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Advances and challenges of the Back Home Program as a deinstitutionalization strategy: an integrative review

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Abstract *The aim of the current article is to identify scientific evidence about advances, possibilities, and challenges of using the Back Home Program (BHP) to deinstitutionalize former psychiatric hospitalization patients. This study is an integrative review based on the scientific literature available in the Virtual Health Library and the PubMed portal, as well as in the Cinahl, ScienceDirect, Web of Science, Scopus, and PsycINFO databases. The analysis of all nine selected studies was based on the interpretation of discursive practices observed in public domain materials. Results have shown that the investigated program is an undeniable social achievement and civilizing advance, and that it contributes to deinstitutionalization, as it helps to change beneficiaries' lives, with emphasis on their new consolidated place in society and on the dispensability of psychiatric hospitals. However, the program needs to overcome some challenges, such as access and equitable distribution in the national territory, professional training, and the involvement of individuals in the appropriation of benefits. It is crucial to emphasize the need to develop strategies to promote autonomy, citizenship, access to a broad mental health network of assistance and care resources, patients' return to family life, and insertion in the labor market.*

Key words *Mental health, Public policy, Deinstitutionalization*

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Introduction

Since its origin, the Brazilian Psychiatric Reform opened up the debate and the construction of new strategies, which defined a new social place for madness within the country's cultural tradition[1]. This is a complex movement, which, in order to build itself as a public policy, organized a series of actions that go beyond the creation of alternatives to de-hospitalized psychiatric patients, push forward the process of deinstitutionalization, as well as result in the mobilization of the subjects involved in the system of institutional action (patients, families, workers, managers, and other agents) and in the transformation of the power relationships between the institution and the people for whom it provides cares[2,3].

The Back Home Program (BHP), together with the Program for the Reduction of long-term hospitalization and the Residential Therapeutic Services (RTS), consists of a strategy to deinstitutionalize and recover the citizenship of individuals suffering from mental disorders who have been submitted to the deprivation of freedom in psychiatric institutions, within the context of the Brazilian Psychiatric Reform. The BHP program was instituted by Federal Law 10,708/2003 as a psychosocial rehabilitation support program (current monthly value of the benefit is R$412.00) aimed at care, follow-up, and integration outside the hospital environment[4,5].

The creation of the BHP was the result of a demand from the Brazilian Psychiatric reform movement, drafted during the 2nd National Conference for Mental Health, which proposed the creation of mechanisms for grants transferred to people who, after a long period of psychiatric institutionalization, were released and needed to reestablish themselves and find their place in the urban space. Following that logic, the BHP is a strategy of deinstitutionalization that contributes to the dismantling of the location assigned for 'madness', as it transforms the intern/subject into an autonomous subject[6,7].

To avoid remaining within the mere boundaries of assistentialism, it is expected that such a program is applied in order to stimulate the autonomy of the subject, which is considered, together with the cultural transformation of society, as one of the bases for the deinstitutionalization process. Therefore, it is necessary to guarantee the access to the benefits which the users are entitled to, and the execution of a sustainable life project which includes coming out of the hospitalization within a mental asylum[6,8].

However, the concession and administration of monetary benefits for users of the network of mental health is one of the knots which support and tie together the work in this field[8], bringing to surface the dilemmas which involve aspects like illness, access to public policies, and the guarantee of minimum rights, social rehabilitation, and contractuality.

To date, no studies have gathered results from different studies related to the BHP and its repercussions on health practices in different realities. It is important to understand the status of the scientific publications on the theme in order to contribute to the reflection on the current scenario of psychosocial care in Brazil, which has been a target for dismantling attempts in recent years. It is also important to evaluate the modifications in process and point out the necessary changes in this context.

As a deinstitutionalization strategy at the level of the Brazilian Psychiatric Reform, and after 18 years of regulation, the authors of the present study pondered the following question: What are the aspects studied in scientific publications in relation to the BHP, as a strategy of the deinstitutionalization of patients who were in psychiatric hospitalization?

To answer this question, this study opted to conduct an integrative review aimed at identifying scientific evidence on the advancements, possibilities, and challenges of the BHP for the deinstitutionalization of psychiatric patients.

Methodology

This is an integrative literature review, a method which allows for a broad understanding and synthesis of the knowledge produced by different studies about a given phenomenon, including experimental and non-experimental studies. In the health field, integrative reviews bring relevant contributions to Evidence Based practice, considering that its systematization and ordering contribute to deepening the understanding about the investigated theme, and may reflect on health practices[9].

The present integrative literature review was developed in two stages: the formulation of the guiding question in a clear manner, relevant for the health field; the process of searching for articles according to the criteria and the selection process; the definition of the information to be extracted and data collection; the evaluation and critical analysis of the studies considering their

characteristics, results, and classification of evidence; the synthesis, discussion, and interpretation of the main results; and the presentation of the integrative review, with a detailed description of all the stages, including the main findings[10]. The recommendations from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) were adopted, in terms of identification, sorting, eligibility, and inclusion of articles in the review[10] , which, even though it is indicated for systematic reviews, was used in the present work to guide the selection of the references and the presentation of the stages of identification, selection, eligibility, and inclusion of the studies found in literature.

To define the guiding question, this study used the mnemonic strategy, represented by the acronym PVO, in which "P" means "participants" (former psychiatric institution interns), "V" represents the variable (Back Home Program), and the "O" means *Outcomes* (deinstitutionalization). With the combination of these three components, the following guiding question was formulated: "What are the aspects covered in scientific productions related to the BHP as a strategy for the deinstitutionalization of patients from psychiatric institutions?"

The search for articles was conducted in the Virtual Heath Library (BVS, in Portuguese), the Pubmed portal, as well as the Scopus, Science Direct, Web of Science, CINAHL and PsycINFO databases, involving the following descriptors: "Public Policy", "Mental Health", "Deinstitutionalization", "Communitary Mental Health Services", and "Assisted Living", in Portuguese and in English, according to the cataloging by the Health Services Descriptors (DeCS) and by the Medical Subject Headings (Mesh). The controlled descriptor from the American Psychological Association (APA) was also used: "Elaboration of Governmental Policies". The keywords "back home" was also used as a way to convey more specificity for the search, according to the guiding question.

From the selected descriptors and keywords, three matches were formulated (A, B, and C), using the boolean operators "AND" and "OR": A - Deinstitutionalization AND Public Policy; B – Deinstitutionalization AND Mental Health; and C – (Public Policy OR Mental Health OR Mental Health Community Services) AND (Deinstitutionalization OR Assisted Living OR Back Home Program).

The search and selection of the scientific productions was conducted by two researchers separately in September, 2020, and the productions were gathered using the Zotero *software*. The titles and abstracts were analyzed in independently by two researchers, based on the inclusion and exclusion criteria. The adopted inclusion criteria was: academic articles evaluated by pairs, available in full and in electronic format, and which covered the BHP as a strategy of deinstitutionalization. No criteria related to the language of the publication or the year of publication was established. Letters, editorials, dissertation, theses, and productions that did not offer elements to respond to the questions proposed by the study, as well as duplicated articles, were excluded from the sample. Figure 1 shows the fluxogram with the results of the stages of identification, selection, eligibility, and inclusion, according to PRISMA recommendations[11].

In the end, nine studies were included in the integrative review, all of which were found in the BVS. Three were also found by using the Web of Science and four using Scopus. However, these versions were excluded beforehand, since they were duplicates. A protocol was used for data collection, created by the authors of this integrative review, containing the information to be extracted from the selected articles. The productions were read in full by two researchers, separately, who collected the following information: title, authors, authors' area of study, month/year of submission, and month/year when the study was published, publication, languages available, descriptors/keywords, source of financing, methodological guidelines, synthesis of the results, recommendations from the authors, and level of evidence.

The level of evidence of the articles was qualified according to the Agency for Healthcare and Research and Quality (AHRQ), which is one of the tools available for the classification of studies at different levels: (I) systematic review or meta-analysis, (II) randomized clinical essays, (III) non-randomized clinical essays, (IV) cohort and case-control studies, (V) systematic review of descriptive and qualitative studies, and (VI) only qualitative or descriptive study[12].

The results were analyzed according to the strategy of interpretation of discursive practices in public domain material, conceived as a process for the production of meaning[13]. From the analysis process, two axes were defined by the approximation of meanings produced: "Ways of being a beneficiary of the back home program' and 'Advancements and challenges of the back home program in the process of deinstitutionalization of life'. Productions by authors who studied the

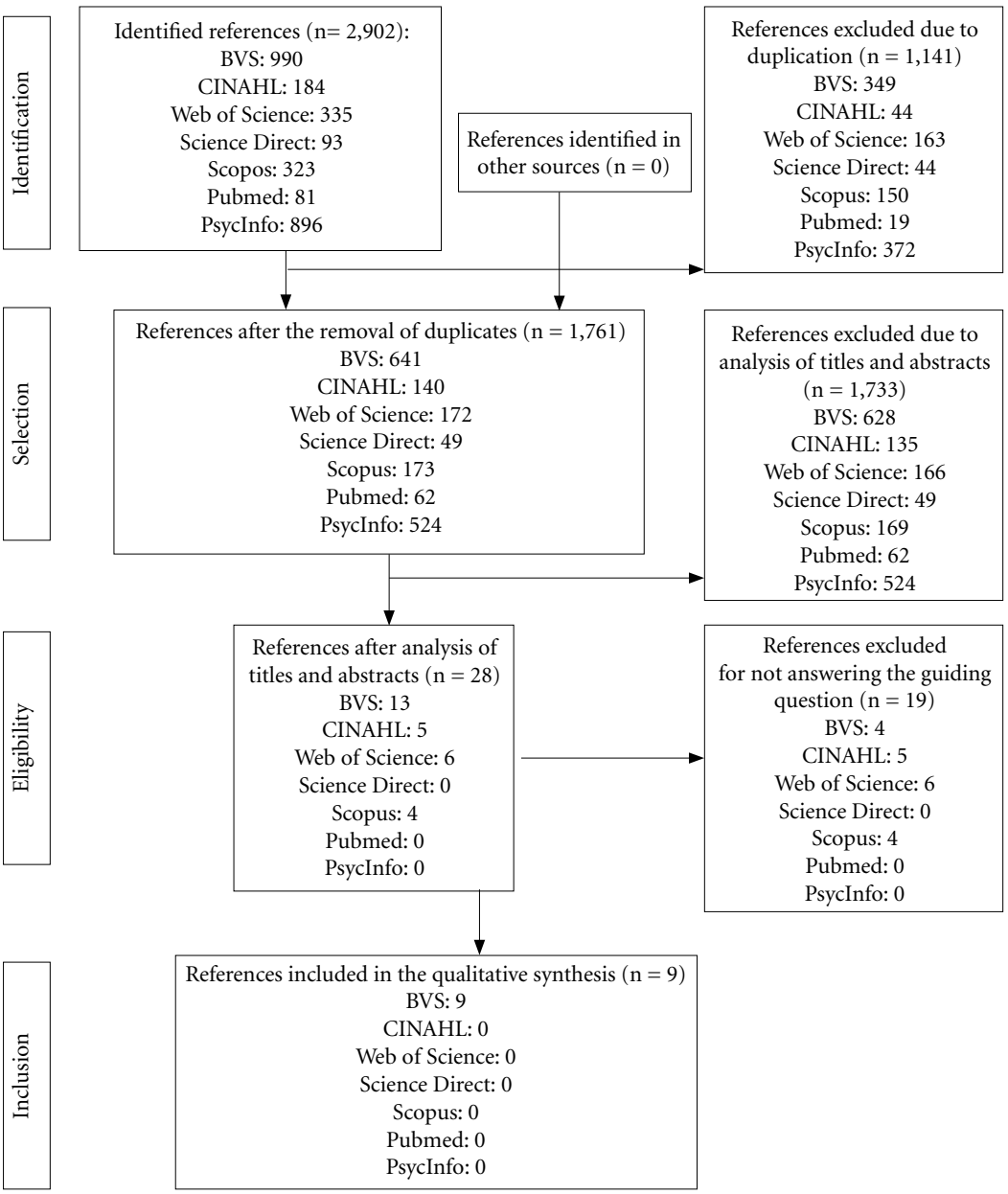

Figure 1. Fluxogram of the selection of references from the databanks, adapted based on PRISMA recommendations, Campo Grande, MS, Brazil, 2020.

Source: Authors.

theoretical constructs of public policies of mental health and deinstitutionalization" were used to base the discussion of the results.

The presentation of the synthesis of knowledge was done by means of a descriptive text about the summarized studies and the presenta-

tion of a table with relevant information about the analyzed studies comprising the literature review.

Results

Chart 1 shows the productions discussing the BHP, not only from the strict point of view of the amount, but according to a broad perspective, associating it with other strategies of deinstitutionalization, such as: RTS and Psychosocial Care Network. Authors with a degree in Psychology were predominant, and the studies were available in Portuguese and published in the periodical Health and Society. Among the 21 descriptors used to identify the theme of the studies, only 11 were cataloged in the DeCs vocabulary. 'Mental

Chart 1. Distribution of the articles selected for the integrative review, according to the title of the study, language available, area or expertise of the authors, periodical, and descriptors/keywords. Campo Grande, MS, Brazil, 2020.

Title of the study	Language available	Area of expertise	Periodical	Descriptors/Keywords
Article 1 - the Back Home Program in the daily life of the beneficiaries[14]	Portuguese, English	Psychology, Medicine	Saude Soc	Psychiatric reform; Mental Health; Deinstitutionalization; Psychosocial Rehabilitation, Back Home Program
Article 2 - Building stories at a slow tempo: deinstitutionalization and narratives in research[15]	Portuguese	Psychology	Saude Soc	Narrative; Mental Health; Deinstitutionalization; Back Home Program; Evaluation of Programs and Health Projects
Article 3 - Narratives and meanings of the Back Home Program: We are back, what now?[16]	Portuguese	Psychology	Saude Soc	Deinstitutionalization; Mental Health; Narration; Evaluation of Programs and Health Projects; Citizen Participation in Science and Technology; Back Home Program
Article 4 - the concession of benefits and the gamble on singularity: a challenge for mental health[8]	Portuguese	Psychology	Rev latinoam. psicopat fundam	Mental Health; Concession of Benefits; Psychoanalysis; Singularity
Article 5 - Disconnect from the asylum, take possession of life: persisting challenges in deinstitutionalization[17]	Portuguese	Psychology	Psicol Soc	Mental Disorders; Mental Health; Psychiatric Deinstitutionalization; Psychiatric Reform; Psychosocial Rehabilitation
Article 6 - Psychiatric deinstitutionalization: from hospitalization in a mental institution to living in the city of Belo Horizonte[18]	Portuguese	Psychology, Theology	Psicol Soc	Residential Therapeutic Service; Subjectivity; Deinstitutionalization; Back Home Program
Article 7 - From the Back Home Program to the achievement of autonomy: necessary paths for the real process of deinstitutionalization[6]	Portuguese	Psychology	Physis	Residential Therapeutic Service; Subjectivity; Back Home Program; Deinstitutionalization
Article 8 - Management of mental health care in the Unified Health System[7]	Portuguese, English	Occupational therapy, Nursing	Rev Esc Enferm USP	Mental Health; Health Services; Politics; Unified Health System
Article 9 - Evaluation of the current situation of the Residential Therapeutic Services at SUS[19]	Portuguese	Physical therapy	Science Collective Health	Evaluation of Necessities; Mental Health; Psychiatric Reform; Evaluation of Programs and Services

Source: Authors.

Health' was used as a descriptor in eight articles and 'deinstitutionalization', in five.

The articles were published from 2006 on; five of them between 2016 and 2019. On average, 4.6 months passed between the date of submission of the articles to the periodicals, and their publication. Information was found referring to funding to conduct the studies in only one selected study.

According to Chart 2, studies with a qualitative approach, developed specifically with patients who were BHPbeneficiaries, were prev-

Chart 2. Distribution of the articles selected for the integrative review, according to the guidelines and the synthesis of the studies. Campo Grande, MS, Brazil, 2020.

	Guidelines	Synthesis of Results
Article 1	Participative research, multiterritorial, conducted with beneficiaries, managers, professionals, and representatives of social movements and from the Legislative Power. Data collection through interviews and focus groups	BHP makes deinstitutionalization possible, as do de-hospitalization, social reinsertion, autonomy, citizenship, and contractualism. Governmental uncertainties, social conflicts, difficulties in access to the program, and regional inequalities in its distribution are a challenge for its effectiveness. The expansion of the scientific production, which evaluates this policy on a national level, is recommended
Article 2	Evaluative research, multicentric, conducted with beneficiaries. Data collection through interviews and the production of narratives	There are regional inequalities in the distribution of benefits. Although there are challenges to bring together the beneficiary and the researcher, it is important to suggest the participation of both in the production of knowledge on the theme
Article 3	Evaluative research, multiterritorial, conducted with beneficiaries. Data collected through participant observation and interviews, analysis of narratives	The BHP promotes deinstitutionalization, de-hospitalization, use of RAPS, social reinsertion, autonomy, contractualism and criticality. Underuse of monetary benefits over the years is criticized
Article 4	Case studies of beneficiaries from Rio de Janeiro, RJ, Brazil. Analysis based on the psychoanalytical perspective	Benefits make social reinsertion viable but may corroborate symptomatic arrangements. Singular practices are recommended, and the implication of the subject in the concession of benefits, besides the social reinsertion through work
Article 5	Qualitative research, based on the constructivist paradigm, developed with beneficiaries in Rio de Janeiro, RJ, Brazil. Data collection from patient files and through interviews. Thematic analysis	The benefit allows for living in the city and expanding decision power and autonomy. Dependence from mental healthcare workers; insufficient appropriation of this financial resource are hurdles for social reinsertion. Training healthcare workers is recommended, as is investment in social insertion through work
Article 6	Action-Research conducted with beneficiaries in Belo Horizonte, MG, Brazil. Data collection through ethnographic observation and field diaries. Categorical analysis.	BHP made the deinstitutionalization policy sustainable. Such a process was possible due to the existence of a mental healthcare network, which takes care of patients and provides continuity of treatment and recovery of citizenship.
Article 7	Qualitative study conducted with beneficiaries and mental health professionals in Salvador, BA, Brazil. Data collection through participant observation, informal conversations and field diaries.	BHP promotes autonomy, empowerment, and self-care. The literature on the theme and its repercussions are still incipient; professionals give little consideration to the program and its potential for deinstitutionalization; beneficiaries do not understand it, do not resort to it, or have no autonomy to use this benefit.
Article 8	Retrospective reflection. Analysis of management mechanisms that affect Psychiatric Reforms	The number of BHP beneficiaries is low. Difficulty in the deinstitutionalization of patients residing in psychiatric hospitals for longer periods of time
Article 9	Data from the evaluation of RTS and BHP in Brazil, obtained in a systematic manner	There are regional inequalities in access to the BHP. The number of beneficiaries is too low. Problems in obtaining documentation and locating families compromise deinstitutionalization

Source: Authors.

alent. From all the studies selected, three were multicentric, and three were done specific in states from southeastern Brazil. According to the AHRQ, every production had a level of evidence VI. The synthesis of the results of the studies showed how the participants were BHP beneficiaries, as well as the progress and challenges of the program as a deinstitutionalization strategy.

Ways to be a beneficiary of the back home program

The results of some of the studies indicate that, although the Brazilian Psychiatric Reform proposed a process of emancipation and the recognition of rights, we must never lose track of the individual who receives it. Historically, the person with mental disorders had a social place where the human being was reduced to an anomalous mass, to ground zero, where their remarks were emptied, misunderstood, and silenced. The consecutive years of institutionalization deposited on that individual the stigma of madness, of the asylum, of exclusion[8,14,15,17].

To some researchers, regardless of strategies to remove this individual from that social place, developed from the movement of Psychiatric Reform, the marks left by the long experience of life in the asylum did not disappear. Former patients of psychiatric institutions deal with the memories of the experience in the asylum: losses, abandonment, the unhealthy living conditions, the disrespect for basic human rights, the scenes of violence, and the alienation suffered when in confinement. Such experiences contributed to the closing of the psychiatric hospitals around the country[15,17].

Among the findings of some studies, what stands out is the fact that being a BHP beneficiary means having a life story affected by the permanence in closed institutions. Subsequently, this permanence provoked ruptures of the individuals with themselves, with family and social connections, with the entire world, and has changed the way that these individuals perceive themselves and their surroundings. The extensive reclusion produced negligence, socioeconomic vulnerability, poor education, institutional dependence, and a loss of working conditions[16-18].

Among the implications of many years of hospitalization, some studies suggest the chronification of the mental disorder with the consequent loss of essential skills needed to live in a community. Even after leaving the asylum, there are cases of former interns with a daily life of stigma and prejudice, difficulties in surviving, poor housing conditions, difficulties with employment, family abandonment, reinstitutionalization in psychiatric hospitals, deterioration in quality of life, illnesses caused by aging, homelessness, and imprisonment[6,15,16].

By contrast, some scientific productions show the attempts of deinstitutionalization through access to living conditions and monthly income, the reconstruction of family connections and other affective connections, creative formats of support networks, and free circulation in the city. In that sense, being a BHP beneficiary also means having the possibility of living in the city, becoming involved in self-care and home management, and attending services in the mental healthcare network and at community living centers[6,14,15,17,18].

The results suggest that only a minority of the beneficiaries has a network which goes beyond the contacts maintained in the network of mental health services. One survey indicated the participation of beneficiaries at the Psychosocial Care Centers and community living centers, although such services are not always recognized as therapeutic by those patients. The family networks are restricted and contacts are sporadic[17]. Such findings seem to reinforce the idea that beneficiaries from the BHP have difficulties in expanding their relationships and connections, as well as in overcoming their dependency towards healthcare mechanisms.

In terms of the use of funding, part of the selected literature indicates that being a beneficiary does not necessarily indicate that a person has autonomy to focus one's expenses exclusively on activities of personal interest. Due to such factors as the insufficiency of resources transferred by the municipal administrations to maintain the RTS, several studies show that part of the costs for maintaining a house and basic necessities (food, clothing, transport, and medication not available in SUS) is covered by the patient's own resources[6,16-18].

Progresses and challenges of the back home program in the process of the deinstitutionalization of life

Studies show the progress of BHP as a deinstitutionalization strategy, since it allows for changes in the life of the beneficiaries, especially in terms of allowing for the concrete occupation of a different place in society and making the psychiatric hospital unnecessary. The most

prominent achievements are: leaving the hospital; becoming part of the community; exercising citizenship; accessing public policies; circulating around the city; establishing a home; acquiring goods and services; expanding the ability of expression, communication, and critical thinking; practicing self-care; establishing affectionate relationships; having access to all the spheres of negotiation and contracting allowed by money; and, most importantly, preserving one's dignity and human rights[6,14-16].

For some researchers, by providing a monthly cash sum, the BHP opens space for the former psychiatric interns to leave a place where they depend on the care of others and enter a different place which represents the freedom of action and the resignification of the subject, through the right to negotiation and insertion in a system of social exchanges. Different initiatives can be cited, such as the funding of activities and projects of the interest to the beneficiary, in some cases[6,16-18].

The findings of some studies indicate that the BHP contributes to boosting the beneficiary's autonomy, considering the level of autonomy that the subjects acquire. For example, the subjects can make decisions concerning their place of residency, their daily routine, the maintenance of private spaces, and the subjects' ability to enjoy living in the city. Such responsibilities allow for the beneficiaries to become the subject of their own lives and point in the direction of autonomy, which goes beyond the simple desire and opens spaces in which the subjects can express themselves[16,17].

Most of the selected studies emphasize that the level of autonomy of the subjects does vary, especially in terms of managing the care that they receive. There are cases of autonomous management, of shared management with third parties, and of exclusively third party management. Some findings indicate that the level of autonomy of some beneficiaries is very limited, which results in implications in terms of handling the benefit, understanding the resource that they have acquired, as well as the limitations in coming and going. Considering this, we reinforce the idea that autonomy is the establishment of interdependence, which occurs with more or with less negotiation. It also depends on specific variables, such as: the local context of the network, the professional team, the family organization, and the beneficiaries' limitations[6,8,16,17,19].

Although the BHP has made progress in the field of deinstitutionalization, there are still challenges that need to be overcome, especially in terms of social integration. Some studies call attention to the fact that the BHP and other deinstitutionalization strategies are not part of the priorities of the country's political agenda. There is a need for the strengthening and financing of innovative actions and professional qualification aimed at improving the support and valuing the professionals in the mental health field[6,14,15,17].

Despite the increase in the number of beneficiaries of the BHP in recent years, the program is still not fulfilling its potential in quantitative terms. Researchers estimate that since 2003, only ⅓ of the approximately 15,000 people who could be receiving the benefit are actually receiving it. Many factors explain this outcome, among which are the absence of family connections or of a curator, and the difficulty in having access to documents, ID cards, proof of residency, bank accounts, and hospital records (hospitalizations, time spent in institutions, different hospitals that provided treatment) [6,7,19].

Regional inequalities in accessing the BHP are also a problem identified by the selected literature. Historically, the places available for psychiatric hospitalization are concentrated in the Southeast and Northeast of Brazil. Currently, both regions lead in terms of the number of beneficiaries and in the implementation of substitutive services. However, the concentration of BHP beneficiaries in those two regions is not proportional when compared to other parts of the country, and there is still a significant number of people who need to be deinstitutionalized throughout the country[14,19].

The criticism to the lack of monetary updating of the benefit, considering the passing of time and the lack of knowledge by some beneficiaries concerning the receiving of the resources, are notorious in some studies. Such findings indicate a reduction in the contracting and negotiating ability - which require money - with the passing of time, and also a gap in the subject's ability to acquire the benefit[6,16,17].

Finally, the results of some studies indicate the difficulties in articulating the strategies of deinstitutionalization (BHP, ARTs) with those for psychosocial rehabilitation, such as work, the generation of income, and social insertion. Although living in a community, the BHP beneficiaries still have a restricted social network and seem to be excluded from a broader social interaction. They still feel dependent on the providers of mental health care and have family connections that are fragile or non-existent. An-

other fact that deserves our attention is the need to develop strategies of social insertion through work. In this context, assisted work projects and income generation workshops could improve the exchange of resources and foster more connections[6,8,17].

Discussion

The authors of this integrative review had difficulties in locating studies which covered the theme, even without using inclusion criteria that could quantitatively restrict the studies found, such as the language of publication or the year of publication. Perhaps the use of non-catalogued descriptors for the identification of the theme of the studies is a factor which makes it difficult to locate other studies covering the same theme.

The quantity of studies selected indicates that the BHP is an issue which deserves more interest and attention in terms of research. New scientific productions could be conducted by researchers specialized in other areas of knowledge, going beyond the field of health, and new studies could be also developed with other social actors, besides the patients, who are important to the process of deinstitutionalization.

The selected scientific literature, and the limited variety of the methodological designs, reinforce the need for more studies, including those of an experimental nature, which could bring results with better levels of evidence. New studies regarding BHP should also be conducted on a more national basis, in different locations, since the program is not distributed evenly throughout the country.

All of the studies included in this integrative review conceived deinstitutionalization, not only as a movement of e-hospitalization and reduction of hospitalized patients, but also as a service which directs people with mental disorders to the community mental health services, shifting from a single option to a broad scope of services and care providers, and deconstructing the institutionalized knowledge and practices prescribed for treating madness. The deinstitutionalization practice is based on the understanding that the psychiatric hospital is not the appropriate space for people with mental disorders, hence it is necessary to build new spaces in which to live and produce subjectivity.

In August 1971, the then director of the Psychiatric Hospital of Trieste, Italy, the psychiatrist, Franco Basaglia, began a project involving many social segments, which sought to de-activate the referred hospital and grant freedom to its patients, allowing for the recovery of their dignity and their citizenship, which had been lost with the institutionalization. To do so, the hospital and asylum treatment were substituted by new care structures and therapies for mental health, and connected to a network of support systems, such as guided work cooperatives and assisted living. The initiative in Italy was the origin of a political struggle to socially transform the way of dealing with madness, which would have expressive repercussions worldwide[20].

In the United States, deinstitutionalization appeared as a series of de-hospitalization measures, which included the prevention of psychiatric institutionalization, the possibility of having community treatment, and the establishment and maintenance of networks of community support for the patients outside of the institutions. Basaglia expanded and consolidated a new meaning for the concept discussed here, which was marked by the epistemological criticism of medical knowledge and by questioning the limitations that mental health imposed on the rights of the citizens[21].

The psychiatric reforms in Italy and Brazil took place in different historical and cultural contexts. Although the National Policy for Mental Health in Brazil has not been able to extinguish psychiatric hospitals, as it happened in Italy, it was quite successful in reducing their numbers and consolidating a network of mental health services, which, at great odds, guides psychiatric care[22].

The lives of the former patients of psychiatric hospitals, who went through BHP, as evidenced in this integrative review, corroborate the fact that deinstitutionalization allows for the construction and the invention of new perspectives of life and subjectivity. Such changes cannot be reduced to mere 'prognosis' or 'evolutions' of mental illness[21].

Psychiatric institutionalization places the subject at a location where there are no exchanges and the relationships of personal dependency are maintained. In the context of deinstitutionalization and territorial care, the actions which change relationships the most, and reorder positions, are those which do not disempower or infantilize the patient. Those actions promote social knowledge and stimulate empowerment, since they favor insertion, social contractualism, as well as expression and symmetry in relationships[23,24].

At this point, autonomy – a construct covered in some of the selected studies – emerges as a key-concept to contemplate the objectives of Psychiatric Reform and to reflect on BHP as a deinstitutionalization strategy. The production of autonomy within excluded individuals, or those in social disadvantage, includes the production of a life articulated with formal and informal networks of support, spaces of community living, work, leisure, culture, and art, as well as access to citizenship and public policies[25].

Regardless of the level of autonomy of the beneficiary, it is important to reiterate the need for further studies to be conducted on BHPs in order to investigate the different types of support available to the patients so as to help them make decisions, to help them take care of the money and understand the value of it in the present-day society. Following the deinstitutionalization logic, such elements may contribute with a better understanding of the process of the production of autonomy by the subject.

Although BHP has contributed to deinstitutionalization, as is evident in the examined literature, movements of psychiatric reform around the world have faced – and still face – challenges related to the rupture with the concepts and practices of the psychiatric model and the creation of a new scientific, ethical, and political paradigm. Due to their very nature of being able to produce tension in different manners, such reforms suffer rejection and social, political, and cultural attacks. Until the present moment, none of those reform movements has established itself as a definite historical achievement[26,27].

Before the Trieste experiment, for instance, Basaglia led two other attempts to overcome the asylum model, at the psychiatric hospitals of Gorizia and Colorno, without the desired success. Among the difficulties to reach the objectives, there was a resistance of the local administration in helping make the deinstitutionalization proposal work and the territorial psychiatric care a success. Administrative problems and a lack of political support were also confronted[20].

To illustrate the transformation of the Brazilian reality, between 2002 and 2015, more than 58% of the psychiatric hospitalization slots (at asylum-like institutions administered by SUS) were progressively closed, and in the meantime, a network of substitutive services was created, and the RAPS was established with a strong territorial basis. By 2016, nearly 2,209 Psychosocial Care Centers and 619 RTS had been implemented, and more than four thousand people benefited from the BHP[28].

Currently, the crisis the country is suffering in the social, political, economic, and sanitary areas, combined with the management by authoritarian political groups, with a liberal mindset and who despise social policies, have caused setbacks in the field of mental health, with the dismantling of RAPS. The new guidelines for mental health policies, for example, have introduced psychiatric hospitals in the RAPS and have created private lines of funding for psychiatric services[26,29].

Furthermore, there are still towns which did not adhere to and did not implement policies or strategies which aim at deinstitutionalization, such as the BHP and the RTS. To aggravate this scenario, the government has not offered resources and incentives required for important components of the network of mental health care, such as community centers and cooperatives, which may contribute to the development of autonomy and to the social reinsertion of these individuals[30].

In synthesis, the scenario found in the current integrative review indicates that being a BHPbeneficiary, means, at the same time having the chance of being the protagonist of one's own life and story. That chance is influenced by the damage to the mental health suffered and by the difficulties of becoming an autonomous social being. Such barriers can be noticed in the problems faced by those individuals on a daily basis. Such problems do affect the beneficiaries in their microspace of interaction, in their daily tasks, in their attempts to belong and in their relationships with others. Moreover, the profile of the former patients of asylums is, in itself, a challenge for care strategies aimed at promoting deinstitutionalization and social insertion.

At the same time, we understand that the idea of the BHP, in the context of mental health promotion and psychiatric deinstitutionalization, does not mean to remove the responsibility of the government, pushing the patients towards total autonomy, which is not always possible. The BHP must act as a booster of participation in society, according to the limits in which the individual is able to establish relationships and live in this society. It is therefore necessary for political conditions to be developed.

Final considerations

Despite the low level of evidence found in the studies, we can say that the BHP brought advancements in the field of social achievements

and in the deinstitutionalization of former psychiatric institution patients. However, the program does face challenges which must be overcome, in terms of accessibility, of equal distribution throughout all the regions of Brazil, of professional training for a better use of the program, and the implications of the individual in the appropriation of the resources.

We recommend the funding and the development of scientific research, with different methodological designs and more levels of evidence, which cover the BHP as a strategy of deinstitutionalization at both local and national levels. It is relevant that such studies include different actors with the aim of identifying the advancements and the hurdles in establishing and strengthening the program. It is also crucial that future investigations interconnect the BHP with other strategies for the production of autonomy, the recovery of citizenship, the access to the mental healthcare network, the return to the family, and the insertion of the beneficiary in the job market.

Collaborations

All of the authors had equal participation in the conception and design of the study, in the analyses and interpretation of the data, and in the writing and critical review of the article.

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