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User perspectives on the ambience in a mental health unit in the hospital context

Perspectivas de usuários sobre a ambiência em unidade de saúde mental no contexto hospitalar

Perspectivas de los usuarios sobre el entorno en una unidad de salud mental en el contexto hospitalario

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ABSTRACT

Objective: to understand users' perceptions of the ambience in a Mental Health Unit in a hospital context. **Method:** a qualitative study conducted with users admitted to a hospital Mental Health Unit in a municipality in the interior of Rio Grande do Sul. Data collection took place between May and August 2023, using semi-structured interviews. The data was analyzed using the content analysis technique and the three axes of the ambience proposed by the Ministry of Health. All ethical aspects of research with human beings were respected. **Results:** users perceive the ambience in its entirety, according to the three axes. However, there are perceptions that the unit's ambience challenges psychosocial rehabilitation and humanized care. **Final considerations:** users' perceptions must be taken into account when implementing and improving the ambience to protect their rights, as guaranteed by public policies.

Descriptors: Mental Health; Mental Health Services; Mental Disorders; Humanization of Assistance.

RESUMO

Objetivo: compreender a percepção dos usuários em relação à ambiência em Unidade de Saúde Mental no contexto hospitalar. **Método:** estudo qualitativo, realizado com usuários internados em uma Unidade de Saúde Mental hospitalar de um município do interior do Rio Grande do Sul. A produção dos dados ocorreu entre maio e agosto de 2023, com emprego de entrevista semiestruturada. Os dados foram analisados por meio da técnica de análise de conteúdo e os três eixos da ambiência, propostos pelo Ministério da Saúde. Respeitaram-se todos os aspectos éticos para pesquisas com seres humanos. **Resultados:** os usuários percebem a ambiência em sua amplitude, conforme os três eixos. Contudo, há percepções de que a ambiência da unidade desafia a reabilitação psicossocial e o cuidado humanizado. **Considerações finais:** a percepção dos usuários deve ser considerada na implementação e aprimoramento da ambiência para garantir os seus direitos conforme asseguram as políticas públicas.

Descritores: Saúde Mental; Serviços de Saúde Mental; Transtornos Mentais; Humanização da Assistência.

RESUMEN

Objetivo: comprender las percepciones de los pacientes sobre el entorno en una Unidad de Salud Mental en contexto hospitalario. **Método:** estudio cualitativo realizado con pacientes ingresados en una Unidad de Salud Mental hospitalaria de un municipio del interior de Rio Grande do Sul. La recolección de datos se realizó entre mayo y agosto de 2023, mediante entrevistas semiestructuradas. Los datos se analizaron mediante análisis de contenido y los tres ejes ambientales propuestos por el Ministerio de Salud. Se respetaron todos los aspectos éticos para la investigación con seres humanos. **Resultados:** los pacientes perciben el entorno en su totalidad, según los tres ejes. Sin embargo, algunas percepciones sugieren que el ambiente de la unidad interpela la rehabilitación psicosocial y la atención humanizada. **Consideraciones finales**: las percepciones de los usuarios deben considerarse al implementar y perfeccionar el ambiente para garantizar sus derechos, tal como lo aseguran las políticas públicas.

Descriptores: Salud Mental; Servicios de Salud Mental; Transtornos Mentales; Humanización de la Atención.

INTRODUCTION

The first movements regarding the Brazilian Psychiatric Reform (BPR) emerged in the 1970s, when health workers encountered neglect and violence in the treatment of people with mental illness in psychiatric hospitals. This triggered a struggle for human rights and the protection of victims of psychiatric violence, giving rise, in 1978, to the Mental Health Workers' Movement (*Movimento dos Trabalhadores em Saúde Mental*, MTSM).

The MTSM was the first collective movement formed by workers, family members, union members, and people with a long history of psychiatric hospitalizations, which emerged to leverage changes in mental health care. This movement was crucial in gaining visibility for the issue of care for people with mental illness, extending to the enactment of Law No. 10.216/01, which established the BPR, responsible for ensuring the rights and protection of people with mental suffering, in addition to redirecting the mental health care model[1].

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After the enactment of the BPR Law, the process of redirecting the mental health care model, previously provided by psychiatric hospitals, toward territorial and community-based services began. Initially, the Psychosocial Support Centers (*Núcleos de Apoio Psicossocial*, NAPS), which later became known as Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS), were responsible for providing care to people with mental suffering. It was only in 2011, through Ordinance No. 3.088/11, that a specialized and decentralized mental health service network was created, known as the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS)[1].

Through this measure, hospital care for people with mental suffering will be provided in general hospital beds as an alternative to psychiatric hospitalizations, which should be used only when all out-of-hospital services prove insufficient to manage mental health crises. Furthermore, beds in general hospitals or Mental Health Units (MHUs) must provide comprehensive and humane care to hospitalized users until the crisis stabilizes, aiming for their return to daily life[2].

With this in mind, the National Humanization Policy (*Política Nacional de Humanização*, PNH) was launched in 2003 to promote and implement humanization in health services, to carry out the principles of the Unified Health System (*Sistema Único de Saúde*, SUS) in the day-to-day running of services, and thus improve the quality and effectiveness of health management and care. To this end, the PNH provides some strategies and methods for articulating actions, knowledge, practices, and individuals that effectively make it possible to guarantee comprehensive, resolutive, and humanized care for users of public health services. Among these strategies is the ambience guideline[3,4].

Ambience refers to the treatment given to a physical space, understood as a social, professional, and interpersonal space that should offer welcoming, resolute, and humane attention to the actors of care, including healthcare workers, patients, and family members. Therefore, it focuses on the development of co-managed projects to pursue institutional democratization, the expansion of clinical practice, and the understanding of the health-disease process based on the production of health and individuals[3,5].

It primarily follows three axes: 1) space aimed at comfort: considers elements such as color, smell, sound, lighting, and morphology to promote individual well-being; 2) space for encounters between individuals, the production of health and subjectivities: considers that intersubjective relationships enhance and facilitate reflection on work processes and the production of protagonism; and 3) space as a tool for facilitating work: favors the construction of spaces desired by individuals. However, for the ambiance to be effective, these three axes must be considered interdependent[3,5].

It is worth noting that humanizing the hospital environment, especially regarding the ambience, requires overcoming traditional models of care and health management so that managers, workers, and patients can interact with each other. Given this, despite the theme being widely discussed, it still raises concerns regarding traditional and verticalized models of work processes in the hospital setting[6], especially regarding humanization, especially the ambience.

Therefore, the present study is guided by the research question: What are users' perceptions regarding the ambience in a Mental Health Unit in the hospital context? Thus, the objective is to understand and analyze, from the perspective of the ambience policy, the users' perceptions about the ambience of a Mental Health Unit in the hospital context.

METHOD

This is a descriptive and exploratory study with a qualitative approach. Qualitative research aims to uncover concepts and relationships between data about the object under investigation and organize them in an explanatory way. Thus, it is an interpretive approach that studies phenomena within their natural context, seeking to understand them in terms of the meanings individuals attribute to them[7].

The study's investigation setting is a hospital-based MHU located in a municipality in the central region of the state of Rio Grande do Sul. The MHU is located on the third floor of a general hospital and is responsible for caring for individuals in mental health crisis, offering short-term admissions until the user is stabilized. It is open 24 hours a day, seven days a week, with no breaks between shifts. It has 30 beds divided between four wards (two male and two female) and two isolation rooms. The wards and rooms are white, with cool lighting and barred windows that allow light and ventilation, helping to maintain a neutral odor. Each ward has approximately seven beds, and each room has one bed with white bedding. It should be noted that the beds in the wards lack privacy, that is, they lack curtains and/or partitions, allowing sounds, such as conversations, to enter from other areas.

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The MHU also has common areas for users, such as a long corridor, a TV room, and a cafeteria, which allow users to gather for therapeutic and daily activities. These are white, with cool lighting and barred windows, and some black armchairs. The cafeteria has about six rectangular white tables, each with two equally rectangular white benches that run the length of the tables. Additionally, the MHU has seven private rooms for the use of the multidisciplinary team and a patio located on the ground floor of the hospital, which features outdoor benches, plants, and a sports court. The latter is accessible to users only at specific times stipulated by the team, so they can be accompanied by healthcare workers.

It should be noted that the MHU does not admit users of psychoactive substances for detoxification. Its function is to assist people in acute mental health crises, offering voluntary, involuntary, and compulsory hospitalization, based on an individual assessment of the vulnerabilities and risks present in each case.

The unit's staff is comprised of professionals with various levels of training, including nursing technicians and assistants, nurses, social workers, psychologists, and psychiatrists. It also includes residents from the Integrated Multiprofessional Residency Program in Health, from the Nursing, Psychology, Social Work, and Occupational Therapy departments, as well as residents from the Uniprofessional Residency Program in Medicine, specializing in Psychiatry.

The research participants were users who were hospitalized at the MHU during the data collection period. Hospitalizations occurred due to conditions such as schizophrenia, bipolar disorder, recurrent depressive disorder, severe depressive episode, personality disorders, and attempted suicide, among others.

Data collection took place from May to August 2023. Users who met the following inclusion criteria were invited to participate in the study: being over eighteen years of age. The exclusion criterion was users with communication difficulties, as assessed by the unit team.

Data collection was conducted through semi-structured interviews with participating users. The semi-structured interviews consisted of a series of questions designed to map the users' profiles, as well as guided questions related to the MHU's ambience, including: a) What was your first impression of the environment when you arrived at the unit?; b) In your opinion, can the unit's environment influence your treatment? Tell me what you think about this; c) How do you perceive the environment (of the unit) about your privacy and individuality? And finally, how do you perceive the unit's environment about the infrastructure (color, smell, sound, lighting, appearance)?

Data were collected by nursing students who had received prior training in data collection, which enabled the collection of information relevant to the research context through dialogue between the interviewer and participants. Invitations to participate in the study were made verbally and deliberately to users during the MHU's established visiting hours.

The interviews only began after the participants had read the Free and Informed Consent Form to ensure their voluntary participation, informing them of the study's objectives, benefits, and risks, and their right to withdraw at any time. The interviews were audio-recorded, after prior authorization from the participants, and then transcribed in full. They took place at the MHU, in a private room, respecting their availability and guaranteeing the confidentiality of the data.

Twenty-two users participated in the study, each being interviewed individually. It is important to note that three users declined to participate and one withdrew during the interview due to clinical reasons. Furthermore, repeat interviews were not necessary. Each interview lasted an average of fifteen minutes. Data collection ended when information began to repeat itself, thus reaching data saturation, which was discussed in a research group.

To preserve the anonymity of the participants, the interviews were identified by the letter “U,” the initial of the word “user,” followed by Arabic numerals (U1, U2, U3, and so on). No software was required to transcribe the interviews.

To analyze the data produced, the content analysis technique proposed by Bardin[8] was used, which follows three stages: pre-analysis; exploration of the material; and treatment of the results obtained, inference, and interpretation. Carrying out a content analysis involves identifying the nuclei of meaning present in a communication, whose presence or frequency is relevant to the intended analytical objective. In this study, the data were categorized and analyzed following the organization of the three axes of ambience, as proposed in the Ministry of Health booklets[3,5].

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The research was developed by the current standards expressed by the National Health Council, according to Resolution No. 466/2012. Furthermore, it was submitted to and approved by the Human Research Ethics Committee.

RESULTS

This study involved 22 patients admitted to a Mental Health Unit, including 11 females and 11 males, ranging in age from 18 to 80. Of these, 13 self-identified as White, eight as Brown, and one as Black. Regarding religion, ten participants reported no religion, four were Catholic, eight were Evangelical.

Among the participants, seven reported having a spouse, while 15 reported being single. Regarding children, 11 participants had no children, while six had one, four had two, and one had three children.

Regarding educational level, the results show a distribution as follows: one with no education, eight with incomplete elementary education, three with completed elementary education, and eleven with completed high school. Regarding occupations, the participants are distributed among those who do not work (9), those who receive social benefits (3), those who perform domestic services (2), those who are retired (2), and those with other occupations (6). Furthermore, eight participants stated that they had no income, eight received up to one minimum wage, one received one to two minimum wages, one earned two to three minimum wages, one earned more than three minimum wages, and three did not know their income.

Based on the analysis of the transcribed interviews and the identification of keywords, the most relevant data, that is, those that were repeated most often, were organized into categories and analyzed according to the three axes of ambience. Thus, the following categories were obtained: ambience as a space that provides comfort; ambience as a space for the production of subjectivities; and ambience as a tool that facilitates work processes.

Ambience as a space that provides comfort

This category was organized based on the identification of the keywords presented in Figure 1.

Themes	Keywords
Colors, smell, sound, and morphology	White; whites; colors
	Old appearance; sad; apathetic; joy; welcoming
	Good smell; cleanliness; neat
	Suffocates; suffocated
	Noise; conversation; silence
	Door; bars
Privacy and individuality	No privacy; shared bathrooms; showers; shared bedrooms
	No individuality

Figure 1: Keywords identified in the statements for the construction of subcategories. Santa Maria, RS, Brazil, 2023.

From the described keywords, the subcategories "comfort related to colors, smell, sound, and morphology" and "comfort related *to privacy and individuality" were created.*

Comfort regarding colors, smell, sound, and morphology

In this study, participants reported noticing that aspects of their environment, such as colors, smells, sounds, size, and access to certain areas, can influence treatment. In this sense, the experience with these aspects can influence users' moods both positively and negatively.

> *We get scared sometimes, because it's only white [...] It would be good if we changed our clothes, because everything is white. Then, from time to time, we suffocate too. (U7)*
>
> *The white walls, the gray doors [...] I can't see these colors, it feels like I'm feeling sick. I found it small because the patio is down there and I have to ask permission to go down [...] The smell is good, because there's always someone cleaning here [...] It's a place, I wouldn't say pretty, but it's a welcoming place, sometimes. (U9)*
>
> *It can influence it. Right now, the noise, a lot of talking (...) I get a little dizzy, and I think that when I'm more silent, I don't get like this. (U19)*

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Some participants reported perceiving the MHU as an apathetic, sad, and noisy environment. And although some users claimed the unit was odorless, others reported smelling a dirty. Participants believe these factors are detrimental to treatment, as they can increase stress and negatively affect well-being.

> *The sound has a lot of screaming, especially from some patients who do not accept the condition they are in. (U8)*
>
> *It seems so dull... It all seems so sad. We know we're in a hospital, but a little joy is good for our health, especially for those of us in mental health. We focus so much on what we see, especially color. The first thing I saw was the locked iron door. I felt suffocated [...]. There's not much of a smell. The staff is very neat, very clean. (U17)*
>
> *It looks very psychiatric... Everything has bars, everything is painted white. It looks a bit old. [...] The girls complain about the smell of urine, but it smells like hospital food. (U18)*

Comfort regarding privacy and individuality

It was clear from the statements of some participants that privacy and individuality are important aspects of treatment. However, they are rarely promoted within the unit, especially regarding privacy.

> *There isn't much privacy, there's no way... The bathrooms are shared, the rooms are shared, and the only thing that's yours here (at MHU) is your bed. (U4)*
>
> *We don't have individuality, and we don't have privacy. It's all very much together. (U6) Zero privacy. Individuality, that's fine. (...) You have no privacy. (U17)*

Some users mentioned that the lack of locks on the doors contributes to a lack of privacy, which indicated some discomfort among users, as it is not common outside of MHU. However, others indicated that they had already become accustomed to the lack of privacy in the unit.

> *[...] There's no privacy in the shower, in the bedroom, or when eating. (U8)*
>
> *You can't have much privacy here (at MHU), because it's an area with a lot of people, everyone living in the same space. (U14)*
>
> *There's no lock on the door. I usually lock the doors when I go to the bathroom, and there isn't one here. (U18)*

Ambience as a space for the production of subjectivities

This category originated from the identification of the keywords presented in Figure 2.

Themes	Keywords
Production of subjectivities that enhance the psychosocial rehabilitation process	Living together; colleague; equal/equals
	Motivates; influences/influenced the treatment; improves/there would be no improvement
	More people with similar problems; influence for good or bad
Production of subjectivities that challenge the psychosocial rehabilitation process	Shouting; not shutting up; talking at the same time; lots of people in the same place
	Aggressive; passive; outburst; sad; anxious
	TV at maximum volume; noise; the environment influences a lot; ignoring the environment

Figure 2: Keywords identified in the statements for the construction of subcategories. Santa Maria, RS, Brazil, 2023.

The subcategories "space that enhances the psychosocial rehabilitation process" and "space that challenges the psychosocial rehabilitation process" were formed.

Space that enhances the psychosocial rehabilitation process

From this perspective, participants understand that interactions between people, as well as their environment, influence the psychosocial rehabilitation process. Coexistence, comparison, and identification among users can positively influence treatment, providing confidence to face the challenges experienced.

> *Living together here (at MHU) motivates us, because there are some (users) with problems much worse than ours. [...] I thought I was at rock bottom and alone. So, it's helping me a lot to overcome my problems [...]. (U7)*
>
> *The first few days, I thought I wouldn't be able to adapt, that I'd be worse off than when I came here... That I'd be sadder, more exhausted, and more depressed than I was. Now I've got used to it. I see that the people are nice, you can get to know them and become friends with them [...]. (U8)*

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> *It can influence, because there are more people with similar problems. [...] if the colleague is aggressive, it will influence negatively, if he is passive, it will be positively. (U18)*

Space that challenges the psychosocial rehabilitation process

It was observed that stressful experiences significantly affect the mental health of MHU users. It was noted that the behavioral and auditory agitation of users experiencing a mental health crisis influences the well-being and psychosocial rehabilitation of those who are more stable.

> *I think the environment greatly influences patients with mental disorders. [...] I managed to improve very quickly. I try to ignore the environment in general and certain patients, because if it depended on that, I don't think there would be any improvement. (U3)*
>
> *It influences me because some people have outbreaks, and I've never had one. Outbreaks aren't good. It seems that, as the saying goes, man is a product of the environment in which he lives. (U10)*
>
> *[...] I get extremely anxious with a lot of people in the same place, and this has had a big impact on my last few days and my treatment as well. There's a colleague who yells, who won't shut up for a second. There's one who's always cursing at the others, another who's just herself. That TV is on full volume, and everyone is talking at once, especially when I'm having therapy with psychologists [...]. (U17)*

Ambience as a tool to facilitate work processes

This category was formed from the identification of the keywords presented in Figure 3.

Themes	Keywords
Tool to facilitate the optimization of human resources	Right routine; bath time; different times from home; everyone at the same time;
	Help/assistance from the team;
Tool that challenges humanized care	Patio (more open); limited visiting hours;
	Lack of: things to do/activities; colorful panel; drawings on the wall; pretty;

Figure 3: Keywords identified in the statements for the construction of subcategories. Santa Maria, RS, Brazil, 2023.

Based on the aforementioned keywords, the subcategories “tool that facilitates the optimization of human resources” and “tool that challenges humanized care” were organized.

A tool to facilitate the optimization of human resources

It was noted that the organization of the MHU's environment, schedules, and routines are aspects that optimize work processes and provide a certain level of comfort to users. Furthermore, the availability of workers, resulting from the organization of the unit, also influences the feeling of comfort.

> *A set routine, for example, a bath time. [...] Each person has their own bath time, at the right time. (U18)*
>
> *[...] the schedules are all different from those at home, and this thing (schedule and organization) of the bath, because everyone goes at the same time. (U20)*
>
> *It can have a beneficial influence... Because the nurses, psychiatrists, and psychologists will be supervising me, evaluating me, and helping me [...] Helping me with words, taking care of my medication... (U21)*

A tool that challenges humanized care

Some users expressed a desire for greater access to the patio and more family visits. Furthermore, they reported the need for changes to the MHU's morphology and the provision of more activities. It is worth noting that these aspects are crucial for humanizing the environment and treatment at the MHU.

> *I don't go down to the patio very often, but I wish it were less controlled, especially when it's sunny, to go down there and stay. (U4)*
>
> *I just think that the visiting days are too long, it's only on Mondays, I think 8 days (of waiting) is too long. (U13)*
>
> *There could be a colorful panel, more drawings on the wall, at least in the main room. Pictures of animals, something cool, pretty [...]. Put up flowers, let patients get inspired. [...]. (U17)*
>
> *The first impression was that there was nothing to do. We just played cards. There's even a recreationist, but there could be more activities here. (U22)*

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DISCUSSION

When analyzing the sociodemographic profile of the research participants, the predominance of users without partners (n=15) and those without children (n=11) was evident. It is known that the family plays a fundamental role in the care of people with mental disorders. Their presence, expression of affection, companionship, encouragement, and caring attitudes towards the person with mental suffering can contribute to improving their quality of life, as well as reducing the demands they reveal. However, in the absence of family support, the people with whom the user has a bond may have difficulty managing behaviors and other symptoms related to mental suffering, leading to fear and insecurity. In this case, the asylum model of care may prevail, characterized by the use of psychiatric hospitalization to provide support and assistance in caring for people in mental health crises[9].

Regarding gender and race/color, it is known that, historically, women and Black people have been disproportionately institutionalized in mental hospitals in Brazil. Not only for mental health reasons, but also as a form of social control, aiming to exclude them from society. This phenomenon can be understood in the context of a patriarchal and racist society that used the incarceration of women and Black people in mental hospitals as a form of oppression and correction of behaviors considered 'deviant' by society[10,11]. However, the data obtained in this research do not reveal a relationship between mental disorders, gender, and race/color, with an equivalence between the genders, male (11) and female (11), and a prevalence of White people (13) compared to other races/colors. This fact may indicate changes in gender and race/color discrimination in the context of mental health, compared to the scenario before the beginning of the BPR.

Although there is a prevalence of users who do not follow a religion, it is worth highlighting that religion plays a vital role in promoting mental health and preventing mental suffering. It is known that religion and psychiatry, as fields of knowledge, have always been in conflict, as since the Middle Ages, the causes of mental suffering were demonic and, therefore, without consideration of natural etiologies. Thus, with the emergence of psychiatry, it is believed that humanity was freed from religious superstitions. However, a study[12] indicates that there is scientific evidence proving a positive association between religiosity and mental health, as religion helps in attributing and maintaining meaning to life, making it an important support for individuals in coping with stressful situations. Therefore, it is understood that both religiosity and spirituality offer emotional support, reduce anxiety and other negative emotions, promote the formation of social bonds, and, thus, can enhance the psychosocial rehabilitation process of individuals with mental suffering. Given this, it is considered important that the health worker evaluates, respects and recognizes the user's religion and/or spirituality as an influential factor in mental health, as it can be an important ally in care actions in this area[12].

Regarding the ambience as a space of comfort, it was observed that users perceive that the colors, sounds, and morphology of the MHU environment can positively and negatively influence treatment during hospitalization. It is emphasized that individuals' understanding of comfort is subjective. However, it is known that some observable references qualify environments, whether in thermal, acoustic, or lighting performance, or in the sensations that their shapes, textures, colors, and odors evoke in individuals who circulate in the space. Thus, it can be said that the comfort of environments involves not only environmental values, but also social and cultural values and the way people experience them[3].

Analyzing the participants' statements, it can be concluded that users' perception of the comfort of the MHU is negative, as they indicated that the white color of the unit and the clothing, odors, lighting, and layout of the rooms cause some discomfort. A study[13] indicates that colors affect psychological, cognitive, physiological, and behavioral aspects of individuals, which depend on the dynamism, size, quantity, warmth, and coolness of the color. In this sense, in healthcare settings, colors are commonly used as an adjuvant in alleviating individuals' mental suffering, especially regarding symptoms of anxiety and depression. However, it is worth noting that the aforementioned study indicates that warm colors, compared to cool or neutral colors, have a more positive effect on alleviating suffering and promoting a sense of relaxation.

As far as smells are concerned, healthcare workers should pay attention to the quality of the air, so that the environment is well ventilated and has neutral odors. As for artificial lighting, it should ideally be indirect, soft, diffused, and intensity-controlled. By paying attention to these aspects, healthcare workers can help to reduce any stress caused by the environment and thus facilitate the psychosocial rehabilitation of those admitted to the unit[14].

Regarding comfort, users reported perceiving the environment as dull, sad, and noisy. It's important to note that ambient noise, or noise pollution, negatively impacts individuals' health, causing headaches, irritability, emotional

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instability, anxiety, loss of appetite, insomnia, fatigue, and reduced productivity[15,16].

Thus, it is understood that both highly stimulating and unstimulating environments negatively influence individuals' mental health, causing or worsening hallucinations, paranoia, and psychomotor agitation. In contrast, relatively stimulating, calm, and relaxing environments can comfort any mental health user[3,14]. In this sense, it can be said that ambience plays a crucial role in creating pleasant spaces capable of promoting feelings of well-being and comfort and, therefore, stimulating levels of greater satisfaction in individuals[16,17].

It was noted that privacy and individuality are important aspects of treatment. However, according to the reports, it can be said that these aspects are little promoted within the unit. It is worth mentioning that privacy is related to the protection of a person's intimacy and can be guaranteed by the use of partitions, curtains, and movable elements, which provide integration and privacy for the user and even the team. In turn, individuality refers to the understanding that each person is unique and, therefore, their daily lives and social spaces are specific. Architecture can contribute to individuality by creating environments that offer individual spaces for storing users' belongings, welcoming their support network, and other measures that can preserve their identity. In this sense, it can be said that the humanization of health services, especially regarding the environment, aims to guarantee the dignity of individuals, to protect the privacy, rights, and unique needs of each person[3,4].

It was noted that some users reported difficulties, particularly when it came to promoting privacy at the MHU. It is noteworthy that this has been the subject of debate in the hospital environment, as it is a collective space and requires constant supervision from healthcare workers, and privacy is intrinsic to the dignity, autonomy, and respect for the human rights of hospitalized users. In this regard, it is essential to find a balance between assisting users and preserving their rights, taking into account the BPR and the PNH[18,19]. Furthermore, an ambience that values people's privacy and individuality improves their well-being, sense of belonging, and connection to the environment. Thus, by integrating these considerations into the planning and management of MHU environments, more welcoming and effective spaces can be created for the treatment and psychosocial rehabilitation of users, in addition to ensuring the rights of people suffering from mental illness, in line with the BPR[4,20].

Regarding the ambience as a space for the production of subjectivities, it was observed that users perceive it as a potential enhancer of the psychosocial rehabilitation process. The premise is that the ambience should enable coexistence among users, which, in turn, allows for comparison and identification with life stories, influencing individuals' subjectivity and potentially empowering them to face the challenges they experience. From this perspective, it is known that the ambience, as a meeting place between individuals, provides and enhances people's capacity for action and reflection and, thus, promotes the protagonism and co-responsibility of users and workers in the act of care, which characterizes the production of subjectivity. Therefore, it can be said that the ambience, to become a producer of subjectivity, must provoke reflection on the practices and ways of operating of the people within the context, so that they can, together, contribute to the development of new situations and transformation of paradigms, thus providing significant changes and pleasurable spaces for coexistence[3,5].

It is understood that, historically, people with mental suffering and those using psychoactive substances are socially stigmatized. Stigmatization is the assignment of derogatory attributes to a person who presents a certain characteristic, which generalizes any others that may manifest[21]. In the case of people with mental suffering, the stigma of insanity is what prevails and makes them feel alone, unaccepted by society, and thus insecure about facing their challenges[22].

In this context, psychosocial rehabilitation is essential, as it is characterized as a process in which healthcare workers have opportunities to stimulate the functioning of people with mental suffering in different areas of life. This involves the development of individual and collective skills that enable actions focused on the formation of social relationships, autonomy, independence, and empowerment of users[23]. Thus, it can be said that the interaction between users and the identification and, therefore, the building of trust are aspects that can promote and/or enhance psychosocial rehabilitation.

Conversely, it has been noted that experiences with behavioral and noise agitation among users experiencing a mental health crisis can negatively impact the well-being and psychosocial rehabilitation of those who are more stable. It is worth noting that a mental health crisis is understood as a moment of disorganization in which individuals find themselves unable to regulate their psychological and behavioral functions. The moment of crisis is often perceived in a pejorative way and not as a human condition, which can reinforce the social stigma

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of insanity. It is therefore necessary for workers to act and encourage users to act with empathy, ethics, and respect for the rights and dignity of people in mental health crisis[24], which can positively affect the coexistence of users in mental health crisis and those who are more stable in the MHU.

Regarding the ambience as a tool that facilitates work processes, it was observed that users perceive that the organization of the environment, schedules, and routine of the MHU are aspects that optimize work processes, provide greater availability to workers, and, therefore, a certain comfort to users. It is understood that ambience alone does not change work processes, as it is related to the attitude and understanding of aspects and practices already adopted in the workers' routine. Thus, it can be used as a tool to facilitate the change processes desired by health workers and users, improving and humanizing the delivery of care[3,5].

It is understood that establishing a routine in the hospital environment facilitates many work processes and can give workers more time. However, it's worth pointing out that beyond specific and routine actions, ambience as a tool to facilitate work processes requires fostering new ways of being and living with users and health workers, with a view to welcoming relationships. Furthermore, it highlights the need to reflect on attitudes and behaviors in the workplace, which are often inert due to routine and mechanistic practices. People admitted to hospitals require, in addition to punctual and routine care, understanding and respect for their uniqueness and dignity[4].

Thus, it can be said that ambience and health are interconnected and interdependent, and cannot be separated. In this case, understanding ambience in the mental health field is fundamental to improving care environments and enhancing the quality of life of users[6]. Thus, it is understood that it is necessary to utilize the physical, social, professional, and interpersonal environments in a balanced way to facilitate and improve work processes. Furthermore, affection in care actions, such as welcoming and daily attention given to patients, positively contributes to their comfort[3,19].

Although participants perceived positive aspects of the ambience as a tool for facilitating work processes, they reported a lack of activities at the MHU and family visits, which challenges the promotion of humanized care at the MHU. It is understood that strategies associated with the ambience aim to promote more interactive, inclusive, and welcoming spaces, valuing subjectivity and empowering the role of users, workers, and family members. Therefore, it is essential to offer activities that value everyday life and human relationships, such as family outings, musical moments, playful and manual work, among others[4]. Playful materials, such as games, graphic productions, and musical instruments, should generally be incorporated into the environment, especially in mental health services, as they are capable of providing new/other forms of expression for users, providing entertainment, tranquility, and paths for dialog[14].

In this sense, the inclusion of adaptable and functional areas for activities such as group therapy, individual therapy, and rest is crucial. It is clear that well-designed physical environments positively influence behaviors and social interactions, creating bonds between users, caregivers, and healthcare workers, as well as encouraging participation and shared responsibility in treatment and promoting psychosocial rehabilitation[14,19].

Given this, it is important to consider reducing waiting times for visits from family and friends, ensuring that they can provide ongoing emotional and social support to the patient. Therefore, it is necessary to promote comfortable and conducive environments for interaction not only between family and friends, but also with the healthcare team[9,18], to improve the experience for everyone involved in the care process.

Study limitations

Although this research shows relevant results regarding users' perceptions of the ambience in a MHU in the hospital context, it does have some limitations: the data was only collected in one MHU; and the sample was limited to a number of users. Recognizing these limitations reinforces the transparency and validity of the research, as well as helping to direct future investigations.

FINAL CONSIDERATIONS

This research enabled the researchers to understand and analyze users' perceptions of the ambience of a MHU in the hospital context, which points to a broad perception of ambience. Furthermore, users' perceptions converged with the three axes of ambience proposed by the Ministry of Health (2010; 2017): space that aims for comfort; space as a tool to facilitate the work process; and space for encounters between individuals. However, it was observed that there are important differences between the participants' perceptions of whether the MHU ambience favors psychosocial rehabilitation and the promotion of humanized care. In this sense, some users

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perceive that factors in the MHU ambience provide psychosocial rehabilitation and humanized care, while others believe that the same factors, such as the organization of the ambience and routine, and interaction with destabilized users, end up interfering negatively in the provision of this form of care. It should be noted that this last perception is in line with the assumptions of the BPR and the PNH.

Given the above, it is worth noting that user perceptions, especially negative ones, should be considered when implementing and improving the ambience at MHU and other health services, as it is believed that this will guarantee the rights of people with mental suffering, as per the BPR and PNH. In this case, given the results presented in this study, there is a need to make the MHU hospital environment more colorful, interactive, and welcoming, to offer more therapeutic and recreational activities to users, as well as to provide spaces with greater privacy, more ways to access the patio and at alternative times, and more opportunities for users to receive visitors and/or contact their family and social support network.

It is important to emphasize that the ambience, when it comes to mental health, emerges as an important component in the care, well-being, and psychosocial rehabilitation of users, as well as in the work processes of healthcare teams. With this in mind, improving the ambience in mental health services should be a priority for managers and staff. However, it is important to emphasize that transforming the environment is not just a matter of aesthetics, but a fundamental necessity to promote effective and humane treatment, capable of comprehensively meeting the needs of users, their companions, and healthcare workers.

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Author's contributions

Conceptualization, L.C.A.S. and D.F.S.; methodology, L.C.A.S., P.M.Z. and C.I.B.; validation, L.C.A.S. and P.M.Z., C.I.B. and E.S.S.; formal analysis, L.C.A.S e P.M.Z., C.I.B. and E.S.S.; investigation, R.P.S. and E.S.S.; data curation, L.C.A.S. and P.M.Z; manuscript writing, R.P.S., D.R.P.C. and R.M.S.; review and editing, R.P.S., D.R.P.C. and R.M.S.; supervision, D.F.S.; project administration, D.F.S. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*User perspectives on the ambience in a mental health unit in the hospital context*".