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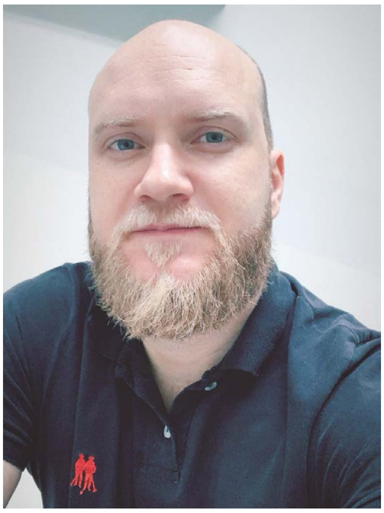
HUMAN RIGHTS, RECOVERY, AND PERSON-CENTERED CARE IN MENTAL HEALTH: EXPERIENCES WITH HEARING VOICES GROUPS AND OPEN DIALOGUE[1]

Direitos humanos, recovery e cuidado centrado na pessoa em saúde mental: experiências com grupos de ouvidores de vozes e open dialogue

Derechos humanos, recovery y atención centrada en la persona en salud mental: experiencias con grupos de oyentes de voces y diálogo abierto



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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

The Recovery paradigm and person-centered care have gained prominence in contemporary discussions about mental health by proposing care approaches guided by autonomy, social participation, and recognition of people experiencing psychological distress as subjects of rights. This article aims to discuss the relationships between human rights, recovery, and person-centered care in the mental health field, presenting Hearing Voices Groups and Open Dialogue as examples of practices committed to these principles. This is a theoretical-reflective article, grounded in national and international literature and in the discussion of Brazilian experiences. The analyzed experiences indicate possibilities for building care approaches less centered on medicalization and the exclusive authority of professionals, valuing lived experience, dialogue, social networks, and shared construction of care.

Keywords: Mental Health Services; Human Rights; Psychosocial Care Center; Anti-asylum Movement.

Resumo

O paradigma do recovery e o cuidado centrado na pessoa têm ganhado destaque nas discussões contemporâneas sobre saúde mental por proporem formas de cuidado orientadas pela autonomia, participação social e reconhecimento das pessoas em sofrimento psíquico como sujeitos de direitos. O presente artigo tem como objetivo discutir as relações entre direitos humanos, recovery e cuidado centrado na pessoa no campo da saúde mental, apresentando os Grupos de Ouvidores de Vozes e o Open Dialogue como exemplos de práticas comprometidas com esses princípios. Trata-se de um artigo teórico-reflexivo, fundamentado na literatura nacional e internacional e na discussão de experiências brasileiras. As experiências analisadas indicam possibilidades de construção de formas de cuidado menos centradas na medicalização e na autoridade exclusiva dos profissionais, valorizando a experiência vivida, o diálogo, as redes sociais e a construção compartilhada do cuidado.

Palavras-chave: Serviços de Saúde Mental; Direitos Humanos; Centro de Atenção Psicossocial; Movimento de Luta Antimanicomial.

Resumen

El paradigma del recovery y la atención centrada en la persona han ganado prominencia en las discusiones contemporáneas sobre salud mental al proponer enfoques de atención guiados por la autonomía, la participación social y el reconocimiento de las personas que experimentan sufrimiento psicológico como sujetos de derechos. Este artículo tiene como objetivo discutir las relaciones entre derechos humanos, recovery y atención centrada en la persona en el campo de la salud mental, presentando Grupos de Oyentes de Voces y Diálogo Abierto como ejemplos de prácticas comprometidas con estos principios. Se trata de un artículo teórico-reflexivo, fundamentado en la literatura nacional e internacional y en la discusión de experiencias brasileñas. Las experiencias analizadas indican posibilidades de construcción de enfoques de atención menos centrados en la medicalización y la autoridad exclusiva de los profesionales, valorando la experiencia vivida, el diálogo, las redes sociales y la construcción compartida de la atención.

Palabras clave: Servicios de Salud Mental; Derechos Humanos; Centro de Atención Psicosocial; Movimiento Antimanicomial.

According to the World Health Organization, human rights are an inseparable foundation of mental health, since psychological well-being depends not only on the absence or management of symptoms, but also on the concrete conditions that allow people to live with dignity, exercise autonomy, participate in social life, and belong to the community (World Health Organization, 2019). From this perspective, the capacity to face adversity and build a meaningful life is directly linked to recognizing individuals as subjects of rights and understanding that mental health is an integral part of the right to health itself.

The World Mental Health Report (World Health Organization, 2022) deepens this understanding by recognizing mental health as a fundamental human right, encompassing protection against risks, access to quality care, and community inclusion. The same document, however, identifies persistent violations of this right, expressed through social exclusion, discrimination regarding basic civil rights, barriers to access to essential opportunities, and institutional abuses such as neglect, inappropriate restraints, and coercive interventions without informed consent.

Given this, mental health care cannot be limited to the clinical management of symptoms. It is necessary to consider the social, economic, political, and cultural determinants that traverse human suffering, as well as to ensure the active participation of individuals in decisions about their care. This requires transforming care models that have historically controlled and silenced people, reduced their experiences to excessive medicalization, sustained segregating practices, reproduced stigmas, limited social participation, and stripped them of the power to make decisions about their own lives.

It is within this transformative horizon that two complementary perspectives emerge: the recovery paradigm and person-centered care. Although distinct in their origins and emphases, both converge in the defense of autonomy, active participation, and recognition of the person as a subject of rights. Whereas person-centered care emphasizes the shared construction of care and respect for individual preferences and experiences, recovery broadens this horizon by incorporating dimensions such as citizenship, community belonging, and social participation as central elements of mental health care. This article examines these perspectives and presents two approaches that seek to actualize them in practice: Hearing Voices Groups and Open Dialogue.

In the field of mental health, the recovery paradigm has established itself as a perspective broadly aligned with human rights principles. Its historical emergence is linked to movements of people with lived experience who challenged exclusionary psychiatric practices and demanded autonomy, respect, and participation (Corradi-Webster et al., 2024). Recovery can be understood as a personal, continuous, and nonlinear process through which an individual rebuilds a sense of positive identity, belonging, and the possibility of living autonomously, even when symptoms persist (Davidson, 2016). It is a singular trajectory of change, in which the individual develops attitudes, values, and skills that allow them to lead their own life, achieve well-being, and realize their potential.

This conception represented a break with the clinical pessimism that had long sustained the idea that people with severe mental disorders could not build full and meaningful lives. As the concept evolved, however, tensions also emerged. In some contexts, the emphasis on personal and individual journeys began to be used to justify reductions in service resources, under the argument that the process depended primarily on individual effort (Rowe & Davidson, 2016). Such a reading disregards the fact that recovery is not built in isolation: it is realized through relationships, access to concrete opportunities, and social contexts that foster participation, recognition, safety, and the exercise of rights (Corradi-Webster et al., 2024).

The recovery paradigm considers the person in their life context, recognizing their agency in defining goals and meanings for their trajectory, while also drawing attention to the role of social and material conditions in enabling those choices (Bøe, Topor, & Ness, 2026; Davidson & González-Ibáñez, 2017). Accordingly, public policies and mental health services must assume central responsibility for creating the conditions that make these pathways possible, in alignment with human rights principles.

The recovery paradigm places great importance on peer support groups. Grounded in the lived experience of people who have navigated psychological distress, these spaces are structured around the sharing of experiences, solidarity, and mutual recognition. By fostering horizontal exchanges, strengthening bonds, and expanding individuals' active participation in their own pathways, peer groups contribute to processes of hope, empowerment, and reconstruction of life projects, while also challenging traditional power relations in the field of mental health (Evans, 2023).

While the recovery paradigm emerged from the struggles of people who had experienced psychiatric treatment and identified themselves as "psychiatric survivors," the clinical field consolidated a perspective that engages with these issues from a different angle: person-centered care. This perspective is rooted in the contributions of Carl Rogers, who postulated the existence of an innate tendency toward human development and argued that the therapist's role was to facilitate this process within a less hierarchical relationship, sustained by empathy, acceptance, and authenticity (Lefurgey, 2025).

In the health field, this approach gained traction from critiques of the biomedical model and advocacy for a medicine oriented toward improving health outcomes. As this debate advanced, the term "person-centered" began to be adopted to broaden the lens beyond the clinical condition, emphasizing an understanding of the individual in their uniqueness and life context (Davidson, Tondora, Miller, & O'Connell, 2015).

In the context of public policy, this perspective is reflected in the development of person-centered care plans, that is, collaborative processes involving the individual, healthcare providers, and their support network, guided by the person's own goals, values, and life projects. When people actively participate in their care, outcomes are more favorable, with greater engagement and treatment retention, improved clinical and functional outcomes, reduced hospitalizations and emergency service use, greater community integration, and better quality of life (Davidson, Tondora, Miller, & O'Connell, 2015).

This model has been incorporated by health regulatory agencies as a guideline for the organization of care, understood as a comprehensive proposal that demands a paradigmatic shift in services. The focus must move beyond an exclusive emphasis on diagnosis to consider the person in their full existential complexity, placing autonomy, legal capacity, and subjectivity at the center of interventions (Organização Pan-Americana da Saúde, 2022).

Accordingly, person-centered care involves recognizing and valuing the potential of each individual, promoting their agency in managing their own condition. Care ceases to be a unilateral practice and becomes a collaborative construction, involving the person, their support network, and the various services required along their pathway. It also presupposes recognition of the right of individuals to make decisions about their own lives, even when those choices do not align with what professionals consider ideal. The care plan is oriented by the person's life goals, not solely by their symptoms, integrating interventions that are meaningful to their trajectory (Davidson, Tondora, Miller & O'Connell, 2015). In clinical practice, this perspective is guided by the protection and expansion of the right to self-determination, enabling each individual to pursue their own life projects (Davidson & Tondora, 2022). A respectful relationship between the professional and the person in distress is not sufficient; care planning must be built collaboratively, not defined unilaterally by the professional. Rather than occupying a passive position, the person must actively participate in defining the priorities, strategies, and supports needed along their pathway.

While person-centered care represents an important advance in the qualification of clinical practices by emphasizing the therapeutic relationship, participation, and respect for individual preferences, the recovery paradigm broadens this horizon by shifting the focus to the person's life in its entirety. In this sense, recovery is not limited to the service context, but encompasses dimensions such as community integration, work, social relationships, and the exercise of citizenship, calling into question the very centrality of mental health services in organizing people's lives.

The current challenge lies not only in discursively adhering to values such as autonomy, participation, and citizenship, but in producing concrete care arrangements capable of redistributing power, legitimizing experiential knowledge, and sustaining genuine forms of inclusion in community life. Among the initiatives that have sought to actualize these principles, practices stand out that expand the participation of individuals and their social networks in care, value lived experience, and shift exclusive agency away from services and professionals. It is within this horizon that Hearing Voices Groups and Open Dialogue emerge.

This article aims to discuss the relationships between human rights, recovery, and person-centered care in the field of mental health, presenting Hearing Voices Groups and Open Dialogue as examples of practices committed to these principles.

Hearing Voices Groups

Hearing Voices Groups constitute an example of peer support aligned with human rights principles and the recovery paradigm. The very term "voice hearer" represents a shift away from traditional psychiatric language, which tends to frame this experience as "auditory hallucination," frequently associated with diagnoses such as psychosis or schizophrenia. By adopting this terminology, the aim is to remove the experience from an exclusively pathologizing framework and broaden its understanding, recognizing that different people may hear voices in various contexts, including religious experiences or situations of intense stress. In this way, the terminology contributes to the normalization of the experience, the reduction of stigma, and its recognition as a possible part of human experience.

These groups have gained prominence in both the Brazilian and international contexts and are grounded in the Hearing Voices Movement (Corradi-Webster et al., 2024). The Hearing Voices Movement is an international movement that aims to transform public and professional perceptions of the experiences of hearing voices and having visions, which have historically and scientifically been associated with psychoses (Higgs, 2020). This movement originated in the Netherlands in the 1980s, from dialogues between voice hearer Patsy Hague and her psychiatrist Marius Romme, in which Hague's personal interpretations of the meaning of her voices were valued over conventional clinical diagnoses. In 1987, this partnership gained public visibility through an appearance on Dutch television, attracting contact from hundreds of people who experienced similar phenomena and culminating in the organization of the first international congress in Utrecht.

From this meeting and subsequent research conducted by Romme and Sandra Escher, it was observed that many people who heard voices did not use psychiatric services and frequently associated their voices with contexts of trauma or social adversity. This trajectory consolidated an emancipatory model that redirected the understanding of voices, previously interpreted as mere symptoms of a biological disease, reframing them as significant human experiences deeply rooted in the individual's life history and self-determination. At the same time, it sought to develop ways of supporting voice hearers in coping with these experiences and broadening the understanding of family members, friends, and professionals. From this broader perspective, the movement points toward transformations in the field of psychiatry itself (Baker, 2019; Higgs, 2020). Today, the Hearing Voices Movement advocates for alternative forms of mental health care grounded in personal narratives, mutual support, cooperation, and respect for the diversity of ways in which psychological distress is experienced (Longden, Read, & Dillon, 2017).

One of the most effective strategies for operationalizing the Movement's proposals is the Hearing Voices Groups (Rufato & Corradi-Webster, 2024). These groups function as collective spaces of mutual support, in which the experience of hearing voices is treated as meaningful and worthy of understanding, rather than something to be immediately silenced or pathologized. Participation is voluntary, and the environment is structured to ensure safety, acceptance, and respect for the different ways of experiencing voices. During meetings, participants share accounts, explore possible meanings of the voices, identify patterns, develop practical coping strategies, and reflect collectively on the impact of these experiences on their lives (Rufato et al, 2023). Facilitators, preferably including people with lived experience, maintain a horizontal stance, encouraging curiosity, autonomy, and the construction of new meanings (Corradi-Webster, Santos, & Leão, 2017). By strengthening bonds, expanding support networks, and promoting hope through accounts of overcoming, these groups contribute to recovery processes, fostering greater understanding, reduction of fear, expanded self-management, and the strengthening of citizenship in the field of mental health (Corradi-Webster, Leão, & Rufato, 2018).

One of the first Hearing Voices Groups in Brazil was established in the municipality of Ribeirão Preto, São Paulo, and over ten years consolidated itself as a space for strengthening participants' autonomy and collectively building new forms of support. Over this period, the initiative expanded to include weekly meetings at the CAPS, remote activities with national reach, monthly meetings at a municipal community library, and continuous support via WhatsApp. Now recognized as an independent social movement, the group draws on its own members to organize and disseminate the initiative across new services in the local mental health network (Corradi-Webster, Coutinho, Candeloro, & Rufato, 2026).

The Ribeirão Preto experience highlighted attitudes that contribute significantly to processes of coping and overcoming. Participants collectively build an environment of acceptance in which different perspectives are respected and narratives of distress find legitimate space for expression. A curious and open stance toward voices is also observed, seeking to understand them and assign new meanings to the experiences, which facilitates the development of more constructive ways of relating to them. The group also enables the strengthening of bonds and the expansion of support networks, aspects essential to community inclusion. Finally, the sharing of trajectories of overcoming and positive transformations experienced by members themselves serves as a concrete source of hope, encouraging the perception of possibilities for change and growth (Rufato et al., 2021).

For participants, the groups constitute spaces of free sharing where it is possible to construct new meanings around the experience of hearing voices, exchange coping strategies, and strengthen bonds of mutual support and self-acceptance. Participation must be strictly voluntary, respecting the individual's agency and autonomy, fundamental principles of the recovery paradigm. In addition to offering resources for coping with distress and discussing topics such as the use of psychotropic medications, peer support expands social networks and helps in confronting the stigma associated with mental disorder (Corradi-Webster, Coutinho, Candeloro, & Rufato, 2026).

Implementing Hearing Voices Groups in Brazilian Psychosocial Care Centers (CAPS) requires a strategic alignment between management and professionals, aimed at ensuring the legitimacy and continuity of the initiative both within and beyond the health service. The professionals responsible for these initiatives generally have a profile engaged in community-based psychiatric reform and initially act as "autonomy incubators," facilitating the process until leadership among service users themselves takes center stage. It is imperative that these practitioners have solid grounding in the recovery paradigm and in the Hearing Voices Movement approach, preventing the group from becoming a conventional therapeutic activity or one focused merely on medication psychoeducation (Corradi-Webster, Coutinho, Candeloro, & Rufato, 2026).

Hearing Voices Groups produce, in daily practice, forms of care aligned with person-centered care, the recovery paradigm, and the defense of human rights in mental health. By recognizing the experience of hearing voices as something that can be understood and shared, rather than merely silenced or pathologized, these spaces promote autonomy, acceptance, and the collective development of coping strategies. The horizontal nature of relationships, the valuing of lived experience, and the strengthening of support networks contribute to recovery processes, expanding hope, social belonging, and participation in community life.

Furthermore, Hearing Voices Groups engage directly with the principles of the Psychiatric Reform and the anti-asylum movement by strengthening community-based forms of care and confronting practices marked by segregation, stigma, and social exclusion. More than therapeutic groups, they constitute spaces for the production of citizenship and agency, in which people with lived experience move away from a passive role in care and actively participate in constructing new meanings for their own trajectories and for the field of mental health itself.

Open Dialogue

The World Health Organization recommends that mental health services be guided by recovery-based practices and highlights Open Dialogue as an approach capable of promoting person-centered care aligned with human rights (Organização Pan-Americana da Saúde, 2022). This is an approach that was developed in Finland and derived from the Needs-Adapted Treatment, initially designed for care in psychotic crises but now applicable to various situations of psychological distress (Seikkula, Alakare, & Aaltonen, 2023).

In the Brazilian context, its incorporation can be understood not as a foreign proposal distant from national reality, but as a deepening of principles already present in the tradition of psychosocial care and psychiatric reform in the country, particularly those related to territorial care, the centrality of the network, and the promotion of autonomy and citizenship. Psychosocial rehabilitation underpins a large part of mental health practices in Brazil, while recovery broadens this field by restoring perspective on the autonomy, agency, and lived experience of individuals (Anastácio & Furtado, 2013). In this sense, Open Dialogue can be understood as an approach that challenges and enriches these practices, contributing to their ethical and clinical deepening by strengthening processes of participation, shared construction of care, and valorization of individuals' narratives.

The approach proposes a territorial, longitudinal, and relationship-centered form of care, actively involving the person's social and family network. Dialogical meetings take place, preferably, in the person's own life contexts, such as the home, with dialogue as the primary care resource (Seikkula, 2014). More than a technique, this represents a shift in clinical and institutional positioning, in which care ceases to be something "offered to the patient" and becomes something built with people in a shared process, sustained by supported decision-making, ensuring the active participation of people with lived experience as protagonists of their own care.

Although grounded in consistent theoretical foundations, Open Dialogue should not be understood as a closed or prescriptive method, but as an approach that is constructed within the relationship, requiring sensitivity to the context, the singularities, and the demands of each territory. Its principles function as guides for practice, rather than fixed rules. Initially developed for the care of psychotic crises, Open Dialogue can be applied across different situations of psychological distress, maintaining the same set of principles as a reference, regardless of diagnosis (Seikkula, Alakare, & Aaltonen, 2023). It provides guidelines for territorial, longitudinal care that involves the user's social and family network (Seikkula, 2014).

Its fundamental principles include: *(1) immediate help* - since the first contact with the person in crisis and their social network takes place within 24 hours of seeking crisis services, helping to prevent the deterioration of the crisis and reduce the need for hospitalization; *(2) inclusion of the social and family network* - as family members, friends, and other significant relationships of the person in crisis are invited to participate not only in the first meeting but throughout the entire follow-up process; *(3) flexibility* - as care is adapted to the specific demands of each case; *(4) responsibility* - as the professional who receives the first request for help organizes and assumes responsibility for the follow-up of the case; *(5) tolerance of uncertainty* - avoiding hasty decisions such as the immediate use of neuroleptics; *(6) psychological continuity* - ensuring continuous follow-up of the person in crisis throughout treatment; and *(7) dialogism* - sustaining the understanding that experience can take on different meanings for each person, with no single truth to be imposed, and that care is built through dialogue, through the shared production of meanings and openness to different possibilities of understanding and action (Seikkula, 2016).

Open Dialogue, as argued by the approach's creator, Jaakko Seikkula, is not a theory-driven practice, but a practice driven by practice itself; it must therefore be adapted to different territories and to the demands that each context presents (Florence & Yasui, 2019). By sustaining a person-centered care practice, it proposes a shift away from the traditional biomedical model, which tends to understand psychological distress as the expression of a pathology to be suppressed. In this model, psychiatric science frequently occupies a hegemonic position, with medication prescription appearing as the primary therapeutic resource. Open Dialogue, by contrast, understands the crisis as a singular, complex, and situated experience that can be approached as an opportunity for the construction of meaning, opening space for dialogue and the reframing of lived experience.

This shift also implies a transformation in the positioning of healthcare providers, who move away from exclusively occupying the role of knowledge holders and become engaged in the joint construction of care. Open Dialogue, in this sense, invites professionals to revisit their practice, recognizing that care is not limited to a technical intervention, but occurs through relationship, presence, and the shared construction of meanings.

By including social determinants, such as housing, work, education, and social bonds, as central elements of care, this approach aligns directly with the principles of psychosocial rehabilitation and recovery. Reducing the individual to their symptoms can erase their history and context, hindering the construction of broader responses to distress. When dialogue is not sustained, there is a greater risk of adopting coercive practices and referrals for hospitalization that could have been avoided. On the other hand, when listening, presence, and relationship are sustained, possibilities expand for supporting individuals in constructing new meanings for their experience, fostering movements toward autonomy, belonging, and continuity of life, even in the face of distress.

In this process, fundamental elements stand out, such as supported decision-making, the active participation of people with lived experience, the valuing of their knowledge, integration with the social network, and consideration of the social determinants of health. The dimension of spirituality is also recognized as a possibility for the production of meaning, hope, and the reconstruction of life projects.

The results associated with this approach have been accumulating over more than 30 years of research conducted in Finland and other countries. The main evidence correlates Open Dialogue with reduced medication use during the follow-up of psychic crises and throughout treatment; decreased hospital admissions; reduced residual symptoms; and expanded social inclusion through study, work, and other aspects (Kantorski, Cardano, 2019). In the United Kingdom, the first randomized clinical trial, entitled Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness *(*ODDESSI), has been underway since 2017 (Organização Pan-Americana da Saúde, 2022).

In Brazil, although experiences with Open Dialogue remain nascent, particularly in public services of the Psychosocial Care Network (RAPS), they have shown favorable results and indicate the viability of adaptation to different territories. In the literature, one original article reports an experience in the municipality of Jaraguá do Sul, in which the approach, over two years of implementation, was associated with reduced medication use, fewer hospitalizations, and improved quality of life during the post-crisis period (Dias, 2017).

Additionally, the literature presents experiences with the approach conducted at a CAPS I in the municipality of Carmo do Cajuru, reported in an article (Paula, 2022) published by the National Council of Municipal Health Secretariats (CONASEMS), and in a master's thesis not yet fully published (Ramos, Figueiredo, 2024). Two experience reports also document the implementation of the approach within the RAPS of the municipality of Divinópolis, Minas Gerais (Ramos, Tibiriçá, Borges, Fagundes, & Coelho, 2025) and at the CAPS Ad in Quixadá, Ceará, through an intervention based on the principles of Open Dialogue (Fiocruz, 2025).

Consistent with findings reported in the international literature, experiences in Brazil have demonstrated favorable results that support the implementation of the approach. Between 2015 and 2016, the approach was applied with 10 individuals in Jaraguá do Sul, and challenges were identified, including the predominance of the biomedical model, difficulties in organizing schedules, and resistance from users, family members, and the team itself regarding the prescription of medications during the first meeting. Despite these challenges, the results indicated a path toward person-centered, less invasive care associated with better quality of life during the post-crisis period (Dias, 2017).

Throughout 2021 (January through December), in Carmo do Cajuru, Minas Gerais, the approach was applied with 37 individuals, 20 of whom were experiencing a first crisis and 17 a re-exacerbation. The reported data, available in summary form in the literature, indicate that 80% of first crises were stabilized within three months, and only 27.8% of these individuals required medication use throughout the follow-up period, with deprescription occurring in 80% of those cases. In interviews conducted with the professionals who implemented Open Dialogue in the municipality, it was reported that the approach was carried out amid challenges and difficulties inherent to mental health care itself and to the prevailing psychiatric model, but contributed to reigniting the expectation of envisioning a mental health system centered on the individual and respectful of their decisions (Ramos & Figueiredo, 2024).

The approach was implemented in the municipality of Divinópolis, beginning in May 2023, and was still under development at the time the experience report was published in December 2025. During this period, 68 cases (individuals) were followed, with the Open Dialogue team responsible for attending referrals from the municipality's Psychosocial Care Centers (CAPS), across different modalities (CAPS III, CAPS AD III, and CAPS ij). According to the report, the experience demonstrated potential for a paradigm transformation in mental health, indicating that person-centered approaches and territorial, non-invasive care that respect human rights and the knowledge of users and family members are possible even amid the challenges faced by mental health professionals (Ramos et al, 2025).

At the CAPS Ad in Quixadá, Ceará, the experience based on the principles of Open Dialogue began in 2022. In addition to these principles, the proposal integrates care with Integrative and Complementary Practices, such as meditation and Community Therapy, and the Family Systemic Approach. According to the report presented, the approach has produced positive results, including the remission of psychotic symptoms. Professionals also observed strengthened family and community bonds, greater adherence to follow-up, reduced use of psychoactive substances, and increased user autonomy (Fiocruz, 2025).

Experiences with Open Dialogue in Brazil are still being built and, while they reveal challenges and difficulties, such as institutional resistance and the need for professional training in dialogical practice, they highlight issues that can be understood and addressed by both management and frontline care professionals. Even so, these experiences indicate the possibility of creating spaces for active listening and joint transformation, in which not only the person in distress is transformed, but also the professionals and the modes of care.

From this perspective, it is possible to understand that practices aligned with Open Dialogue approach psychosocial rehabilitation when they produce the development of concrete competencies, the strengthening of agency and decision-making capacity, expanded community bonds, social participation, and a greater capacity to navigate crises with less need for guardianship (Anastácio & Furtado, 2013). They reveal that, even when not applied exactly as originally developed in Finland, such practices can be implemented in Brazil, as they are aligned with an ethical, clinical, and political approach to mental health care in the country, with the potential for results similar to those observed in their country of origin and in other international experiences. Accordingly, Open Dialogue does not represent a wholesale importation of the Finnish model, but a concrete possibility for deepening and radicalizing existing practices in the field of Brazilian mental health.

Final considerations

The experiences analyzed in this article are part of a broader historical process of transformation in Brazilian mental health, strongly influenced by the Psychiatric Reform and the anti-asylum movement. By challenging practices centered on institutionalization, excessive medicalization, and social exclusion, these movements opened the way for forms of care guided by autonomy, social participation, and the recognition of people experiencing psychological distress as subjects of rights.

It is within this context of the strengthening of human rights in the field of mental health that the recovery paradigm, person-centered care, and practices such as Hearing Voices Groups and Open Dialogue come to occupy a central place in contemporary discussions about care, autonomy, and social participation.

The experiences discussed throughout this article indicate the possibility of building forms of care less centered on control, medicalization, and the exclusive authority of professionals. By expanding people's participation, valuing lived experience, and strengthening networks of support and dialogue, these practices indicate modes of care more committed to autonomy, social belonging, and life in the community. They are initiatives that reaffirm the need for a clinical approach that recognizes psychological distress without reducing it to rigid diagnostic categories, but understands it in its relational, social, and existential complexity.

At the same time, the article shows that the incorporation of these practices in the Brazilian context still takes place amid significant tensions, such as the persistence of biomedical logics, hierarchical relationships, and institutional difficulties in sustaining more horizontal and community-based forms of care. It is necessary to strengthen public policies that promote continuing professional training, institutional support, and the expansion of community-based mechanisms guided by human rights principles.

The analyzed experiences demonstrate that it is possible to develop, within the territories and public services of Brazil, practices aligned with human rights without merely reproducing international models, but rather adapting them to local realities and to the historical trajectories of the Brazilian Psychiatric Reform.

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