

# Living in psychosocial rehabilitation: analysis between Two Residential Therapeutic Services

## *O habitar na reabilitação psicossocial: análise entre dois Serviços Residenciais Terapêuticos*

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**ABSTRACT** The objective of this study was to analyze the relation of housing conditions and needs of users with severe mental disorders at therapeutic residential services regarding social inclusion and autonomy. A cross-sectional study was conducted with 74 residents of residential therapeutic services in a city in the countryside of São Paulo. The Instrument for the Study of the Housing Conditions of People with Severe Mental Disorder was applied. Data were processed using the Statistical Package Social Sciences program through descriptive measures and statistical analysis with the chi-square test. A Confidence Interval of 95% and p-value <0.05 were considered. There was a predominance of the variables female gender, white, illiterate, without partners and without employment relationship, with users who had been residing for more than two years in the residential service and who were, on average, 38 years under psychiatric treatment. Differences between residential services in relation to social inclusion and autonomy of users were identified and the influence of the geographic location of these services is discussed. The centrality of therapeutic residences within the health network implies the promotion of insertion, autonomy, and satisfaction of residents. Thus, the fragility of housing compromises the effectiveness of psychosocial rehabilitation comprised in the triad work, social network and housing.

**KEYWORDS** Deinstitutionalization. Health mental. Mental health services. Health services research. Housing.

**RESUMO** Buscou-se analisar a interlocução das condições e das necessidades de moradia dos usuários em sofrimento psíquico grave dos Serviços Residenciais Terapêuticos em relação à inserção social e à autonomia. Pesquisa transversal realizada com 74 moradores dos Serviços Residenciais Terapêuticos de um município do interior do estado de São Paulo. Foi aplicado Instrumento para Estudos das Condições de Moradias de Portadores de Transtorno Mental Grave. O tratamento dos dados ocorreu por meio do programa Statistical Package Social Sciences, utilizando medidas descritivas e análise estatística com o teste qui-quadrado, considerando Intervalo de Confiança de 95% e p-valor <0,05. Entre os participantes, predominaram: sexo feminino, cor branca, não alfabetizado, sem parceiros e sem vínculo empregatício, morando mais que dois anos no serviço residencial e, em média, há 38 anos em tratamento psiquiátrico. Identificaram-se diferenças entre os serviços residenciais em relação à inserção social e à autonomia dos usuários e se discute a influência da localização geográfica desses serviços. A centralidade das residências terapêuticas à rede de saúde implica a promoção de inserção, autonomia e satisfação dos usuários em sofrimento psíquico grave. Assim, a fragilidade do habitar compromete a efetivação da reabilitação psicossocial compreendida no tripé: trabalho, rede social e moradia.

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**PALAVRAS-CHAVE** Desinstitucionalização. Saúde mental. Serviços de saúde mental. Pesquisa sobre serviços de saúde. Habitação.



## Introduction

The Brazilian Psychiatric Reform has brought about a transformation in the mental health care model. The repercussions of this process are numerous and are distributed in a continuum whose pattern is characteristic of socio-historical and cultural movements with advances and setbacks<sup>1</sup>. The approach proposed in this research refers to Residential Therapeutic Services (SRT) that are care devices that are part of the Psychosocial Care Network (Raps) and that represent a central implication in the process of psychosocial rehabilitation of people with severe and persistent mental disorders<sup>2</sup>.

Thus, the SRTs were made official in the Unified Health System (SUS) through Ordinance No. 106, 2000, published by the Ministry of Health. This document proposes that the SRTs be inserted, preferably, in the urban space and receive up to eight patients that had been in-hospital for long periods and who come from asylum institutions, counting on clinical and psychosocial support<sup>3</sup>. Subsequently, psychosocial rehabilitation assistance was instituted with the Programa De Volta pra Casa (Back to Home Program) (PVC) under Law No. 10,708, 2003, regulated by Ordinance No. 2,077, 2003, aimed at patients living in SRT and people affected by severe mental disorders who had been living in institutions for a minimum period of two years without interruption<sup>4</sup>.

Considering the health needs of people with severe and persistent mental disorders in the context of deinstitutionalization, two types of SRTs are proposed. Type I is intended for people with long-term hospitalization without family and social ties. It should receive from four to eight residents, who are linked to a reference mental health service/team to get the technical and specialized support necessary for the residential service. Residents are followed up according to their respective unique therapeutic projects, so as to create a space to build autonomy and have a daily routine and

social reintegration. Such support focuses on the process of psychosocial rehabilitation and insertion of residents in the existing social network (work, leisure, education, among others). The resident can have a caregiver, whose inclusion must be evaluated by the technical team responsible for the SRT monitoring, linked to the reference health equipment. It will depend on the care need of each group of residents, taking into account the number and level of autonomy of the residents<sup>5</sup>.

Type II consists of a modality aimed at those people with a greater degree of dependence, requiring intensive and specific care that demands directive actions with daily technical support and permanent staff, such as caregivers and nurses. It accommodates between four and ten residents. The referral of these patients should be planned according to the unique therapeutic project, elaborated during discharge from hospital, focusing on the re-appropriation of the residential space as a home, on developing skills for daily life, self-care, food, clothing, hygiene, ways of communication and increased conditions to establish emotional bonds, with the insertion of these patients in the existing social network. The home environment must consider changes and adaptations in the physical space that best meet the needs of residents<sup>5</sup>.

Housing acts as a social factor and, specifically for mental health, it becomes fundamental to insert, integrate, and maintain the user with a severe mental disorder in the social environment, which, together with work and the social network, constitutes the triad of psychosocial rehabilitation<sup>6,7</sup>.

In the SRT spaces, care should be provided in an assisted daily life, as the institutionalization at asylums caused the fragmentation of values, autonomy and family ties. The importance of a new perspective of life is emphasized, based on the rescue of the subject as a protagonist of his/her own history. In summary, the dimension of assistance is centered on the intermediation between care and autonomy, in the

sense of being able to recognize the subject's fragility in being part of and in performing daily activities intrinsic to living at a place<sup>8</sup>.

Although some advances from the implantation of SRTs and other services guided by the territorial and community reasoning for the process of reorganization of mental health care in Brazil are undeniable, some weaknesses are identified in the work process of these services and constitute challenges for the work and care in the SRT spaces. Among these, the following stand out: the distancing of the reference teams in mental health and care centered on the biomedical practices, which leads to the lack of unique therapeutic projects for the residents; the extremely diversified scope of the activities of caregivers, privileging concrete and everyday actions to the detriment of actions aimed at psychosocial rehabilitation and autonomy development; and the practice of surveillance and control, making it difficult to build a space for the sake of privacy<sup>9</sup>.

In addition to the issues mentioned, the municipality investigated in this research is in expanding the units of SRT and has two Psychosocial Care Centers (Caps) intended to take care of the people affected by serious and persistent mental disorders whose demand extrapolate the possible care provided by the services. It is worth mentioning that these services are managed by the municipality and the state, which leads to a peculiar organization and confers a particularity that differentiates them and that has consequences in the daily care.

From the above, the following research question is posed: 'How are the conditions and housing needs identified by users with severe mental distress at the SRT related to social inclusion and autonomy?'. Considering this question, the objective was to analyze the relationship between the conditions and housing needs of users in severe psychological distress in the SRT regarding social inclusion and autonomy.

## Material and methods

This is a cross-sectional descriptive and analytical research aimed at verifying the exposure (conditions and needs when residing in SRTs) in two groups of similar participants and their respective outcomes (social insertion and autonomy) in a single moment<sup>10</sup>.

Data collection was performed in a city in the countryside of the state of São Paulo/Brazil. Raps has 20 Basic Health Units, a Mobile Emergency Care Unit, two General Hospitals, one of which has a psychiatric inpatient unit with six beds, and a Reference Service on Alcohol and Other Drugs for inpatient care. The Comprehensive Health Care Center offers a psychiatric inpatient unit with beds for people with acute mental disorders, Type II Caps, an Alcohol and Drug Caps, a Therapeutic Workshop, and an STR. In addition, the municipal management also has an STR and Type I Caps. As a psychosocial rehabilitation strategy, 'Arte Convívio' is mentioned, which is based on solidary economy equipment that works as a cooperative.

All six SRTs in the municipality and their respective residents were included. Under state management, there were three therapeutic residences, two of which were type I and one type II, with 33 residents inserted in an assistance complex far from the urban area, approximately seven kilometers from a mall. Thus, without any kind of stores and services that could be attended by residents, their social life was restricted to the staff, family members, and other residents. Specialized technical support was provided by Caps II, which was part of the aforementioned care complex, and by a Family Health Unit, administered by the municipal administration.

Three other houses, classified as type I, were under the responsibility of the municipal administration and had 41 residents. These houses were distributed among neighborhoods in the urban area, close to shops and public places, allowing the residents to go out and have a greater social integration into the daily

lives of people who do not have a severe mental disorder. Expert technical support, in turn, was offered by Caps I and the Basic Health Unit, both administered by the municipality.

In the study, the outcomes of autonomy and social insertion are compared according to the geographic location of the therapeutic residences, which varies from complete social isolation, identified by the acronym SRT1, to the insertion in common neighborhoods in the municipality, which are identified as SRT2.

The sample consisted of all 74 users provided with the respective services, who met the following inclusion criteria: 1) to be a citizen of the city of study; 2) to live in an SRT dwelling; and 3) to show interest in participating in the research. Exclusion criteria were not listed. If a participant with severe cognitive impairment was not able to answer the data collection instrument, the caregiver was requested to respond to the data collection instruments. A piece of the information was accessed through the medical records of the participants who were consulted in the Caps where they were provided with service.

For data collection, the 'Instrument for the Study of Housing Conditions of People with Severe Mental Disorder' was applied. It is a questionnaire designed to investigate two main aspects of the concept of housing for those in severe psychological distress in the context of deinstitutionalization: aspects of material and

social life. It consists of 71 items distributed in 6 blocks: 1) Identification; 2) Aspects of the clinical picture; 3) Socioeconomic; 4) Property features; 5) Social insertion and Autonomy; and 6) Housing and Satisfaction<sup>11</sup>.

Data were analyzed using the Statistical Package for Social Sciences program, version 13.0, involving descriptive (absolute and relative frequencies, trend measures) and analytical statistics, with the chi-square test, considering a 95% confidence interval and p-value <0.05.

The study was approved by the Research Ethics Committee of the School of Medicine of Botucatu, receiving a favorable opinion on June 7, 2018, under No. 2,699,279. The Free and Informed Consent Term was adopted for the participant's legal guardian, and the Free and Informed Consent Term, for the research participant.

## Results

With regard to sociodemographic characteristics, the average age was 65.5 years (34-88 years). There was a predominance of women, white, illiterate, single, unemployed, and living in the SRT for more than two years. *Table 1* shows the absolute and relative frequencies of the sociodemographic variables.

Table 1. Characterization of the sociodemographic profile of the research participants. Botucatu (SP), Brasil, 2019. (n=74)

Variables	n	%
<b>Gender</b>		
Male	35	47.3%
Female	39	52.7%
<b>Color</b>		
White	42	56.8%
Black	17	23.0%
Yellow	12	16.2%
Brown	3	4.1%

Table 1. (cont.)

Variables	n	%
<b>Education</b>		
Literate	23	31.1%
Illiterate	51	68.9%
<b>Marital status</b>		
Single	72	97.3%
Widow/widower	1	1.4%
Divorced	1	1.4%
<b>Professional status</b>		
Unemployed	68	91.9%
Retired	2	2.7%
Wage earned with no official record	4	5.4%
<b>Time living in the SRT</b>		
Greater than or equal to 24 months	64	86.5%
Between 12 and 24 months	8	10.8%
Less than 6 months	2	2.7%

Source: Own elaboration.

As for the financial aspects, 81.1% (n = 60) received some type of government benefit, such as the Benefício de Prestação Continuada (BPC) and PVC. Part of the amount received by the participants was used to maintain the house and their household expenses. Their access to the rest of the money was intermediated and controlled, making it difficult for the users to have the autonomy to manage their financial resources. Regarding the number of residents per household, an average of 7 users was observed, ranging from 1 to 10, generating an average income of R\$ 713.90 (R\$ 240.80 to R\$ 1.020.80) for the group. Finally, a significant portion, 67.6% (n = 50), claimed to receive donations or help from third parties.

To describe the clinical profile, a medical diagnosis based on the International Statistical Classification of Diseases and Related Health Problems (ICD-10) was used. There was a higher frequency for the F20-F29 group – Schizophrenia, schizotypal and delusional

disorders, registered for 54.05% (n=40) of the participants. The second most prevalent group was F70-F79 – Intellectual disabilities, for 32.43% (n=24) of the participants. Then comes the F10-F19 group – Mental and behavioral disorders due to psychoactive substance use, with 4.1% of participants (n=3). With the same frequency, there is the diagnosis of other specified mental disorders due to brain injury or dysfunction and physical illness (F06.8). Two participants (2.7%) were diagnosed with histrionic personality disorder (F60.4), one participant, with bipolar affective disorder (F31.2) and another one with organic mental disorder (F09).

The duration of psychiatric treatment averaged 38 years, ranging from 1 to 64 years. During this period, the participants reported the number of hospitalizations ranging from 1 to 16 times, with an average of 2 hospitalizations. All of them reported having been admitted to a psychiatric hospital; 20.3% (n=15) to

Caps III; and 1.4% (n=1), to a private clinic. In contrast, 94.6% (n=70) denied admission to a general hospital. There were no occurrences of hospitalization in the therapeutic community. All users reported treatment with psychotropic drugs and follow-up by a professional or a team at Caps. Of these, 95.9% (n=71) reported being able to perceive that they could count on the help of a Caps provider or team.

The notion of the severity of the mental health problem was reported by 86.5% of the participants (n=64). Most users (79.7%, n=59) stated that their mental health problem has an extremely negative influence on their daily activities. A smaller portion indicated subtle (9.5%, n=7), very subtle (6.8%, n=5) or no influence (4.1%, n=3). Among the most affected activities, the relationship with family members was most frequently mentioned and reported

by 86.5% (n=64) of the participants, followed by housing (75.7%, n=56), relationships with other people (71, 6%, n=53), leisure (62.2%, n=46), and, finally, work and studies (23%, n=17). The relationship with a boyfriend/girlfriend was mentioned by a minority, 6.8% (n=5) of the participants.

Table 2 shows the comparison between the participants of the two SRTs regarding the activities that they perceived to be affected by the severity of the mental disorder. There was no statistical difference in the variables family relationship (p=0.712) and marital status (p=0.651). The SRT1 participants perceived a greater influence in leisure, housing, and relationships with other people, while the SRT2 participants pointed out work and studies, which showed statistically significant differences.

Table 2. Statistical analysis of activities influenced by severe mental disorder. Botucatu (SP), Brazil 2019. (n=74)

Variables	SRT 1 (n=33)		SRT 2 (n=41)		p-value
	N	%	N	%	
Occupation	4	12.12%	13	31.17%	0.056
Studies	4	12.12%	13	31.71%	0.056
Leisure	29	87.88%	17	41.46%	<0.001
Housing	30	90.91%	26	63.41%	0.007
Relationship with other people	31	93.94%	22	53.66%	<0.001

Source: Own elaboration.

Still regarding the clinical profile, 71.6% (n = 53) of the participants answered having comorbidity, which was distributed according to affected body systems. Cardiovascular and endocrine systems were more prevalent and were identified in 43.24% (n=32) and 36.48% (n=27) of the population, respectively. The others were respiratory (5.40%, n=4), motor (1.35%, n=1), nervous (6.77%, n=5), immune (4.05%, n=3) and gastrointestinal (6.77%, n=5) systems.

Regarding the legal condition of the house, 62.2% (n=46) reported having the house

provided by the government or the institution, while 37.8% (n=28) live in a rented house, with the cost being divided among the residents. As for the structure, 79.8% (n=59) lived in houses with four or five rooms. All houses fit into the category of an isolated building, and, on average, each participant shared the room with another user; however, this varied between not sharing or sharing with three other roommates.

Regarding places nearby (where they could go on foot), all of them said they lived near

some health service (hospital, first-aid stations, Basic Health Unit or Caps). Approximately half of the population (52.7%, n=39) reported being close to an education service (daycare centers or schools); and bank branches, shops in general, bakery, butcher, pharmacy, green-grocer, grocery store, supermarket and bars were mentioned by 55.4% (n=41). Places for entertainment (community centers, clubs, and squares) were less frequently mentioned (37.8%, n=28), as well as places for religious practice (32.4%, n=24). All of them stated that

security (police station) or social assistance services – Social Assistance Reference Center (Cras) – were not close to the houses.

Table 3 shows the comparison between the participants of the two SRTs regarding the social insertion and autonomy of the data collection instrument. In general, SRT2 participants had greater availability of services close to their homes, greater contact with strangers, and greater independence in daily activities. On the other hand, SRT1 participants received more visits.

Table 3. Statistical analysis of the variables of social inclusion and autonomy of participants according to SRT. Botucatu (SP), Brasil, 2019. (n=74)

Variables	SRT 1 (n=33)		SRT 2 (n=41)		p-valor
	N	%	N	%	
<b>Services close to the house</b>					
Education	33	100%	6	14.63%	<0.001
Markets and shops	0	0%	41	100%	<0.001
Entertainment	0	0%	28	68.29%	<0.001
Religion	0	0%	24	58.54%	<0.001
<b>Services close to the house they visit</b>					
Entertainment	2	6.06%	11	26.83%	0.030
Markets and shops	7	21.21%	24	58.54%	0.001
<b>People they talk with outside the house</b>					
Strangers	0	0%	12	29.27%	<0.001
<b>People who visit them at the house</b>					
Family	7	21.21%	2	4.88%	0.032
Neighbors	11	33.33%	0	0.0%	<0.001
People from the shelter	8	24.24%	1	2.44%	0.009
Nobody	16	48.48%	38	92.68%	<0.001
<b>Activities they do alone and without help</b>					
Personal Hygiene	16	48.48%	30	73.17%	0.029
Going to places of interest in the city	0	0.0%	13	31.71%	<0.001
Taking medication	0	0.0%	8	19.51%	0.007

Source: Own elaboration.

Of the services that are close to the house, there was no statistical difference between the SRTs analyzed for the variables security and social assistance services. The same

analysis occurred regarding the places that the participants attended: all of them said they went to health services (p=1.000); none of the participants in both SRTs attended security,

education services, or places for religious practice (p=1.000); two of each SRT attended Cras (p=1.000).

Despite the place of residence, the participants talk to neighbors, other users, or professionals of the Caps or SRT, with co-workers or traders. They did not mention people from the same religious background or lovers. For both situations, there was no statistical difference, with p-values > 0.05.

There was also no statistical difference for the question ‘when you have a problem and need help, who do you look for?’: Family members (p=0.195); users of other health services (p=1.000); church staff (p=1.000); city hall staff (p=1.000); Caps users (p=1.000); neighbors (p=0.084); shelter staff (p=0.499); co-workers (p=1.000); nobody (p=0.249).

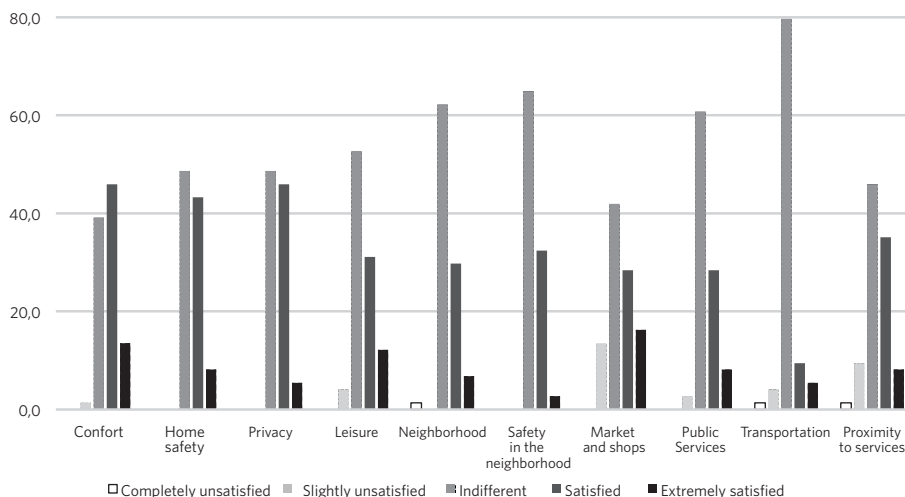
The participants did not report having received visits from users of other health services, church staff, city hall staff, Caps users, or co-workers. All of them reported

having received visits from health professionals from some basic or strategic psychosocial care service. For both cases, there were no statistical differences (p> 0.05).

Regarding the activities that the participants were able to do alone, 4.88% (n=2) reported being able to go to the bank to receive their money, and 9.76% (n=4) reported making purchases and payments, all of which were residents of SRT2 (n=41) – with no statistical difference between the SRTs, with p-values equal to p=0.124 and p=0.449, respectively.

Finally, the degree of satisfaction of the participants in relation to the SRT in which they resided was verified. The SRT2 participants were more satisfied since the overall score was 33 (SD ± 31-43) for the SRT1 participants and 36 (SD ± 31-51) for those in SRT2. The analysis of this variable showed a statistically significant difference with a p-value of 0.039. *Graph 1* details each of the factors analyzed.

Graph 1. Participants' satisfaction regarding the SRTs. Botucatu (SP). Brazil, 2019. (n=74)



Source: Own elaboration.



## Discussion

The profile of the residents of the surveyed SRTs shows an age group that characterizes an elderly population, with a slight predominance of women, illiterate and without partners. Regarding gender, in a similar population in a study in Brazil, there was a predominance of males, differing from the findings of this research<sup>12-15</sup>. The age range of the population investigated in this study was greater than the one found in the profile of SRT residents in other regions of Brazil<sup>12-15</sup>, in general, with a difference of ten years. The following characteristics are similar: marital status and lack of literacy<sup>12-14</sup>.

Almost half of the sample corresponded to people who received a psychiatric diagnosis of schizophrenia, followed by intellectual disabilities. This characteristic can also be verified in other studies in which primary psychotic disorder was prevalent (76.8%)<sup>13,16-17</sup> and corresponds to an inheritance of the asylum model. In a similar population, the occurrence of psychiatric diagnoses also focused on schizophrenia and intellectual disabilities<sup>14</sup>, but the latter was found more in this research.

Still regarding the psychodiagnosis, there was a number of institutionalized users in psychiatric hospitals that need to be better understood (35.8%); this population has been described with unspecified organic psychoses or unspecified schizophrenias or other schizophrenias<sup>16</sup>. In contrast, the results of this research showed an occurrence of 12.16% (n=9) of unspecified psychodiagnosis; however, this percentage was higher than the one found in an investigation with SRT residents in northeastern Brazil<sup>14</sup>.

It is worth noting that 40.54% of the population (n=30) were admitted only once to a psychiatric hospital, remaining institutionalized after that, under drug treatment and asylum practice. This situation corroborates the results of other studies<sup>15-17</sup> and refers to the discussion of the centrality of the asylum model in the care of the user with a severe mental disorder, associated with the fragility

of operationalizing community-based and territorial care, with sufficient substitute services in Raps – characteristics of the Brazilian asylum model that has been gradually deconstructed with the Psychiatric Reform<sup>18</sup>.

Another side of the asylum model observed in this population was the impact on daily activities, especially family relationships. This starts even in the psychiatric hospitalization of people with severe mental disorders, since a significant percentage (74.4%, n=55) indicated that they did not receive visits<sup>16</sup> – and this lasts throughout their stay in the asylum apparatus, as reflected by residents of an SRT of the São Paulo metropolitan region<sup>19</sup>. It is worth noting that a small number of participants (12.16%, n=9) reported having received visits from family members at the SRT, which differs from another survey that registered just over half of the investigated sample<sup>14</sup>.

The asylum model produced the exclusion of madness from social life, so the patients were isolated from the city, family, leisure, work, culture, and the right to social participation, leading to the loss of the citizenship status<sup>20</sup>. This issue has harmed and harms emotional relationships and social exchanges, which are extremely important for psychosocial rehabilitation.

The results of this research allowed us to observe that the residents of SRT2 have a greater perception of the impacts attributed to severe mental disorders in their daily activities. From this perspective, it can be inferred that the departure from the asylum apparatus with consequent re-establishment in the territory, through the SRTs, allows the person with severe mental disorder to develop the perception of psychosocial losses resulting from the asylum model.

This characteristic supports an uncompromising defense about the insertion of SRTs in the central spaces of the city. Curiously, in relation to this positioning, the results found among residents of SRT1 and SRT2 pointed to different characteristics: although the geographic location of SRT2 is favorable for the

insertion and autonomy because it is close to several community services, in the SRT1, the residents receive more visitors. It is important to note that both differences showed statistical significance.

Social reintegration must consider possible reconstruction, within the limits of each subject. The conquest of the spaces of the territory is fundamental in the construction of the reintegration scenario and can be a space for experiments offered by the encounter between madness and the city<sup>21</sup>, advancing in the socio-cultural dimension of Psychiatric Reform, as it mobilizes the social ideal in order to resolve the stigma and prejudice surrounding madness<sup>1</sup>.

Regarding the social insertion of the residents of the SRT in this study, the centrality of this device in health services was observed. Concretely, the exclusive relationship between SRT and the health care network became evident when all of them reported having attended health services and, at the same time, not attending education, security, or religious services. Therefore, there is an extremely restricted social occupation centered on health services. When observing the profile of the participants, the need to constitute work in the SRT based on intersectoral equipment is pointed out.

Leaving the psychiatric institution and arriving at the SRT does not guarantee that people with a severe mental disorder have a real change in the asylum lifestyle, and they can reproduce the institutionalized daily life in the house, locking themselves in their rooms, refusing to participate in house chores and remaining in a situation of profound passivity waiting for care and protection to which they were once subjected<sup>8</sup>.

As a result, the perpetuation and renewal of the asylum mode in community care practices are verified, producing a great difficulty in turning SRTs into homes, since these residents are subject to multiple rules and hardly have spaces for privacy, where there is nobody listening or staring, with constant presence and control of workers and housemates<sup>6</sup>.

SRTs have the characteristic of standardizing

the arrangement of furniture and objects, mainly due to the concern of caregivers in maintaining order in the place, making it difficult to listen to and accept demands that are not part of the routine. It is evident that there are rules and moral values that guide residents in the way they act or behave with each other. The housing space requires plasticity to the intentions of its residents and flexibility in supporting. It is a diversification not restricted to the simple expansion of the predefined types that will impose the construction of external ideas on the subjects and their specific needs<sup>6</sup>.

It was observed that 81.1% (n = 60) received some kind of benefit from the government, a context that indicates the importance of PVC<sup>4</sup> for SRT users, since all participants in the research use all the amount received to maintain the housing, promoting conditions of survival and a greater possibility of social insertion. For this reason, we defend the maintenance of the guarantee of constituted rights for people with severe mental disorders, represented by the political-legal dimension of Psychiatric Reform<sup>1</sup>, which has been intensely discussed in view of the threats and setbacks suffered since the end of 2015<sup>22</sup>.

In addition to the institutional guarantee of obtaining the financial benefit, there is the autonomy of the people with severe psychological distress to manage their own resource or part of it. This right represented an important element for the sociability of the residents of SRT in the research that observed that shops and markets were the most visited by the population studied<sup>19</sup>. An inverse situation was observed in this investigation, in which excessive control over the access to the benefit amount was identified, as well as an important question regarding the destination given to the assistance received by the residents. Associated with this situation, the geographical distance from the shopping center observed in the SRT1 group of residents represents another element that weakens the development of autonomy of the participants in this study.

The initial step in the recovery of people with severe mental disorders, through housing, must permeate work and education, without excessive protection of caregivers in all areas of life. A great difficulty is the impossibility of having a formal job because they receive a benefit, an issue that does not take away the dreams and expectations of a profession, and directly impacts one of the pillars of psychosocial rehabilitation that corresponds to work with social value<sup>8</sup>.

Economy strategies and solidarity cooperatives, equipment for Raps's<sup>2</sup> psychosocial rehabilitation, are possible solutions for this issue. The municipality of this research has a cooperative and therapeutic workshop aimed at people with severe mental disorders, but with minimal relation with the residents of SRT1. In these spaces, several workshops focused on work and therapy are offered; thus, in addition to allowing work with a social function, participation in these services brings the potential of social and affective exchanges, triggering processes of subjectivation<sup>7</sup>.

The fragility in the articulation can be understood in several situations: in the services of the Raps among themselves, in the SRT, and the intersectoral aspect; as well as the SRT with the various services of markets and shops, leisure, and culture. The isolation of SRT and its disarticulation make us think of another way of perpetuating the institutionalization of the lives of residents, which, at the same time, atrophies the production of subjectivities and life projects that are built up as the urban space is occupied<sup>19</sup>.

As an assessment of the SRT in this study, users' satisfaction is related to characteristics such as comfort, safety, privacy, leisure, neighborhood, security of shops, public services, transport, and proximity. There was a predominance of indifference and satisfaction, a result that differs from other studies that showed high satisfaction of residents regarding some dimensions of the SRT, including physical conditions and comfort<sup>17,23</sup>. It was also identified that the satisfaction of SRT2

participants is higher when compared to SRT1, a difference with statistical significance. These findings allow us to discuss the importance of being inserted and living in the territory as a fundamental aspect to involve the person with a severe mental disorder in the sense of living<sup>8</sup>.

'Being at home' represents the right to come and go, and a space for the expression of subjectivities, socialization, allowing for the potential of life and freedom<sup>24</sup>. Going out whenever you want or if you want to clean a garden, buy goods, discovering or rediscovering ways to have relations with other people, developing a job, whether paid or not, making friends, discovering rights, and finding a date, having the possibility of expressing faith. These will help someone in psychological distress to recover their citizenship. The care in the SRT is characterized by moving from the internal world towards the external: to the street, to life<sup>8,25</sup>.

The conduction of this study contributes to the discussion about the importance of the SRTs necessarily operating in the intersectoral logic, as an exercise for the development of the three pillars of psychosocial rehabilitation, causing the de-characterization of these services as points of health care in order to objectify the deconstruction of practices that perpetuate the asylum model. In this direction, possibilities of action are pointed out for workers who work in these services, considering them as objects that are aligned with the objectives of psychosocial rehabilitation, which necessarily implies acts that go beyond technical and specialized activities focused on health services.

The sample size and the study scenario represent the limits of this research and can weaken possible generalizations of the results found.

## Final considerations

The results of this investigation allow us to observe that the SRT of the studied

municipality are centralized and are characterized exclusively as health equipment. This characteristic makes it difficult to operationalize the objective of therapeutic residency as a means to rescue the dimension of living proper to psychosocial rehabilitation. Consequently, the assessment that people with severe mental disorders make about housing needs and conditions shows a weak implication, as well as the indifference to aspects of social insertion through living.

## Collaborators

Acebal JS (0000-0001-5438-6605)\* contributed to the conception and planning, to the

preparation of the draft, and to the approval of the final version of the manuscript. Barbosa GC (0000-0002-7433-8237)\* contributed to the critical review of the content and approval of the final version of the manuscript. Domingos TS (0000-0002-1421-7468)\* contributed to the analysis and interpretation of the data, to the preparation of the draft, and to the approval of the final version of the manuscript. Bocchi SCM (0000-0002-2188-009X)\* contributed to the critical review of the content and the approval of the final version of the manuscript. Paiva ATU (0000-0002-8457-628X)\* contributed to the conception and planning, and to the approval of the final version of the manuscript. ■

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## References

1. Amarante P. Saúde Mental e Atenção Psicossocial. 3. ed. Rio de Janeiro: Fiocruz; 2007.
2. Brasil. Ministério da Saúde. Portaria nº 3.588, de 21 de dezembro de 2017. Institui sobre a Rede de Atenção Psicossocial, e dá outras providências no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União [internet]. 21 Dez 2017. [acesso em 2021 jan 25]. [https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588\\_22\\_12\\_2017.html](https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588_22_12_2017.html).
3. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Residências terapêuticas: o que são, para que servem. Brasília, DF: Ministério da Saúde; 2004.
4. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Programa de Volta pra Casa: liberdade e cidadania para quem precisa de cuidados em saúde mental. Brasília, DF: Ministério da Saúde; 2003.
5. Brasil. Ministério da Saúde. Portaria nº 3.090, de 23 de dezembro de 2011. Dispõe, no âmbito da Rede de Atenção Psicossocial, sobre o repasse de recursos de incentivo de custeio e custeio mensal para implantação e/ou implementação e funcionamento dos Serviços Residenciais Terapêuticos (SRT). Diário Oficial da União [internet]. 23 Dez 2011. [acesso em 2021 jan 25]. Disponível em: [http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3090\\_23\\_12\\_2011\\_rep.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3090_23_12_2011_rep.html).
6. Furtado JP, Tugny A, Baltazar AP, et al. Modos de morar de pessoas com transtorno mental grave no Brasil: Uma avaliação interdisciplinar. Ciênc. Saúde Colet. [internet]. 2013 [acesso em 2019 ago 15]; 18(12):3683-93. Disponível em: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232013001200024](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232013001200024).
7. Saraceno B. Libertando identidades. Da reabilitação psicossocial à cidadania possível. 2. ed. Rio de Janeiro: TeCorá; 2001.
8. Kantorski LP, Cortes JM, Guedes AC, et al. O cotidiano e o viver no Serviço Residencial Terapêutico. Rev Eletr Enf [internet]. 2014 [acesso em 2018 out 10]; 16(4):759-68. Disponível em: <https://www.fen.ufg.br/revista/v16/n4/pdf/v16n4a08.pdf>.
9. Furtado JP, Nakamura E. Inserção social e habitação de pessoas com sofrimento mental grave: um estudo avaliativo. São Paulo: Unifesp; 2014.
10. Sampieri RH, Collado CF, Lucio MPB. Metodologia de pesquisa. 5. ed. Porto Alegre: Penso; 2013.
11. Furtado JP, Moreira MIB, Nozabielle S, et al. Desenvolvimento de questionário dirigido às condições de moradia de usuários de CAPS. Saúde debate [internet]. 2013 [acesso em 2018 abr 5]; 37(96):62-75. Disponível em: <http://www.scielo.br/pdf/sdeb/v37n96/08.pdf>.
12. Alves C, Coutinho I, Reis T, et al. Perfil dos pacientes de três residências terapêuticas de um hospital psiquiátrico municipalizado do estado do Rio de Janeiro. Rev Pesq. [internet]. 2010 [acesso em 2019 out 5]; 2(supl):149-152. Disponível em: [http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/848/pdf\\_105](http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/848/pdf_105).
13. Lago EL, Machado RS, Vieira TS, et al. Perfil de moradores de serviços residenciais terapêuticos. Rev Enferm UFPI [internet]. 2014 [acesso em 2019 ago 25]; 3(1):10-7. Disponível em: <https://revistas.ufpi.br/index.php/reufpi/article/view/1113/pdf>.
14. França VV, Alves MP, Silva ALMA, et al. Quem são os moradores de residências terapêuticas? Perfil de usuários portadores de transtornos mentais desinstitucionalizados. Saúde debate [internet]. 2017 [acesso em 2019 out 5]; 41(114):872-84. Disponível em: [http://www.scielo.br/scielo.php?pid=S0103-11042017000300872&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S0103-11042017000300872&script=sci_abstract&tlng=pt).
15. Soares LML, Silva PRF. Serviços Residenciais Terapêuticos na cidade do Rio de Janeiro: uma análise da estrutura e do processo de cuidado. Saúde debate [in-

- ternet]. 2019 [acesso em 2020 ago 16]; 43(spe7):102-13. Disponível em: <https://www.scielo.org/article/sdeb/2019.v43nspe7/102-113/>.
16. Melo MCA, Albuquerque SGC, Luz JHS, et al. Perfil clínico e psicossocial dos moradores em hospitais psiquiátricos no estado do Ceará, Brasil. *Ciênc. Saúde Colet.* [internet]. 2013 [acesso em 2019 set 21]; 20(2):343-52. Disponível em: [https://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232015000200343&lng=en&nrm=iso&tlng=pt](https://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232015000200343&lng=en&nrm=iso&tlng=pt).
  17. Oliveira WG. Avaliação da satisfação dos moradores com os Serviços Residenciais Terapêuticos [dissertação] [internet]. São João del-Rei: Universidade Federal de São João del-Rei; 2018. 94 p. [acesso em 2020 ago 15]. Disponível em: <https://www.ufsj.edu.br/portal2-repositorio/File/ppgpsi/DISSERTACAO%20FINAL%20Welly%20Gouvea%20oliveira.pdf>.
  18. Zanardo GLP, Moro LS, Ferreira GS, et al. Factors associated with psychiatric readmissions: a systematic review. *Paidéia (Ribeirão Preto)* [internet]. 2018 [acesso em 2019 out 19]; 28(21):e2814. Disponível em: [https://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0103-863X2018000100202&lng=en&nrm=iso&tlng=en](https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-863X2018000100202&lng=en&nrm=iso&tlng=en).
  19. Massa PA, Moreira MIB. Vivências de cuidado em saúde de moradores de Serviços Residenciais Terapêuticos. *Interface Comun Saúde Educ* [internet]. 2019 [acesso em 2020 ago 15]; 23:e170950. Disponível em: <http://www.scielo.org/article/icse/2019.v23/e170950/>.
  20. Amarante P, Torre EHG. “De volta à cidade, sr. cidadão!” – reforma psiquiátrica e participação social: do isolamento institucional ao movimento antimanicomial. *Rev Adm Pública* [internet]. 2018 [acesso em 2019 set 27]; 52(6):1090-107. Disponível em: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S003476122018000601090&lng=pt&nrm=io](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S003476122018000601090&lng=pt&nrm=io).
  21. Antonacci MH, Kantorski LP, Guedes AC, et al. O trabalho no serviço residencial terapêutico: possibilidades na reconstrução de vidas fora dos manicômios. *Rev Pesq* [internet]. 2017 [acesso em 2019 set 27]; 9(3):831-9. Disponível em: <http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/5582>.
  22. Rossano CL. O avanço da Contrarreforma Psiquiátrica no Brasil. *Physis* [internet]. 2019 [acesso em 2019 set 27]; 29(1):e290101. Disponível em: <https://www.e-publicacoes.uerj.br/index.php/physis/article/view/43077>.
  23. Maluf R, Bandeira M, Oliveira D. Psychiatric patients' satisfaction in the therapeutic residence services: A positive experience of psychiatric deinstitutionalization. *Estud Psicol* [internet]. 2017 [acesso em 2020 ago 15]; 22(3):274-84. Disponível em: [http://pepsic.bvsalud.org/scielo.php?script=sci\\_arttext&pid=S1413-294X2017000300004](http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-294X2017000300004).
  24. Amorim AKMA, Dimenstein M. Desinstitucionalização em saúde mental e práticas de cuidado no contexto do serviço residencial terapêutico. *Ciênc. Saúde Colet.* [internet]. 2009 [acesso em 2019 set 28]; 14(1):195-204. Disponível em: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232009000100025](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232009000100025).
  25. Bessoni E, Capistrano A, Silva G, et al. Narrativas e sentidos do Programa de Volta para Casa: voltamos, e daí? *Saúde Soc* [internet]. 2019 [acesso em 2020 ago 15]; 28(3):41-53. Disponível em: [https://www.scielo.br/scielo.php?pid=S0104-12902019000300040&script=sci\\_arttext](https://www.scielo.br/scielo.php?pid=S0104-12902019000300040&script=sci_arttext).

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