Therapeutic Residential Services in the city of Rio de Janeiro: an analysis of the structure and process of care

Serviços Residenciais Terapêuticos na cidade do Rio de Janeiro: uma análise da estrutura e do processo de cuidado

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ABSTRACT This paper aims to analyze the structure and the process of care in the existing Therapeutic Residential Services for people with mental health problems in the city of Rio de Janeiro. This is a cross-sectional study focused on the collection of primary information through a structured instrument. The research was conducted in all facilities operating in December 2016. In Rio de Janeiro, Therapeutic Residences receive mainly long-stay patients from mental hospitals (94.3%), with a large number of vacancies in devices with a 24-hours daily presence of staff (63.8%). A significant part of dwellers had a low frequency in the care activities of the Psychosocial Care Centers (48.7%). The internal care in the residential facilities points to a model with strong interweaving between housing and the psychosocial rehabilitation actions. The low turnover of users shows a trend towards the establishment of services with long-term care, which should be taken into account in the maintenance and expansion of the program to plan effective services. The results show that grants to support deinstitutionalization, and mainly the income received from the Continuous Cash Benefit program are vital to the program's sustainability.

KEYWORDS Deinstitutionalization. Mental health care. Residential facilities. Brazil.

RESUMO *O objetivo do artigo foi analisar a estrutura e o processo de cuidado nos Serviços Residenciais Terapêuticos existentes no município do Rio de Janeiro. Trata-se de um estudo transversal que se concentrou na coleta de informações primárias por meio de instrumento estruturado. A pesquisa foi realizada em todos os dispositivos em funcionamento no mês de dezembro de 2016. No Rio de Janeiro, as Residências Terapêuticas recebem essencialmente pacientes egressos de internações psiquiátricas de longa permanência (94,3%), com grande oferta de vagas em dispositivos com presença de equipe nas 24 horas do dia (63,8%). Foi constatado que parte significativa dos moradores apresentava baixa frequência nas atividades assistenciais dos Centros de Atenção Psicossocial (48,7%). O cuidado interno nos dispositivos residenciais aponta para uma modelagem com forte entrelaçamento entre a moradia e as ações de reabilitação psicossocial. A baixa rotatividade de usuários mostra uma tendência para constituição de serviços com cuidado de longo prazo, o que deve ser levado em conta na manutenção e na expansão do programa no intuito de planejar serviços efetivos. Os resultados apontam que as bolsas de apoio à desinstitucionalização e, principalmente, a renda contínua aferida mediante o Benefício de Prestação Continuada são vitais para a sustentabilidade do programa.*

PALAVRAS-CHAVE *Desinstitucionalização. Saúde mental. Serviços Residenciais Terapêuticos. Brasil.*

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Introduction

Since the 1950s, several countries have implemented mental health policies based on the common central element of shifting the axis of care from hospital to the community, characterizing the process called deinstitutionalization of psychiatric care[1]. This paper aims to analyze the functioning of Therapeutic Residential Services (TRS) in mental health in the city of Rio de Janeiro in 2016, with an emphasis on its structure and the care process.

Shorter[2] affirms that the primary issue in the post-WW2 years is the gradual inclusion of mental health in the scope of social insurance and the welfare state. He considers that the 1970s witnessed the important inflection concerning deinstitutionalization, with lower availability of beds in all European countries, marked by the integration of psychiatric care with health systems.

As stated, the paradigm shift in treatment for people with mental disorders has shifted from the psychiatric hospital-centered model to community-based treatment. Among the principles of European psychiatric reform are: 1) deinstitutionalization and closure of beds in psychiatric hospitals; 2) implantation of community devices; 3) integration with other health devices, and 4) integration with social and community devices. The deinstitutionalization process was not uniform in all European countries, with different levels of service implementation, but most countries, especially in Western Europe, have a comprehensive network of quality community services in mental health[3].

Among the so-called community devices are homes with clinical and social support implemented to allow people with mental health problems to live in the community. They are currently considered crucial permanent components of mental health systems and are gradually replacing psychiatric hospitals for long-term care[4].

People requiring these services often have severe and complex mental health problems such as schizophrenia, with associated difficulties that impair their ability to manage everyday life. The support they require includes assistance with medication management, personal care, and other activities of daily living. Many have health problems related to a combination of inadequate diet, lack of exercise, smoking, and psychotropic side effects. Most have no job and can be socially isolated. They may then require support to access community resources and to stay in touch with family and friends[5].

Although they were initially created to enable long-stay patients to be discharged from psychiatric hospitals, residential devices have acquired other functions over time, such as the provision of rehabilitation services for a limited time, accommodation for people living in the streets with mental disorders, crisis intervention as an alternative to hospitalization, and transition to independent life after short hospitalizations. They may evidence different realities between countries or even regions of the same country, differing in goals, rules, size, location, level and characteristics of teams, length of stay, environmental features, and target population[4].

In Brazil, the housing program aimed at the dehospitalization of patients with mental disorders in a situation of prolonged hospital stay was implemented as an official policy of the Ministry of Health in 2000. The device was named SRT (TRS in English)[6] under the Unified Health System (SUS). By definition of their regulating ordinance, they are configured as community-inserted dwellings, destined to people discharged from prolonged hospitalizations in psychiatric hospitals (up to eight residents per module), with rare or no family support, from the perspective of psychosocial rehabilitation. In 2011, Ordinance Nº 3.090 was published, creating

a typology of Therapeutic Residence (TR), where type II residence is for users with higher levels of dependence that require more intensive care, and can accommodate a maximum of ten residents[7].

Following the guidelines of the national policy, the mental health policy of Rio de Janeiro has pointed to a gradual decline in psychiatric hospital beds, with a significant fall in the last two decades. Part of the extinct beds was occupied by people living in psychiatric hospitals (long-term institutional stay), with low possibilities for hospital discharge, without adequate psychosocial support. The TR program is the main instrument to enable them to return to community life. This study aims to contribute to the improvement of the city's public mental health policy.

Methods

The exploratory, case study, cross-sectional, and descriptive study focused on the collection of primary information to describe the structure and care process in TR under the management of the Municipal Health Secretariat of Rio de Janeiro.

The research was carried out in all 80 TRS operating in the city in December 2016. Data were collected by a structured instrument built in the form of modules to achieve the objective, as follows: unit identification; structure; access and turnover; mental health care; general health care; work, leisure and income; TRS daily routine and team composition. The instruments were distributed to the 80 respondents for completion and subsequent return. The option of self-completion was due to a large amount of administrative information demanded that required time to respond. The respondents were professionals called Therapeutic Companions (TC), who are the home's reference technicians (one per home). They are top-level health professionals with work focused on the psychosocial rehabilitation of patients with severe and persistent mental disorders. Moreover, they exercise a function of supervision and organization of the caregivers' work process[8].

The data were analyzed using descriptive statistics in SPPS 24.0 environment. The research project was submitted to the Research Ethics Committee of the National School of Public Health Sergio Arouca (CEP – Ensp), and of the Municipal Health Secretariat of Rio de Janeiro (CEP – SMSRJ), and was approved under numbers 57805816.0.0000.5240 and 57805816.0.3001.5279, respectively.

Results and discussion

The structure of Therapeutic Residential Services

Eighty residential modules with an installed capacity of 464 vacancies were in place in the city of Rio de Janeiro at the time of data collection. In total, 439 people were living in the devices, reflecting a very high occupancy rate of 94.6%. Of the vacancies, 57% were occupied by men, while 43% were women. Of the residents, 41% were over the age of 60 *(table 1)*.

Table 1. Profile of residents and structure of Therapeutic Residential Services (TRS) (N=439). Rio de Janeiro, December 2016

Description		Frequency	%
No of male residents		252	57
No of female residents		187	43
No of residents aged 60 years and over		179	41
No of residents originating from long hospital stay		414	94,3
Residents who entered the TRS in the last 12 months		125	28,5
TRS Type	Type I	29	36,2
	Type II	51	63,8
Property Type	Home	61	76,3
	Apartment	19	23,7
Property	Rented	61	76,3
	Owned	19	23,7
Accredited at the Ministry of Health	Yes	38	47,5
TRS outside the boundaries of psychiatric hospitals		80	100
TRS located up to 15 minutes from commercial centers (walking distance)		78	97,5

Source: Research 'Structure and care process in Therapeutic Residential Services in the city of Rio de Janeiro'.

It is worth mentioning the number of older adults residing in residential modules, as they will probably require more complex care over time. Silva and collaborators argue that the shift of institutionalized older adults with severe mental disorders from the hospital to community devices can be a particularly difficult experience since, in this population, the condition of vulnerability observed in other seniors in the face of physical and mental health conditions is aggravated by the deleterious effects of institutionalization, such as the loss of autonomy and abilities for daily life[9].

Of all residents, 414 (94.3%) originated from long-term psychiatric hospitalizations, here understood as hospitalizations of two years or more. This finding sets a well-defined admission criterion and characterizes a profile of homes aimed almost exclusively at the deinstitutionalization of residents of psychiatric hospitals, not benefiting people with severe mental disorders, with no history of lengthy psychiatric hospitalizations, but who require intensive care, including housing. As Furtado et al. comment, the fact that TRS are intended only for long-term patients neglects part of the population served at the Psychosocial Care Center (Caps) with housing needs and who are not backed by public policies and systematic support that are intended to this question[10].

During the last 12 months, 125 patients entered the city's TRS, representing 28.5% of the total number of existing residents, with 14 of the existing TRs inaugurated in 2016. In the same period, 26 deaths were recorded, and 9 people stopped living in residential modules. When respondents were asked about the fate of residents who stopped living in the TRs in the last year, the answer was that six moved to other TRS, and three returned to the family.

The low rate of departures (except deaths) of the TRS points to a trend towards building long-term care homes. Thus, homes acquire a permanent housing character, in which the residents live indefinitely, and it is not

expected that a user's itinerary will occur in the sense of higher autonomy settings and for the autonomous exit to community life.

Fakhoury and collaborators consider that, for a group of residents, residential devices can be characterized as long-term care settings. In contrast, for others, new forms of psychosocial rehabilitation are essential to allow the transformation of devices into transition places for more independent community life[11]. This conception is consistent with the Canadian experience of the residential continuum in which the patient moves, depending on the complexity of the necessary care, in residential devices ranging from more structured homes to homes with lower support for autonomous life[12].

In a study on the typology of residential devices for people with severe psychological distress in England, Bigelow points out that a significant part of patients from long-term beds has the potential for rapid recovery if sufficiently intensive rehabilitation services are provided, including the way-station modality. This type of home works as a gradual model, in which the objective is to learn abilities for independent living[13].

In Brazil, the number of vacancies per device is limited to 8 for type 1 homes, and 12, for type 2 homes, due to the Ministry of Health's regulations. The mean number of vacancies per home in Rio de Janeiro's residential devices was 5.8. It is expected that a low number of residents per household will allow for more individual monitoring and increase the possibility of adopting a less institutionalized environment. Trieman points out that building bonds among them and achieving greater cooperativism is highly likely in environments with a lower number of residents since a smaller setting favors exchange between peers[14]. In Italy, the parameter of the capacity of residents per home is more flexible, reaching a limit of 20 people per home[15].

Analyzing the structure of the TRS, concerning the type of residential devices, 51 (63.8%) were type II modules, with 24-hour intensive care (with the presence of a team); and 29 (36.2%) were type I, with flexible monitoring of the team in the homes – in a variable period that reaches up to 12 hours a day.

The presence of a team in the modules can provide a more institutional character to the homes, and often contrasts with the opinion of users, as there is evidence of their preference for more independent models of living, in ordinary homes with more flexible home support, valuing independence and privacy, instead of living permanently with the team's presence. This desire often conflicts with the opinion of care teams and relatives, who tend to choose more structured options, with more intense monitoring[16].

The devices were predominantly distributed in homes (73.6%) in the rental mode (73.6%). The TR program of the Municipal Health Secretariat of Rio de Janeiro is run through a management contract with a non-governmental institution responsible for renting homes.

The homes were located outside psychiatric hospitals, and almost all were close to urbanized areas, which is essential to promote social integration. Among the existing TRs, 38 of the 80 homes were accredited by the Ministry of Health, with regular financial transfers of resources by the Federal Government to 47.5% of the residential modules, resulting in a financial burden for the municipal authority. As for the physical structure, the mean number of rooms was 3.6 rooms per TRS, with a mean of 0.6 rooms per resident, and 1.96 bathrooms per home (0.4 per resident). The subjective experiences of users can be influenced by a range of factors, such as, for example, the characteristics of the service, relationships with staff, the intensity and nature of the support. Besides these factors, the physical structure of the environment should be included, which can be a component that positively affects the quality of care[17].

The care process

In Rio de Janeiro, the 160 existing neighborhoods are clustered by the Municipal Health Secretariat into ten Programmatic Areas (AP): 1.0 (Centro e adjacências), 2.1 (Zona Sul), 2.2 (Grande Tijuca), 3.1 (Região da Leopoldina), 3.2 (Grande Méier), 3.3 (Região de Madureira e adjacências), 4.0 (Região de Jacarepaguá e adjacências), 5.1 (Região de Bangu e adjacências), 5.2 (Região de Campo Grande e adjacências), 5.3 (Região de Santa Cruz e adjacências)18.

AP 4.0, which encompasses the neighborhoods of Jacarepaguá and Barra da Tijuca, concentrated almost 50% of the TRS, with 39 houses within their territory. This health region is specific due to the location of the Juliano Moreira Municipal Institute (IMJM), which has been developing a residential deinstitutionalization program since 2000, geared to its inpatients and patients coming from some psychiatric hospitals with beds contracted by the SUS that have been de-accredited over time. Next, AP 3.2 appeared as the second area with the highest number of TRS (10), justified because it is the region of the city where the Nise da Silveira Municipal Health Care Institute (Imas) is based, which, similarly to the IMJM, was a large psychiatric hospital that has been developing deinstitutionalization programs for several years.

Regarding the process of implementing TR in the city of Rio de Janeiro, the first TR was implemented in 1998, linked to the Philippe Pinel Municipal Institute, at the time still under federal management. In 2000, more residential devices were gradually being implemented with the TRs already standardized by the Ministry of Health. A substantial expansion of the program was observed in the last six years after a low implementation triennium (2008-2010), corresponding to almost 69% of the units implemented, as shown in *table 2*.

Table 2. Therapeutic Residential Services by year of implementation. Rio de Janeiro, December 2016

Years of implementation	Frequency	%
From 1998 to 2007	19	23,75
From 2008 to 2010	6	7,5
From 2011 to 2013	23	28,75
From 2014 to 2016	32	40
Total	**80**	**100**

Source: Research 'Structure and care process in Therapeutic Residential Services in the city of Rio de Janeiro'.

As for the organization of the mental health care process, all TRs in the city are institutionally linked to the Caps. They are expected to be the psychosocial care and monitoring devices of TR residents. The follow-up team is the name adopted by the Municipal Health Department to designate the Caps team that monitors TRS and manages cases in the territory. It thus differs from the team located in the Caps and offers

other types of care. It consists of one coordinator, one Therapeutic Companion (TC), caregivers, and nursing technicians – the latter are for type II modules. The team is responsible for offering daily support, favoring home care, and it is expected that they operate as a resource for building the social bond of patients in the process of deinstitutionalization, and as a point of integration of community resources for psychosocial rehabilitation projects[8,19].

An intense concentration of TRS linked to a few Caps was observed: two Caps from AP 4 (Arthur Bispo do Rosário and Manuel de Barros) were responsible for monitoring almost half of the residential modules – 23 (28%) and 16 (20%) of the total teams, respectively. Caps Clarice Lispector was responsible for 8 TRS (10%), and the remaining TRS were distributed among 14 Caps, ranging from 1 to 4 TRs per Caps. As expected, 425 (96.8%) of TR residents were enrolled in the Caps, of which 166 (37.8%) attended the service weekly, 59 (13.4%), fortnightly, and 214 (48.7%) attended Caps monthly or more sporadically. Some residents attended services less than quarterly, characterizing care with less intensive features, and fourteen residents did not attend services.

This situation points to the relevance of the segment teams as a care strategy. When asked which psychosocial care actions were taking place in the TRS, undertaken by the team of caregivers, TA, and nursing technicians (segment teams), the respondents answered that leisure, residents appropriating the home and the territory, building autonomy, and self-care are the most frequent actions. It can be considered that a psychosocial rehabilitation work internal to the residential devices is in place (carried out within the homes). This model can be included in the typology proposed by Nelson and supportive housing collaborators, in which housing and psychosocial rehabilitation[20] intertwine.

The low presence of TR residents in the city of Rio de Janeiro in Caps care activities can be compared with a similar situation in England that shows that, among all patients who live in residential modules, only half attend mental health treatment centers. One of the arguments that explain this phenomenon is the fact that these patients carry out rehabilitation activities through the teams of the residential modules, not demanding the treatment offered by the community mental health care team. The authors warn that this arrangement may not reflect active rehabilitation and may hardly do anything to improve patients' autonomy[21].

Regarding the technical monitoring of residents, 42 (52.5%) of the modules held regular meetings to discuss cases; and 47 (58.8%) of the users had Unique Therapeutic Projects (PTS). These two indicators were established as a reference for assessing the quality of care. These findings may point to a low integration in clinical management and point to a possible problem in the quality of the follow-up performed by Caps. By definition of Boccardo and colleagues, the PTS is a plan whose care strategy is to organize, through articulated actions developed by a multidisciplinary team and defined from the individual's uniqueness, a continuous psychosocial care process that enables the production of autonomy, leadership and social inclusion of users[22].

Table 3 shows that, among all residents, 316 (72.0%) were diagnosed with schizophrenia. The literature points out that, as in the case of Rio de Janeiro, schizophrenia is the predominant diagnosis among residents of residential devices, as observed in English, Italian, and Danish homes[21,23,24]. Thornicroft and Tansella state that one of the most important findings in the epidemiology of schizophrenia is the proportion of patients who suffer from moderate and severe levels of disabilities in the personal, domestic, family, and work spheres. The

mental health service must be involved in providing a range of integrated and long-term interventions, both to prevent the condition from deteriorating and minimize the disabilities caused by the disorder[25].

Table 3. Mental health care provided to residents of Therapeutic Homes. Rio de Janeiro, December 2016

Description	Frequency	%
No of residents with schizophrenia diagnosis	316	72,0
No of residents using psychoactive drugs	406	92,5
No of residents using three or more psychoactive drugs	306	69,7
No of residents using anti-psychotic drugs	340	77,4
No of residents without care at Caps by a psychiatrist for three or more months	142	32,6
No of residents in individual psychotherapeutic care	106	24,1
No of residents who attended therapeutic workshops	147	33,7

Source: Research 'Structure and care process in Therapeutic Residential Services in the city of Rio de Janeiro'.

Regarding the types of mental health care offered to residents of the city's TRs, the pharmacological intervention was the most prevalent: 406 (92.5%) residents used psychoactive medication, with 306 (69.7%) using three or more psychotropic drugs; and 340 (77.4%) used antipsychotics. Despite the extensive use of psychiatric drugs, 142 (32.6%) residents were without psychiatric medical care for more than three months.

The international literature calls for the use of two or more psychoactive medications used to treat the same individual or for the same diagnostic or symptomatic condition of polypharmacy[26]. In a study on the prescription of psychotropic drugs in Italian residential devices, Tomasi and colleagues refer that the average use of psychotropic drugs is 2.7 (median 3) per resident. The authors point out that polymedication is common and that international guidelines for prescribing medications for schizophrenia do not recommend the associated use of antipsychotics. On the contrary, monotherapy is associated with benefits for the general medical condition. The use of multiple psychotropic drugs is associated with an increase in adverse effects and a declining survival rate. They conclude that the prescription pattern in homes has a high rate of use associated with multiple medications, with variations in the prescription patterns and a weak relationship between diagnosis and prescription[27].

According to the conclusions of a systematic review study published in 2013, the evidence for the effectiveness of polypharmacy use with antipsychotics emanating from clinical trials is inconsistent. However, therapy is associated with a range of undesirable effects and low adherence to treatment. They state that all clinical guidelines for schizophrenia recommend monotherapy and suggest the use of polypharmacy as the last resort[28].

Regarding other technical interventions, 106 residents (24.1%) received individual psychotherapeutic care, and 147 (33.7%) participated in therapeutic workshops, and

this was the primary non-medication follow-up offered by Caps to TR residents. When asked which therapeutic workshops were most attended by residents, the activities of music, body expression, manual activities, and sports and leisure were mentioned. The therapeutic workshop is a generic term that encompasses a set of varied activities within a perspective of psychosocial care. According to Ribeiro and collaborators, the workshops can be characterized as group activities aimed at socializing relatives and users, expressing emotions and feelings, and developing autonomy and skills[29].

As for the mechanisms of economic support for deinstitutionalization, most residents benefited from grants and income transfer policies, with 331 (75.4%) receiving the Continuous Cash Benefit (BPC), 159 (36.2%) received the incentive grant for monitoring and integration outside the hospital unit (Bolsa Rio), provided for by Municipal Law Nº 3.400/2002, 31 (7.1%) resorted to Psychosocial Rehabilitation Assistance from the 'De Volta para Casa' ('Back Home') Program (PVC) and 50 (11.4%) received pensions or other benefits *(table 4)*.

Table 4. Benefits and grants received by residents of Therapeutic Homes. Rio de Janeiro, December 2016

Description	Frequency	%
No of residents receiving BPC	331	75,4
No of residents receiving Bolsa Rio	159	36,2
No of residents receiving PVC	31	7,1
No of residents receiving pensions	21	4,8
No of residents receiving another type of benefit	29	6,6

Source: Research 'Structure and care process in Therapeutic Residential Services in the city of Rio de Janeiro'.
BPC = Continuous Cash Benefit; PVC = Going Home Program Benefit.

The BPC is a constitutional right linked to the Ministry of Social Development and Fight Against Hunger (MDS) and regulated by the Social Assistance Organic Law (Loas), and is operationalized by the National Social Security Institute. It was instituted to transfer income to older adults and disabled people and integrates basic social protection within the Unified Social Assistance System. As an eligibility criterion, per capita family income must be proven to be less than a quarter of the minimum wage[30].

One of the possible explanations for the low adherence to PVC is the amount of the aid, since the municipal grant pays a minimum wage, while PVC pays R$ 412.00. Unlike the BPC, the municipal and federal grants are not cumulative. As for the municipal grant, the requesting subject must have been institutionalized by the year 2000 and with at least three consecutive years of hospitalization in a psychiatric hospital[31]. Many residents are no longer entitled to this income due to more recent institutionalization. Regarding PVC, the current selection criterion is psychiatric hospitalization for 2 years[32].

Final considerations

In Rio de Janeiro, the TRS program was

undergoing substantial expansion (mainly in the 2011-2016 period), pointing to a remarkable effort by the municipal authority in its implementation. It aimed to provide community life and psychosocial support for people with severe mental disorders who were previously institutionalized in psychiatric hospitals.

The program is characterized by long-term care. Discharges occur mainly due to deaths. Managers must take this data into account when maintaining and expanding the program to plan effective services. The results show that scholarships and, mainly, the continuous income measured through the BPC are vital for the sustainability of the program.

The physical structure of the TRS was entirely satisfactory, and the quality of the facilities can positively influence the quality of care. The average number of people living in a house was small when compared to other countries, as well as concerning the baselines established by the guidelines of the Ministry of Health. A home consisting of few residents can be a successful experience for the deinstitutionalization process since more closely dates the interaction and daily life of a home. The economic impact of homes with few residents on the sustainability of more extensive programs should be the subject of further research.

It is noteworthy that a significant part of the TRS residents did not regularly visit the Caps, were without a unique therapeutic project, and their cases were not subject to systematic clinical discussion. These are data that point to weaknesses in the implementation of the TR program, and one of the reasons may be related to the intense concentration of residential modules in a few Caps. While a service served more than 20 TRS, others served only one, which probably overburdens Caps teams, compromising the services' capacity to monitor residents.

Another issue that deserves additional attention is the management of psychiatric medication in the context of TRs. The results of the study indicate that TRs in the city of Rio de Janeiro were highly medicalized environments – 406 residents regularly used psychotropic drugs. Therefore, medication played a central role in mental health intervention for the population studied. It should be noted that almost a third of users were not regularly monitored by psychiatrists and that almost half of the residents had low frequency in the Caps.

Finally, it is concluded that the TRS in Rio de Janeiro were intensive care devices for patients, with a psychosocial rehabilitation process provided by the teams of the residential modules of the houses and with a broad offering of vacancies 24 hours a day, which ensures the provision of care for those patients who demand more complex care. On the other hand, it is essential to assess whether this process is sufficient for active rehabilitation and improvement of autonomy or if there is a weakness concerning the psychosocial rehabilitation work that Caps-based community care teams can provide. A future challenge for residential programs is related to its expansion to new groups of people with mental disorders, besides those who have been hospitalized in psychiatric hospitals for long periods.

Collaborators

Soares LML (0000-0003-4051-560X)*, Silva PRF (0000-0003-0811-4080)* contributed equally to the elaboration of the manuscript. ■

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