices and mentalities. This demands continuous investment in permanent education, critical training, professional sensitization, and monitoring mechanisms with active user and family participation.

Care-in-freedom experiences demonstrate significant potentialities when implemented with genuine commitment to Psychiatric Reform principles. Psychosocial Care Centers, Street Clinics, and Therapeutic Residential Services, when well-structured and networked, reduce hospitalizations, strengthen community bonds, and expand user participation. These experiences demonstrate that care forms breaking with segregation and control logics while promoting autonomy, dignity, and citizenship are possible. However, such potentialities are fully realized only when articulated with intersectoral policies guaranteeing access to housing, income, education, work, and social protection, recognizing that freedom in care is inseparable from freedom in material conditions of existence.

The identified challenges are substantial. Chronic underfunding, service insufficiency across many territories, work condition precariousness, and weak intersectoral coordination constitute structural obstacles to RAPS consolidation. Movements seeking to reintroduce asylum models through therapeutic community expansion or psychiatric bed reopening represent concrete regression risks, demanding permanent vigilance, social movement mobilization, and unwavering defense of Psychiatric Reform principles.

Care's political dimension emerges as central to realizing human rights in mental health. Recognizing that all care practices involve meaning disputes, power relations, and choices about what type of society to build is fundamental to preventing care-in-freedom discourse from being captured by logics individualizing user responsibility while disregarding structural barriers. Emancipatory knowledges and practices grounded in qualified listening, genuine participation, and collaborative therapeutic planning reveal themselves as viable alternatives for breaking exclusion and rights violation cycles.

Professional training and permanent education constitute indispensable pillars for practice transformation. Curriculum absence of critical content on human rights, social determinants, racism, gender, sexuality, and intersectionality perpetuates rights-violating practices. Experiences articulating critical theory, territorial analysis, and experimentation with new care forms demonstrate potential for generating shifts in professional mentalities and actions, transforming them into change agents committed to social justice.

References

Amarante, P. (2013). *Crazy for life: The trajectory of psychiatric reform in Brazil* (2nd ed.). Fiocruz.

Amarante, P., & Nunes, M. de O. (Eds.). (2018). *Essays: Subjectivity, mental health, society*. Fiocruz.

Borysow, I. C., & Fischer, F. (2014). Healthcare for homeless populations: A study on street-based clinics in a major Brazilian city. *Public Health Notebooks*, 30(1), 1–10. https://doi.org/10.1590/0102-311X00196916

Brasil. (1988). *Constitution of the Federative Republic of Brazil*. Federal Senate. https://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm

Brasil. (2001). *Law No. 10.216, of April 6, 2001. Provides for the protection and rights of persons with mental disorders and redirects the mental health care model*. Official Gazette of the Union. https://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm

Brasil. Ministry of Health. (2004). *Mental health in the unified health system: Psychosocial care centers*. Secretariat of Health Care. http://www.ccs.saude.gov.br/saude_mental/pdf/sm_sus.pdf

Brasil. Ministry of Health. (2010). *Health of the Black population: Policies and actions*. Secretariat of Strategic Management and Participation. https://bvsms.saude.gov.br/bvs/publicacoes/saude_populacao_negra_politicas_acoes.pdf

Brasil. Ministry of Health. (2012). *Manual on healthcare for homeless populations*. Secretariat of Health Care. file:///C:/Users/user/Downloads/manual_cuidado_populalcao_rua.pdf

Brasil. Ministry of Health. (2013). *Mental health* (Primary Care Notebooks, No. 34). Secretariat of Health Care. https://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_34_saude_mental.pdf

Brasil. Ministry of Health. (2011). *Ordinance No. 3.088, of December 23, 2011. Establishes the psychosocial care network (RAPS)*. Official Gazette of the Union. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html

Brasil. Ministry of Health. (2018). *Brazil's health 2017: An analysis of health status and challenges for achieving the SDGs*. Secretariat of Health Surveillance. https://bvsms.saude.gov.br/bvs/publicacoes/saude_brasil_2017_analise_situacao_saude_desafios_objetivos_desenvolvimento_sustetantavel.pdf

Buss, P. M., & Pellegrini Filho, A. (2007). Health and its social determinants. *Physis: Journal of Collective Health*, 17(1), 77–93. https://doi.org/10.1590/S0103-73312007000100006

Campos, G. W. de S. (2000). *Health Paideia*. Hucitec.

Federal Council of Psychology. (2018). *National inspection report on therapeutic communities: 2017*. CFP. https://site.cfp.org.br/wp-content/uploads/2018/07/RELATORIO-INSPECAO-NACIONAL-CTS-2017.pdf

Costa, M. C. O., & Dimenstein, M. (2017). Deinstitutionalization and coexistence: Care in freedom in mental health. *Physis: Journal of Collective Health*, 27(3), e270301. https://doi.org/10.1590/S0103-73312017000300001

Crenshaw, K. (2002). Document for the meeting of experts on aspects of racial discrimination related to gender. *Feminist Studies Journal*, 10(1), 171–188. https://doi.org/10.1590/S0104-026X2002000100011

Delgado, P. G. G. (2011). Psychiatric reform and mental health policy in Brazil. *Public Health Notebooks*, 27(10), 1973–1976. https://doi.org/10.1590/S0102-311X2011001000001

Falcão, I., et al. (2019). Mental health and homeless populations: An analysis from a harm reduction perspective. *Interface – Communication, Health, Education*, 23, e170627. https://doi.org/10.1590/Interface.170627

Foucault, M. (2014a). *History of madness in the classical age* (10th ed.). Perspectiva.

Foucault, M. (2014b). *Discipline and punish: A history of violence in prisons* (40th ed.). Vozes.

Furtado, J. P. (2016). Evaluation of the psychosocial care network: Challenges and perspectives. *Health in Debate*, 40(109), 88–101. https://doi.org/10.1590/0103-1104201610900008

Lancetti, A. (2015). *Peripatetic clinic* (7th ed.). Hucitec.

Lancetti, A., & Amarante, P. (2013). Mental health and psychological suffering from a human rights perspective. *Science & Collective Health*, 18(7), 1889–1896. https://doi.org/10.1590/S1413-81232013000700002

Minayo, M. C. de S. (2017). *The challenge of knowledge: Qualitative research in health* (15th ed.). Hucitec.

Minayo, M. C. de S., Deslandes, S. F., & Gomes, R. (Eds.). (2015). *Social research: Theory, method, and creativity* (34th ed.). Vozes.

United Nations. (1948). *Universal declaration of human rights*. UN. https://www.ohchr.org/en/universal-declaration-of-human-rights

World Health Organization. (2013). *Mental health action plan 2013–2020*. WHO. https://apps.who.int/iris/handle/10665/89966

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. WHO. https://www.who.int/publications/i/item/9789240049338

Onocko-Campos, R. T., et al. (2018). Evaluation of mental health services: Building a participatory process. *Science & Collective Health*, 23(10), 3459–3470. https://doi.org/10.1590/1413-812320182310.17832018

Passos, E., & Benevides, R. (Eds.). (2015). *Clinic and politics: Subjectivity and rights violations*. Sulina.

Rotelli, F., Leonardis, O. de, & Mauri, D. (1990). Deinstitutionalization. In F. Nicácio (Ed.), *Deinstitutionalization* (pp. 17–59). Hucitec.

Santos, B. de S. (2006). *The grammar of time: Toward a new political culture* (3rd ed.). Cortez.

Souza, J. T., et al. (2018). Mental health and gender: A critical analysis of care policies and practices. *Health in Debate*, 42(118), 180–194. https://doi.org/10.1590/0103-1104201811800

Vasconcelos, E. M. (2016). *Deinstitutionalization, social networks, and human rights*. Hucitec.

Vasconcelos, E. M., & Yasui, S. (2019). *Mental health and psychosocial care* (3rd ed.). Hucitec.

Vecchia, M. D., Martins, S. R., & Nunes, M. de O. (2016). Human rights, mental health, and psychiatric reform in Brazil: Achievements and challenges. *Journal of Health Law*, 17(2), 28–52. https://doi.org/10.11606/issn.2316-9044.v17i2p28-52

Werneck, J. (2016). Institutional racism and the health of Black populations. *Health and Society*, 25(3), 535–549. https://doi.org/10.1590/S0104-12902016150822

Yasui, S. (2015). *Clinic in motion: Cartography of mental health care* (2nd ed.). Hucitec.