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Deinstitutionalization and autonomy: outcomes from a Brazilian mental health policy

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Abstract *Therapeutic Residential Services (SRT, in Portuguese) are structures implemented in the context of the Brazilian Psychiatric Reform (BPR), which aims to support psychiatric deinstitutionalization. This paper compares residents of SRTs in two cities in Brazil, analyzing the relationship among the deinstitutionalization strategies and the different types of autonomy they produce. Nineteen individuals from two cities (referred to as Paulo Delgado – PB and Franco Basaglia – FB) participated in this study. Participant observation visits were performed, and five managers and professionals who worked at the psychosocial care networks were interviewed. Narratives were created based on the field diaries and the transcription of the interviews. All the participants raised their degree of autonomy, when compared to the time in which they lived in the psychiatric hospitals. The different ways in which SRTs are organized in both cities produced different manners of exercising autonomy: in PD, home autonomy predominated, while in FB, autonomy in circulating throughout the territory predominated. In both cities, autonomy in managing financial resources was restricted. It was concluded that public policies for deinstitutionalization were effective, although their operationalization could be enhanced.*

Key words *Deinstitutionalization, Mental health, Narration, Program evaluation and health projects*

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Introduction

The Brazilian Psychiatric Reform (BPR) originated not only from the conjunctural criticism to the national subsystem of mental health care and to the private character of health policies in the country, but also, and primarily, from the structural criticism to the classical knowledge about psychiatric institutions, in the wake of all the political and social stir which characterized the conjuncture of re-democratization[1]. Therefore, it has a critical attitude towards the exclusion of people who do not fit into the socially accepted standards, by denominating them as "mad", and segregating them in asylums[2,3], under the justification of treating their diseases and dealing with the social peril which is attributed to them. Basing itself on the Italian model, whose main reference is Franco Basiglia[4,5], the BPR understands madness as inseparable from society, based on the *polis* and its economic and social relationships. Therefore, it considers that we should not humanize the asylums, but rather deconstruct them, thereby operating the deinstitutionalization[6].

The Psychosocial Care Centers (CAPS, in Portuguese) and Residential Therapeutic Services (SRT, in Portuguese), among other mechanisms of the BPR, are an undeniable progress. In the long history of the BPR, the 1st National Mental Health Conference defined the movement when it broke away from its initial proposal, which aimed only at improving care, and began to aim toward an anti-asylum philosophy. The 2nd National Mental Health Conference was relevant for considering that people with mental disorders are individuals, beyond the diagnosis, switching the expression "mental illness" to "psychic suffering"[6-8]. Finally, we highlight the relevance of the anti-psychiatry from Laing[9], when it denounces that, behind the supposedly scientific theories and their metaphorical vocabulary, there is a radical segregation, which defines the existence of a standard for human beings, which the "mentally ill", especially the "psychotic", will never reach.

However, there is still the need for constant reflection on the practices, since the trajectory of the BPR also involves crystallizations and setbacks, and the processes of de-hospitalization do not always lead to true deinstitutionalization[7]. Deinstitutionalize "means to understand the institution in the dynamic and necessarily complex sense of the practices and knowledge which produce certain ways of perceiving, understanding, and relating to the social and historical phenomena"[6] (p. 49), demanding changes that develop along three main axes: from institutionalization to freedom, from tutoring to autonomy, from protected work to production of life[10].

According to the Basiglian perspective, one cannot refer to deinstitutionalization if the medical, asylum-like logic becomes reproduced in the scenario of substitutive services. However, this characteristic constitutes a paradox, especially concerning SRTs: the promotion of deinstitutionalization by creating new institutions. Therefore, it is important to analyze to what extent there has been a deconstruction of madness and its connection with peril, as well as to go from the notion of tutoring to autonomy.

The objective of this article, therefore, is to compare two towns in the state of Bahia, in terms of the ways autonomy has been developed by the people who live in SRTs[11] and who are beneficiaries of the Back Home Program (BHP)[12,13], analyzing their relationship with the strategies of deinstitutionalization built in each territory, which are valuable analyses, since articles about the deinstitutionalization experiments are often local[10,14,15] and do not compare territories.

What autonomy are we talking about?

Autonomy is one of the ideals of the BPR and can even be considered a synonym for a cure. It presents an inseparable relationship with the concept of subjectivity, since a subject is necessarily someone autonomous[16]. It is a polysemic term that has been interpreted in many different ways. In the context of the anti-asylum fight and deinstitutionalization, one of the most accepted definitions is the individual's ability to produce norms for one's life, from the possibility of expanding the relationships with the social reality. In this case, it is understood as interdependency: As the subject is a product of social relationships, that subject becomes more autonomous as he/she establishes the greatest number of relationships with people and things[16,17]. Therefore, autonomy is not the opposite of dependency, it is instead the "ability of the subject to deal with a network of dependencies", defined as a "process of co-construction of greater capacity by the subjects to understand and act upon themselves and upon the context according to democratically established objectives"[18] (p. 670). Consequently, it is never absolute, but rather presents coefficients and graduation[18].

Understood as a health necessity, the "autonomy in the way of dealing with life"[19] refers to the

possibility of reconstruction and resignification of the meanings of life and of the ways of living, covering as well the fight to satisfy one's necessities"[20] (p. 790). The concept, therefore, has to do with the possibility of the subject to make choices which improve his/her capacity of adaptation and survival.

In Campina Grande, Paraíba, Brazil, a study[10] that sought to identify the social representations of autonomy in professionals who worked at an SRT, identified a nucleus of meanings for "autonomy", including: the capacity to move around the community independently, the presence of the responsibility for one's self and for the community, and the ability to handle money. It was considered that the individuals did not have full autonomy, but that there had been social reinsertion, perceived in the freedom to move around in the symbolic and real scenarios, and that the possibility of real monetary exchange in the market allows for social integration and the possibility that the subjects with psychic problems are perceived as citizens.

In Salvador, Bahia, Brazil, a study[15] concerning the use of BHP and of the Continuous Cash Benefit Program (BPC, in Portuguese) for the construction of the autonomy of its beneficiaries analyzed interactions and daily routines, highlighting, the possibility of choosing objects and brands that the participants would like to purchase as a favorable element to develop autonomy. However, they did not have experience in withdrawing the benefit, which was administered by CAPS and by professionals from the SRTs. Only part of the resources was passed straight to the beneficiaries, and many choices concerning the purchased products were done by the reference teams or by the caretakers.

Therefore, although in the level of ideas there is an aim for a democratic management of the SRTs, the experiences here described[10,15] show that the power relationship persists, continuing in a hierarchy. However, the residents of the SRTs are not passive in relation to the strategies taken by the reference and caretaker team, since they cleverly design tactics[21] which constitute a different kind of autonomy, usually perceived as "rebellion" or de-adaptation to the norms of social living. Therefore, in order to understand the development of autonomy, we must hear not only the worker, but also the beneficiaries, who are both the subjects and the objects of deinstitutionalization, and who have tactics to achieve autonomy that they have not yet, legitimately, received.

Methodological path

The current study is a section of a multi-territorial and multi-methodological (mixed) research which sought to evaluate the impact of the BHP in the process of deinstitutionalization and social reintegration of beneficiaries, whose methodological path was described by Guerrero and collaborators[12]. This study was approved by the Research Ethics Committee from Fiocruz Brasília, logged under CAAE 57627316.4.0000.8027, Decision number 1,699,082.

The results will be described referring to two towns – their names will be substituted by pseudonyms, both large-sized cities, with high population density, from the State of Bahia. The field work included participant observations and interviews, conducted by two researchers. The selection of participants was intentional, seeking BHP beneficiaries who had been in the program since its first year (2004). In both towns, it was identified that all the users in those conditions were residents of SRTs – an arrangement that was later discovered to be related to the history of the deinstitutionalization processes in those areas, since SRTs were considered the most agile solution for de-hospitalization, given the difficulties in locating families to mediate the return of the subjects.

In the first town, which we will refer to as Paulo Delgado, one of the 10 beneficiaries of the BHP who were chosen refused to participate; therefore, the sample consisted of nine individuals. Thirteen interviews were done for participant observation in five SRTs, in the period from September to October 2017. In the second town, which we called Franco Basaglia, 11 beneficiaries were selected, and one refused to participate. Seventeen visits were done for participant observations between January and February 2018.

Five in-depth interviews were also conducted, with actors involved in BHP management, assistance, and follow-up, three in Paulo Delgado and two in Franco Basaglia. The scripts were created by the team of researchers, and the interviews were recorded, transcribed using the Verbatin method, and sent to the participants for evaluation. The field researchers reported their experiences and observations in field diaries. Those records, together with the transcriptions of the interviews, subsidized the construction of a narrative[22] for each one of the 19 beneficiaries selected. All of the names used in the narratives were also fictitious.

The present study sought to analyze the narratives based on categories built *a posteriori,* from

a fluctuating reading of the material and based on the literature. Inspired by the work of Macedo, Silveira, and Eulálio[10], and by Certeau[21,23], this study sought to analyze autonomy in a practical sense, referring to the daily lives of the participants, from the nuclei of meanings, which emerged from the interviews and the observant participation at the SRTs. Finally, for each category and for the integration of the findings, it was assumed that there were three levels of analysis: the individual's level (each narrative), the Therapeutic Residential Services (SRT), and the municipality.

Results and discussion

The participants of the current research, according to Chart 1, lived in nine SRTs. These were between 30 and 79 years of age, with a predominance of people above 60. Nine (47.4%) were females. Most of the participants had little education, and many were illiterate. Only one participant had finished High School.

Next, this study will describe and analyze the nuclei of meanings referring to autonomy that emerged from the interviews and the participant observations at the SRTs, organized in four categories: living at home, moving around, consuming and managing financial resources and transgressing.

Living at home

The first characteristic which called our attention during the visits for participant observation was the visual feature: the physical spaces and location of the houses. In Paulo Delgado, we found ample houses, well-kept, and located in middle-class neighborhoods, near commercial establishments. In Franco Basaglia, however, the locations varied, there were SRTs in central and tourist neighborhoods, but also in a places considered dangerous by the local residents. The housing infrastructure was more precarious and the users complained of broken toilets, for instance.

One characteristic which was present in all the houses was personalization. The residents, in general, were happy to show us personal objects which decorated their rooms: dolls, photographs, bedspreads with the pictures of dolls or symbols of football teams. Some walls had writings or drawings. Such traits, quite common in every home, in that context end up taking on another meaning: the joy in having a space that people can call their own, in contrast with the sober and anonymous spaces in the asylums, in which elements which defined identities were not allowed[3].

Almost all of the participants are self-sufficient in terms of hygiene habits, as referred to by the caretaker as a gradual accomplishment since de-hospitalization. Domestic tasks, in all the SRTs, are shared among the residents and the caretakers. In Paulo Delgado, in comparison with Franco Basaglia, the residents most often performed tasks like cooking and cleaning.

The food is usually prepared by the professionals, or it is delivered already cooked. Some participants reported making coffee, snacks, or some recipes they liked. The participants fed themselves, except for the SRT-G from Franco Basaglia, where the professionals serve the residents. The use of perforating utensils (and, therefore considered potentially dangerous) for eating, in contrast to what happened at the hospital, was referred to as a sign of emancipation by a caretaker from SRT-F (FB): "The residents nowadays already use plates and glass cups, no longer break things, and do not want to eat without a fork".

There was an evident difference in terms of the roles that the caretakers took up in either town. In Paulo Delgado, the SRTs in general had one caretaker for each shift, who performed several tasks: cleaning, cooking, supporting activities of personal hygiene and feeding, managing medication, accompanying outings, helping in the management of money, mediating conflicts, among others. We observed that there was a strong affective connection between the caretakers and the residents, who verbalized considering them as members of the family, and in some cases, literally called them "mother". In some of the SRTs, there were shifts or even weekends when the residents were not supervised. In Franco Basaglia, by contrast, there was a more numerous team of workers and a greater division of tasks; some were exclusively cleaning professionals, other exclusively nurses, and so on, which gave the impression that the SRTs were more similar to a service than to a home.

In terms of family relationships, practically all of the participants reported having lost contact with their families and only a few had sporadic contacts with relatives. The families, in general, have unknown whereabouts, relatives are no longer alive or do not want to maintain communication. The feeling of abandonment was common, as verified in a previous study[10]. However, many beneficiaries consider the co-res-

Chart 1. Characteristics of the SRTs and their participants.

Town	SRT	Configuration of SRT	Participants (gender, age and education)
Paulo Delgado (PD)	A	2 male residents under the care of 3 professionals, with 1 paid by the city and two by the residents.	Antônio (male, 76, elementary education)
			José (male, 63, elementary education)
	B	3 female and 2 male residents, 2 caretakers paid by the city.	Márcia (female, 46, illiterate)
			Camila (female, 63, Technical School)
			Manoel (male, 59, illiterate)
	C	3 female residents and 1 male, 2 caretakers paid by the city	Gilmara (female, 51,illiterate)
			Dora (female, 59, completed Middle School)
	D	6 female residents and 3 caretakers paid by the city	Valentina (female, 71, elementary education)
	E	5 male residents and 3 females, two caretakers paid by the city.	Margarida (female, 71, illiterate)
Franco Basaglia (FB)	F	6 male residents and one female, 12 professionals	Helena (female, 56, completed Middle School)
			Marcos (male, 79, illiterate)
			Arthur (male, 57, education level unknown)
			Vicente (male, around 70, educational level unknown)
	G	9 male residents (all from a custody hospital), 8 professionals	Moisés (male, 77, illiterate)
			Lucas (male, 57, unknown educational level - he has studied and had been a public worker)
			Pedro (male, 73, went back to school after going to the SRT but quit)
	H	6 residents, 15 professionals	Jurema (female, age unknown – seems to be over 40 years of age, went back to school after going to the SRT)
			Amélia (female, unknown age, seems to be 40 or 45, finished elementary school)
	I	7 male residents, 15 professionals	Anderson (male, 30, went back to school after going to the SRT)

Source: Authors.

idents and the caretakers from the SRTs as their current family and use the money from the BHP to buy them presents, organize parties, or go on outings, where they intensify such relationships.

When analyzing the two configurations, more autonomy was observed in Paulo Delgado than in Franco Basaglia, especially in terms of ways of living, characterized by more participation in domestic tasks, in the possibility of being able to live temporarily without a caretaker, and in terms of the residents choosing who they want to live with, authorizing or refusing new residents, which was not allowed in Franco Basaglia.

Moving around

Concerning Category 2 (moving around the territory) inversely, a greater autonomy could be seen in Franco Basaglia when compared to Paulo Delgado. In that town, one could notice the integration of the SRT residents with their territories and communities. They are known in their neighborhoods, interacting with salespeople and neighbors; some use public transportation on their own and maintain daily routines of circulation, such as going to school or to the gym – activities which no resident of Paulo Delgado performed. We noticed that many of them were going in and out of their homes, and in general, there were no restrictions to such outings, although there were established rules. As an example, we present an extract from Vicente's narrative (SRT-F, FB):

Vicente was in and out so frequently that, often, we didn't even notice. He has quite a busy life in the community. He usually goes to the

clinic (name excluded) and to the Public Attorney office, where he drinks coffee and chats with the workers. He drinks black coffee with sugar at a barrow located on RT street. Weekly, for eight years, a neighbor gives him R$80.00, which Vicente makes sure he picks up personally. Although there is freedom to come and go, there is an agreement among all the users and the team that the residents do not go out at night. Amélia (caretaker) also reminds Vicente that he needs to be back for his medication, at 3pm.

In Paulo Delgado, on the other hand, none of the participants uses public transportation. When unaccompanied, most of them only go to places near their homes, and on foot, to make small purchases, chat with neighbors, or go to the CAPS, for instance. For farther outings, they always call the same taxi driver, who already knows them, and do not leave the house if he is not available. That was commonly a story that, in the past, they used to have more autonomy to go around town, including taking a bus and going to other towns unaccompanied, but as the years went by, they became limited by the loss of physical mobility resulting from aging.

The caretakers from Paulo Delgado justify the restrictions to the freedom of the residents with gestures that convey the idea of 'careful', because of urban violence, the risk of getting lost, or because of physical limitations which impair mobility. They told stories of falls, robberies, and of Manoel (SRT=B), who once disappeared for a month and was found walking on a highway. In Franco Basaglia, we heard similar stories, which, however, not always resulted in restrictions to the outings. Helena (SRT, FB) once got lost and managed to return to home only at three in the morning, worrying the caretakers. But she was not prohibited from leaving again. At the SRT-G, the area is considered dangerous as it has a high incidence of crimes, and most of the residents do not leave the residency. Lucas is an exception, as he strolls around the neighborhood and considers it very peaceful, even though he suffered an attempted mugging, and he mentioned seeing shootings because of drug trafficking conflicts.

Consuming and managing financial resources

According to the adopted methodology, every participant received the BHP benefit. Some residents had other resources, such as retirement or BPC, but none performed a paid activity. In general, the possibility of having access to money facilitated the relationship with the territory: they buy, they sell, they loan, they have credit, and in doing so, they establish exchanges and contractualities, becoming able to perceive and to be perceived as citizens[13,15]. These relationships with the territory mediated by money were constructed over time:

According to the caretaker Amelia, "at the hospital they had no access to money. Initially, they would get the money, tear it apart, throw it away. They did not know what money was". They have learned what money is, and if we had to take that away from them now, it would be very difficult". It is noticeable that the residents already know what they want: "They go to the market, they know the value of things, they recognize and differentiate the money bills." (SRT-F, FB)

The small things acquired by the beneficiaries themselves express singularities and desires which allow for the recovery and consolidation of their identity. As one caretaker from SRT-C (Paulo Delgado) reported: "they like to spend, they feel joy. When we have money, we like to spend, and with them, it is no different". Often in our visits, participants showed us the brands of the products they would like to buy, for example, the toothpaste, the pads, or the razor. Corroborating previous studies[15], the possibilities of choices present in the details of daily life revealed themselves as producers of autonomy and builders of subjectivity in the process of deinstitutionalization. That view of the simple daily things is important, since it helps us understand the role of the BHP in the construction of autonomy.

However, autonomy was limited by the way the money of the participants is managed in both towns, centralizing it in the hands of one of the CAPS professionals and distributing it to the beneficiaries in fractions, usually weekly – differently from what is defined by Law 10,708[24], which established that the benefit should be paid in full directly to the beneficiaries. The fact that they cannot withdraw the benefit contributed, in some cases, to the elaboration of fantasies on how much they actually receive and what they could do with the money,[15] as well as verbalizing that they were being robbed or deprived of their freedom.

In some SRTs, caretakers or reference professionals assumed the responsibility of choosing even clothes or items of personal hygiene, corroborating a previous study[15]. This type of practice destroys part of the function of the BHP, which seeks to build autonomy by rescuing subjectivity. However, within the same SRT, there are

differences in the level of autonomy of each resident. Antonio (SRT-A, PD), for example, is the only beneficiary who keeps his BHP card, and when – depending on his limitations of mobility – he needs the caretaker's help to buy things or to make payments, he asks for all of the receipts. Therefore, the level of autonomy in the management of financial resources varied, according to individual factors and to the reference team of each SRT.

In both towns, similar histories were reported: in the beginning of the program, the caretakers of the SRTs managed the benefits together with the user, but that caused an overburden, so that activity was transferred to the CAPS. This matter has been tensioned by the teams, which recognize that the ideal situation would be that each beneficiary could manage his/her own money. However, this proposal failed to be put into practice. According to one of the caretakers, "the money should not be managed by the nursing team. Even if they provide receipts, there is no real freedom for the beneficiaries".

Some of the reasons that led to the management of the money by CAPS are operational. Other reasons have to do with perceptions and values of the reference team. The justifications were: 1) physical or mental limitations which compromise or hinder the realization of the necessary tasks; 2) a measure of financial security, keeping a reserve for emergencies; 3) to afford items which are considered fundamental (such as high cost medication) or fixed expenses requested by the users, like cable TV; 4) to avoid a bad use of the money, understood as buying things which the professionals consider futile or destroying the money; 5) to avoid risks and health problems, like alcoholic beverages and dangerous items (such as knives), or that can be exploited by ill-intentioned people; and 6) the practice of leaving the management of resources entirely to the beneficiaries has been attempted, but several problems were encountered.

Transgressing

In the dictionary (https://www.dicio.com.br/), the term 'transgress' is described as "not obeying (not observing an order, a law, or regulation), to infringe, to violate". It also means to "go beyond, to cross over". In this category, we will discuss the tactics created by the patients in opposition to the strategies established at the SRT[21], going beyond the autonomy that is given to them and producing for themselves slightly more freedom.

As we have already mentioned, one of the main prohibitions presented by the SRTs is the integral management of the beneficiaries' money. The amount they effectively receive is considered small, and some beneficiaries have conceived tactics to gain access to more resources. The most common example is the habit – rejected by the team – of asking for money. Although sometimes considered as a mechanical act, inherited from the asylum, we suggest that it is more likely to be motivated by a dissatisfaction with the amount received and with the impossibility of managing one's own financial resources[25], which was mentioned by some participants.

Some relationships between residents of the SRTs are also mediated by money. Antônio (SRT-A, PD) said that money is important for dating: his girlfriends. Some residents of the SRTs also exchange sexual relations for money, which he offered happily. At SRT-G (FB), by contrast, there is an internal economy: two residents act as loan sharks, lending money with interest and selling cigarettes at higher prices than those found in the area. Another resident, trying to expand his purchasing power, went into debt by borrowing money from his housemates. Borrowing or contracting debts are possible choices for those who do not have the diagnosis of "mad"; however, inside the SRTs, this transgression resulted in the intervention of the reference team.

Transgressions of the house rules were also observed, such as restrictions to the consumption of cigarettes and alcohol. Aiming to reduce the damage, some caretakers limit the quantity of cigarettes allowed per day. Some residents contested or violated this rule, hiding themselves to smoke. Interventions by CAPS professionals were reported, asking bar owners not to sell alcoholic beverages to patients. One of them agreed not to sell to Manoel (SRT-B, PD), but the other clients kept buying alcohol for him. As a result, the reference team had to decide for moving home. At SRT-G (FB), curiously, a small elevator was improvised, using an opening in one of the windows, through which the residents could pass money and receive products (usually, sweets, cigarettes, and alcoholic beverages) from the market next door. The owner, when questioned by the CAPS professionals, did not agree to help with the regulatory process, stating that he was a businessman.

At SRT-A (PD), we observed an interesting point of conflict concerning the care of the vegetable garden. The caretaker encouraged the two residents to water the plants, saying that it was a

healthy activity, but José refused, justifying that the garden did not belong to him and demanding payment for the work. Actually, as he explained, he feared that his BHP benefit could be interrupted "by the President ", since the benefit cannot be paid to people who do work. When we analyzed this negative point, we remembered that, regardless of the good intentions of the team, the idea that work is therapeutic (labor therapy) and does not need to be paid, it is also a characteristic of total institutions, such as the asylum[3]. Since the initiative of planting a garden did not come from José, the resistance in engaging in that activity can be seen as a fight for this autonomy.

Ways of autonomy and its relationships with the setup of the institutions

For all the participants in this research, in all the SRTs and in both towns, the actual levels of autonomy are always higher, when compared to those reported by the residents themselves and the caretakers when they left the asylum. This autonomy does not constitute a total independence, but rather is the reduction of the dependency on a single institution – the psychiatric hospital – and the construction of an interdependency in relation to many people and mechanisms of the network, within the territory[16,17,18].

In every analyzed case, the individuals became more autonomous in the way of dealing with life[19], since they established a greater number of relationships with things and people[16,17] and gradually became capable of dealing with this larger and more complex network of dependencies. The possibility that the subjects are able to make choices expands the chances of reconstructing and giving new meanings to life, in a virtuous cycle, with an increased possibility of making better choices, since they were better adapted, and act upon their needs and upon the context.

According to the methodological path adopted (qualitative, with intentional sampling), the object of this study is not to compare, quantitatively, the level of autonomy of each patient, of each town, in each SRT. The analyses have allowed us to observe that the ways the SRTs are organized in both towns have produced different ways of exercising this autonomy: generally, we understand that in Paulo Delgado, there was the predominance of autonomy in living, while in Franco Basaglia, an autonomy in circulating within the community predominated.

According to Certeau[23], the elementary daily life practices are the possible level in the ingenuity of the citizen. For instance, when cooking, the subject established a relationship with tradition, expressed in the recipes and combinations of foods and practices, and involves a series of complex behaviors: choose ingredients, compare prices, make plans chronologically, especially in the kitchen, serve, throw away, clean, tidy up, preserve, readapt to adversities (as in the case of a spilled ingredient). However, that activity was observed in few SRTs, all of which were located in Paulo Delgado. In the others, it is more common for the residents to receive the food ready from a restaurant or prepared by the caretakers.

The freedom in circulating within the community promotes contact between the public and the private space[23], in such a way that the public space is the "place of the others". A citizen establishes trajectories based on the recognition of the places, in the relationships with the neighborhood and the businesspeople. There is visible behavior in the social space of the street, translated by the dress code and the courtesy code, by the pace of walking and by the valuing or the avoidance of a given public space. In this sense, the neighborhood, according to Certeau[23], would be the progressive privatization of the public space, in a solution of continuity between what is the most intimate (the private place of residency) and what is the most unknown (the city). The autonomy for circulation was most present in the town of Franco Basaglia, where the residents were, in general, quite integrated with their neighborhoods.

It is important to consider that the evaluation of what is at stake changes, depending on the point of view from which one looks at the world, and that the construction of the narratives and lives can be found in the articulation of a series of dimensions, traditions, scientific productions, habits, and new forms of public administration, which are present in the lives of those people, acting as elements of pressure and as limits. Therefore, it is essential to know what function is performed by the technical work at those institutions, which power relations are intertwined with such work, what the echoes of the work are, what makes it express itself or remain silent, in other words, on what basis the relationship between caretaker and patient is established.

In Paulo Delgado, the SRTs had few caretakers, who took up a maternal role, which included a sense of protection. Therefore, a tendency of restricting the freedom of circulation was observed, according to the justification that risks should be avoided. In Franco Basaglia, however,

the residents lived in houses with a more precarious structure and with more caretakers. They were never unattended to and they performed less domestic activities. In that town, living in less inviting and less family-like homes, the residents had the possibility of circulating and were able to insert themselves in the territory and the community, appropriating public space.

Finally, we must analyze the autonomy in consumption. Since they do not produce their own goods, consumers use those which are imposed upon them. However, they do not necessarily follow availability and do their own operations defined by cunning[21]. Hence, autonomy also passes through consumption choices, which have been made possible by the BHP. The benefit has allowed passage through the real and symbolic spaces, expanding contractualities by means of monetary exchanges[10]. However, for most users, in both towns, the centralization of the management of money persists, although tensioned by the teams of mental health professionals and by the critical attitude of some beneficiaries.

In that sense, it is important to mention that it is not a coincidence that people considered to be "mad" are treated like children. The "mad" are considered incapable, incomplete, fragile. Madness and infancy are similar in many ways in the eyes of psychiatric and psychological science, and are seen as uncommitted to critical thinking. The differences and singularities are transformed into inequalities, from which new techniques and theories arise, built in hierarchic environments which have the purpose of maintaining the *status quo*.

Final considerations

We consider this study relevant because it is applicable to professional practice, as it shows different forms of autonomy and their associations with the ways of care offered in the SRTs, as well as the importance of the BHP for the reconstruction of the beneficiaries' subjectivity. Ideally, the freedoms of inhabiting, circulating, and consuming are equally relevant. According to Moreira and Andrade[7] when analyzing the SRTs, "the main issue is to live in the city and to conquer the territory of citizenship, and for that what is required is a specific living space which is configured as a home and not as a place of treatment" (p. 51). Therefore, such conditions should be the object of frequent reflections and discussions with the reference teams, caretakers, and patients in order to make it possible for the beneficiaries to move progressively towards more autonomy. We also suggest independence be improved in the management of the BHP money, giving the possessions of the card to each beneficiary, as the horizon for singular therapeutic projects, with a constant monitoring of the level of autonomy achieved in the management of those resources. From a scientific point of view, in the future, it would be relevant to study the ways and the level of autonomy achieved by the BHP beneficiaries who live outside the SRTs, as well as former patients of psychiatric institutions who do not receive this benefit.

Collaborations

GA Silva participated actively in the conception of the study, the alignment of the research, analysis and interpretation of data, writing of the manuscript, and coordination of the research. She also approved the final version to be published and takes responsibility for the content. AJC Cardoso participated actively in the conception of the study, the alignment of the research, analysis and interpretation of data, writing of the manuscript, and coordination of the research. He approved the version to be published and takes responsibility for the content. AC Peixoto participated actively in the analysis and interpretation of data, writing of the manuscript, and critical revision of the text. He approved the final version to be published and takes responsibility for the content. C Rudá participated actively in the analysis and interpretation of data, writing of the manuscript, and critical revision of the content of the text. He approved the final version to be published and takes responsibility for the content. DV Silva participated actively in data collection, analysis, and interpretation of data, and critical revision of the content of the text. She approved the final version to be published and takes responsibility for the content. SMJ Branco participated actively in data collection, analysis, and interpretation of data, and critical revision of the content of the text. He approved the final version to be published and takes responsibility for the content.

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