Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

RESIDENTS OF A RESIDENTIAL THERAPEUTIC SERVICE: STORIES THAT PRINT A PROFILE

MORADORES DE UM SERVIÇO RESIDENCIAL TERAPÊUTICO: AS HISTÓRIAS QUE IMPRIMEM UM PERFIL

PERSONAS QUE VIVEN EN UN SERVICIO RESIDENCIAL TERAPÉUTICO: LAS HISTORIAS QUE IMPRIMEN UN PERFIL

Lilian Sayuri Otiyshi Matsumoto[1], Sônia Barros[2], Jandro Moraes Cortes[3]

RESUMO

Objetivo: compreender as representações nos relatos das vidas de usuários de um Serviço Residencial Terapêutico. ***Método***: estudo descritivo, com abordagem qualitativa, realizado em um Serviço Residencial Terapêutico do município de São Paulo/SP, Brasil. Foram sujeitos deste estudo seis moradores que aceitaram participar da pesquisa e conseguiram se expressar verbalmente, e que assinaram o Termo de Consentimento Livre e Esclarecido. Os dados foram coletados a partir de um instrumento com questões fechadas que caracterizaram o perfil sociodemográfico dos moradores e foram realizadas entrevistas semiestruturadas. A análise foi realizada pela técnica de análise de conteúdo temática. Os resultados foram agrupados em três categorias empíricas: << Características sociodemográficas >>; << Processo saúde-doença >> e << Reabilitação psicossocial >>. ***Conclusão***: as redes familiar e social são escassas e nenhum morador trabalhava. A reabilitação psicossocial é um processo crucial em suas vidas, entretanto, há ainda muito o que melhorar, como transitar pela comunidade, pois não têm um trabalho ou geração de renda, e não administram seu próprio dinheiro. ***Descritores***: Reforma Psiquiátrica; Moradias Assistidas; Enfermagem Psiquiátrica; Desinstitucionalização; Saúde Mental.

ABSTRACT

Objective: to understand the representations in the accounts of users living in a Residential Therapeutic Service. ***Method:*** this was a descriptive study with qualitative approach carried out in a Therapeutic Residential Service in São Paulo/SP, Brazil. The participants were six residents who agreed to participate and were able to verbally express themselves and signed the Informed Consent. Data were collected through an instrument with closed questions covering the socio-demographic profile of residents and semi-structured interviews were conducted. The analysis was conducted through the thematic content analysis technique. The results were grouped in three empirical categories: << Sociodemographic characteristics >>; << Health-disease process >> and << Psychosocial rehabilitation >>. ***Conclusion:*** family and social networks are scarce and no one resident had job. Psychosocial rehabilitation is a crucial process in their lives. However, there is still much room for improvement, as for example, transiting in the community, and in relation to the fact that no one resident had a job or income and that they do not manage their own money. ***Descriptors:*** Psychiatric Reform; Assisted Living Facilities; Psychiatric Nursing; Deinstitutionalization; Mental Health.

RESUMEN

Objetivo: comprender las representaciones en los relatos de las vidas de usuarios de un Servicio Residencial Terapéutico. ***Método***: estudio descriptivo, con enfoque cualitativo, realizado en un Servicio Residencial Terapéutico del municipio de São Paulo/SP, Brasil. Fueron sujetos de este estudio seis personas que viven allí y que aceptaron participar de la investigación y consiguieron expresarse verbalmente, y que firmaron el Término de Consentimiento Libre y Aclarado. Los datos fueron recogidos a partir de un instrumento con preguntas cerradas que caracterizaron el perfil sociodemográfico de los que vivían allí y fueron realizadas entrevistas semie-structuradas. El análisis fue realizado por la técnica de análises de contenido temático. Los resultados fueron agrupados en tres categorías empíricas: << Características sociodemográficas >>; << Proceso salud-enfermedad >> y << Rehabilitación psicosocial >>. ***Conclusión***: las redes familiares y socialles son escasas y nadie que vivía allí trabajaba. La rehabilitación psicosocial es un processo crucial em sus vidas, sin embrago, hay mucho para mejorar, como transitar por la comunidad, ya que tienen un trabajo o generan renta y no administran su propio dinero. ***Descriptors:*** Reforma Psiquiátrica; Vivienda Asistida; Enfermería Psiquiátrica; Desinstitucionalización; Salud Mental.

[1]Nurse, Resident student in Mental Health (R/1), School of Nursing, University of São Paulo/EEUSP. São Paulo (SP), Brazil. E-mail: lilian.matsumoto@usp.br; [2]Nurse, PhD in Nursing, Full Professor, School of Nursing, University of São Paulo. São Paulo (SP), Brazil. E-mail: sobarros@usp.br; [3]Nurse, PhD in Sciences, School of Nursing, University of São Paulo/EEUSP. São Paulo (SP), Brazil. E-mail: jandrocortes@usp.br

INTRODUCTION

In the decade starting in 2000, the project of de-institutionalization in Brazil gained strength with the norms of the Ministry of Health that proposed mechanisms for reduction of psychiatric beds and establishment of community services, the Centers for Psycho-social Attention. However, for the reduction of psychiatric beds and the consequent maintenance of people with mental illness in the community, even those without family, various support mechanisms and devices were necessary for the process of de-institutionalization.[1]

Because of the need for a resource in the community to help the user come out of hospitals and be reinserted into society, the Program "Back Home" was implemented. This program established the aid-rehabilitation for people leaving long-term psychiatric hospitalizations and this aid was defined by Law nº 10,708. This way, psychiatric care was humanized, effective care for psychosocial rehabilitation was ensured and policies to improve the quality of mental health care in the context of descentralization around hospitals was implemented.[2]

Still in this context, the Ordinance/GM nº 106 of February 11, 2000, regulating the creation of Residential Therapeutic Services (RTS), was implemented. Each unit of the RTS must have as physical structure: living room, bedrooms, dining area, kitchen, all furnished and suitable for the comfort and well being of residents. They should accommodate a maximum of eight users in a proportion of up to three users per bedroom.

Following the rules of the Ministry of Health, by the year 2011, there were 596 RTS in Brazil serving approximately 3236 users. In recent years, the expansion and consolidation of RTS are the main concerns of the de-institutionalization of psychiatric patients.[2]

In the context of psychiatric patients living in houses in the community, this research was necessary due to the lack of studies that deal with the characterization of users of mental health services. The majority of the studies does not discuss the characterization of users and, therefore, do not analyze their sociodemographic characteristics. Knowing the profile of such residents is important because by describing their sociodemographic profile and daily lives and the process of living, voice is given to the resident of the house-service. This, in turn, supports the consolidation of public policies geared to these residents. Thus, the guiding question of this study was: what are the socio-demographic characteristics of people with mental disorders living in a RTS and how do these characteristics relate to their daily lives?

OBJECTIVE

- To understand the representations in the accounts of users living in a Residential Therapeutic Service.

METHOD

Descriptive study with qualitative approach carried out in a Residential Therapeutic Service in São Paulo/SP. Study participants were six residents who agreed to participate and were able to express verbally, and who signed the Informed Consent. Residents who did not have cognitive conditions to answer the questions, or who refused to participate, were excluded from the study.

Data were collected using an instrument with closed questions for characterization of the socio-demographic profile of residents, and after that, semi-structured interviews were conducted. For data analysis, we adopted the thematic content analysis technique. Thus, the following empirical categories emerged: socio-demographic characteristics of residents of the RTS; health-disease process; and axes of psychosocial rehabilitation.

Ethical principles were respected at all stages of the research. The project was approved by the Research Ethics Committee of the School of Nursing of the University of São Paulo and by the Research Ethics Committee of the municipal government of São Paulo. To preserve the anonymity of the subjects, codes such as "SUBJ" were assigned to participants, followed by the number of the interview with the location of the thematic phrase.

RESULTS

♦ Characterization of the residente of the RTS

♦ Socio-demographic characterization of residents of the RTS

Four out of the total of six residents of the RTS were females and two were males, aged between 34 and 64 years, born in São Paulo/SP and Minas Gerais/MG, and one resident did not know his origin. As for the race/skin color, two (33.33%) residents reported being brown skinned, two (33.33%) residents said they are swarthy, one (16.66%) resident said he is dark and one (16.66%) resident said he is white.

The results showed that among the six users, five (83.33%) were single and one (16.66%) was a widower; five (83.33%) had a religion and one (16.66%) had no religion, and three (50%) were Catholic, one (16.66%) was a believer and one (16.66%) was Mormon. Regarding income, five residents (83.33%) had some source of income and one (16.66%) did not know. All subjects had not completed elementary school, had no private health insurance and were not working at the time.

In the case of three residents, the administration of the money was held by professionals of the RTS, in the case of two residents (33.33%), by relatives and one resident could not answer who managed his money. Among the interviewed users, two (33.33%) of them reported that they had not gone through any psychiatric hospitalization, but according to the recorded medical stories of these users during interviews, we learned that only one (16.66%) of them had not gone through psychiatric hospitalization.

Regarding psychiatric disorders, it was found that users had little knowledge of the medical diagnosis that they have, and only one could say the name of the disease in question.

♦ Habits of the resident

No one could inform what were the psychoactive substances used in daily basis, and thus, it was necessary that we sought a folder with the medications along with with RTS professionals. As for life habits, all subjects reported that they do not make use of licit and illicit drugs, but during this research in the RTS, it was observed that one user is a smoker. Only two users performed some physical activity routine.

As for receiving visits, four users reported that they do not receive any visit in the house and two users reported that they were visited by their therapeutic companions (TC). As for leisure activities, four users reported some activities and two users reported not taking any leisure activity.

♦ The RTS from the viewpoint of the resident

According to the results, four of the residents have been living in the RTS for 5 years, one of them has been living for two years and only one has just recently moved into the house, but during the interview it was found that five residents had arrived 5 years ago in the house and one had arrived 15 days ago. In the assessment of the daily life and the process of living in the RTS, three users rated the experience as 5; two rated as 10; and one rated as 0, when they were asked to rate the process on a scale from zero through ten.

When asked if they were respected and treated with dignity in the RTS, users answered 'more or less'. Two said they always felt respected and one reported that he generally feels respected. Regarding the reception of professionals, four said they were very friendly, one said they were more or less friendly and one said that they were unfriendly. As for the friendship among the residents, three responded that the relationship was more or less friendly, one said that it was very friendly and one said that it was unfriendly.

As for the comfort and appearance of the RTS, two users are very satisfied, three are satisfied and one is dissatisfied. Regarding the general conditions of the RTS, three residents reported that they are excellent, and two users said that they are good and one said that they are bad.

Another aspect identified was about what users liked most in the RTS and what they like least. It was found that what they like the most is to watch television, what was mentioned in the responses of five users, but other answers such as some domestic activities, sleep, read, write, dance, also appeared. As for the things they do not like much, there was no one single response with high frequency. There are residents who do not like the fact that men and women live together, some do not like some household activities or a specific situation, but some say that there is nothing that they do not like much in the house.

♦ Health-disease process

The speeches of the subjects showed the representations of users about their disease, leading to conformation of the theme "conception of health and disease."

Historically, the mental health-disease process is understood in different ways, from the earliest times to the present times, and this is due to the different cultures, the ways of perceiving life and humans and also the welfare changes over time.

The thematic sentence below reveals an understanding that the resident has on his state of becoming ill that refers to a Greco-Roman design, conceiving this process as an imbalance between natural forces on the individual's body.

> The doctor said I had thick water on the head and I would have to take it out, and God told me that this was going to come out through the ear and the nose. Then pus came out from the ear and the problem through the nose. (SUBJ I / P1 L28)

From the mid-nineteenth century until the early twentieth century, pathology studies gained special importance. There, the body was the center of imbalances of all kinds, so the organismic conception of the process of becoming physically and psychologically ill winned big impact. This conception of the process of becoming mentally ill is evidenced in the following thematic line:

> *I started to have a seizure, my mother began to hold me for not to fall under the bed, I ended up under the bed, to take me out, I think, only a very strong woman[...] (SUBJ V / P1 L1-3)*

During the Renaissance, rationalism thought by Descartes preached that humans could have two forms of existence: the reasonable and the unreasonable. This rationalist conception of mental illness can be seen as follows:

> *Because we're not crazy, we have brains, we have consciousness. And the person says we're crazy. No, we think as everyone thinks. (SUBJ I / P3 L3-5)*

The secular work as a way to impose discipline and as a form of social utility refers to a pinelian medical-moral conception, as it was also evident in the thematic phrase that follows:

> *I stopped working out, because of my disease [...] (SUBJ V / P2 L1-2)*

In the half of the twentieth century, Basaglia proposed a new way of looking at madness, putting the disease in parentheses and focusing on the subject instead of on the disease. How to care for people with mental illness was no longer centered inside a hospital, but in the community where social exchange is favored. The residents understand that a mental illness is one of the dimensions of their life and not the opposite:

> *My father left me sick, and I had very deep depression and a very serious problem in the head, which is mental, I dabbled my tongue, it was horrible. Not that I was horrible[...] the problem was. (SUBJ I / P1 L6)*
>
> *But this resident, he does not consider himself a sick person: I was never sick[...] (SUBJ II / P1 L1)*

♦ Psychosocial Rehabilitation

Psychosocial rehabilitation is understood through three axes, namely: housing, social network and work.

♦ Living

The quality of life of a subject and his contractual capacity is demonstrated by how much a this person that "is" anywhere can "inhabit this place". The subject has little or no property of a space when only he "is" in a place of which he has no decision-making power. When inhabiting a space, there is a large contractuality with material and symbolic organization of the own space.[3]

In the housing axis, the following sub-themes emerged: Psychiatric Hospital, Therapeutic Residential Service and Other Living Experiences. Users showed how it was the experience of being in a psychiatric hospital; how it was the process of living in the house (RTS) and their daily lives; and how it was to live other residence experiences beyond those already mentioned.

♦ Psychiatric hospital

The psychiatric hospital is defined as a place that promotes the reproduction of the disease. The Basaglia design understands that a sanatorium, because it is a total institution, is a *timeless locus*, that is, it is a place that, by its nature, never changed nor will change its functional structure.[3]

The thematic phrases show how was the experience of being in a psychiatric hospital, suffering all kinds of suppression of human rights, physical abuse, punishment, abuse, under the guise of treatment:

> *[How it was in the PH] Because there, I was going to get shocks in the head ... (SUBJ IV/ P17, 18, 19)*
>
> *Sometimes I could not even get out of bed [...]the time I spent in the hospital, I got like a skeleton because I could not drink water, I could not do anything, it would cover my throat and I can not eat anything. (SUBJ IV/ P5 L1-3)*

♦ Therapeutic Residential Service

In this theme, we see the importance of the RTS for the residents, how is the experience of living in the RTS and what meaning this has:

> *[RTS] I consider this my home. I am the man of the house here.*
>
> *They brought me here. [...]here is a thousand times better. (SUBJ IV/ P17, 18, 19)*
>
> *I'd rather live here than live in the hospital [...]because here is better, we are welcome here[...] (SUBJ III/ P15)*
>
> *I think that here is my home, because here they welcomed me at the time I needed the most, because otherwise I'd be on the street [...] (SUBJ III/ P17, 18)*
>
> *Here must be my home[...] For the people who live here, they live here and I accept me, here in my house. (SUBJ V/ P9)*

♦ Other experiences of living

In addition to these two modes of living evidenced above, other residence experiences that users have had over their lives were also unveiled:

[Experience in the hostel] Hostel, it was very bad there, I had to have breakfast 5 am [...] then, sometimes I had to go out in the rain, I would get completely wet! (SUBJ IV/ P8)

[Prior to living in the house] I lived on the street (SUBJ II/ P3)

♦ Network

Saraceno (2001) says that the social network is the participation in exchanging identities or the invention of places to enable the exchange. The weak link between subjects and their families is seen in their speeches:

My family used to say that I did not exist, that it was for me to stay in the hospital, that they would not going to take me out, not. (SUBJ IV/ F36 L1-2)

Then I came home to the RTS, because my family did not accept me. (SUBJ I/ F5 L1)

However, the speech reveals the existence of a strong bond in relation to the family showing sorrow for not having them around:

I left there (parental home) after my mother died. My parents had a house here and then my mother died, and I had to come to São Paulo, because there would not be condition for me to live there. Then she died and we got very disheartened, very sad, then we decided to come to São Paulo. (SUBJ III/ F21 L3-4)

It was nice, they treated me well, my father and my mother. All I wanted they bought for me; if I were in the mood to eat a snack and they would go there and buy it. But now I have no father and no mother, right? They already died. (SUBJ IV/ F37 L1-3)

A sense of longing and solidarity between the resident and his former social network was evident in the thematic phrases below:

And people criticized, "she will die, you have to leave her[...]". And the person never believed that I could go over, that I could recover. So this lady [...] then this neighbor took me to take care of me. And she fought hard to see me healthy. (SUBJ I/ P1 L6-10)

"You will not let anyone hurt me?". She said: "No, I won't let anyone mess with you nor harm you." And she fulfilled what she said (SUBJ I/ P1 L14-15)

♦ Work

The work is the way to overcome the needs, the way to change the nature and be changed by it, to create knowledge and invent new things.[4] The reports indicate the difficulty that the resident has had to find work, the types of work that they could find and what was that work about:

(I lived on the street) I would collect cardboard to sell[...] (SUBJ II/ P3)

Then I came to work in a house, as a babysitter. (SUBJ IV/ P41 L1-7)

I think a month after that I found a house of a colleague of mine and I went to live with her. Then I would took care of her children and she would work ... (SUBJ IV/ P9 L1-3)

♦ Daily life

The subtopic daily life includes the speeches of residents about their day-to-day life in the RTS, their activities, their leisure and the way of managing their own money. It was understood that some residents think of the RTS as their home:

Ah, (on a typical day in the house) I'm resting, I'm happy with my dog, sometimes she does something funny and I start to laugh, it is my joy! (SUBJ I/ P12)

Instrumental activities of daily living are the activities undertaken in the user's daily life in their social environment and demonstrate the individual's ability to lead an independent life in the community, such as using means of transportation, perform household chores, prepare meals, take care of their own finances.[5]

[What he does from the time he wakes up] I get rid of the poops of the dog, give him water, give food, regular[...] rest a bit, right?! Because, it is sometimes a rush. Sometimes I'm washing dishes until noon I go there, I see the R. [puppy] to see if it's okay [...] (SUBJ I/ P13, 14)

[A typical day in the house] I wake up, do the laundry, wash the dishes [...]. (SUBJ V/ P5)

On the other hand, the thematic phrases below show the leisure activities of residents in their day to day:

[day to day] It's good right? When you wake up, you have a breakfast to take[...] when'm not with headache then I'm fine[...] I start to sing[...] I get a backcountry music and start singing[...] (SUBJ IV/ P24 L1-3)

[day to day] Sometimes I stay at home, sometimes I do not go out not even to walk [...] I stay at home doing the service, if there is service, I do the service[...] If there is no service, I watch TV. (SUBJ IV/ P28 L1-3)

♦ Human rights and citizenship

The thematic phrases show that the rights of the residents were taken away during the course of life, but when they were reintegrated in society, the reappropriation of those rights can be seen:

But I have no desire for men no more. First I had a fire to have a man, I was running around looking for men in town. Then the police: "You did not come here find men, right?" No, I'm just walking here [...] (SUBJ IV/ P52 L17-20)

Because she was very angry because she found out that I had a serious problem in the brain and I was cured. And she sent me to the hospital by mistake. Even though I was not sick, they admitted me. He wanted me interdicted, so I do not gain anything. They did not want me to win anything to interdict me, and the "Y" which is a psychologist, went to court and took my cause and I'm here. (SUBJ I/ P6 L1-2)

DISCUSSION

♦ Health-disease processes

The thematic sentences showed that the people who live in the RTS and the people from their network do not have only one single view of mental illness. It was observed that they had various concepts on health such as: religious-magic; Greco-Roman, organismic; moral; pinelian medical moral and also basaglian. The statements refer to the period of prehistory (sacred deities), Greco-Roman civilizations (diseases of the spirit) and even the contemporary, where the medical-moral conception of mental illness prevails and whose treatment was made by the exclusion of individuals and drug treatments.[4,6]

It was also found that there is an association between the disease and the loss reason which is approximated to the mental health- disease design of the Classical Age in which Rationalism prevailed and humans could be divided into two forms of life: the reasonable and the unreasonable. In carrying out this division, it can be said that the reason humanizes man and frees him from the divine rulership, and the unreason take man close to animality. Foucault, Goffman and Castel are authors who discuss the historical trajectory of madness, psychiatry, psychiatric institution and medicine, and also observe the changes of the transformation of madness into a mental disease in the nineteenth century. At this time, it can be said that the hospice has as the main assignment to enclosure and hospitalize, and in the Classical Age this was focused on hosting.[4]

The thematic phrases indicate that there are residents that understand the disease as something outside oneself, that is, the disease is not part of the person itself, but is only one part of its life. Another resident understands that he has no mental illness and, according to the Basaglia design, the person does not realize how mentally ill is because the person does not consider such disorder as an actual disease.

The understanding that the disease is only one dimension of human life, and not its entirety, that the human being is not the disease itself, approaches the design that has guided nursing, as the science of care. The denial of the mental illness by the resident leads us to discuss the diagnosis in mental health and its appropriation through the traditional psychiatry.

Psychiatry, since its creation as practice, has the diagnoses as the descriptors of the patients functioning anomalies. At the time of Freud, Kraepelin and Bleuler, psychiatry had a psychopathological and phenomenological feature. However, psychiatrists of this period had a great influence of the hermeneutical ideals of Dilthey and considered the patient's speech as a way to learn about the disease.[7]

On the other hand, the efficiency of treatment with psychotropic drugs at the time had not come to acceptable levels in relation to the medicines of the end of the twentieth century and the definition of symptoms does not help psychiatrists to fight against the "forms of madness". Because of this, certain thinkers questioned the need and effectiveness of psychiatrists.[7]

The conceptions of the disease process of people refer to various understandings that the historical rescue allowed us to review. It is worthy to highlight that these understandings are not linear in time, but they are dialectic. These understandings that people themselves have about getting mentally ill refer to social understandings, which in turn exclude and segregate what is different.

Despite the change of the hospital-centered model to the psychosocial model in which users are treated in the community, social exclusion of the crazy ones and stigma related to the disease are still present in our society. This shows us that it is not only by deconstructing the psychiatric hospital that social inclusion of these people will happen. Because of this, it is important to think about how we can include them in our social context and reduce the stigma related to the disease.[8] This way, therefore, we will set the foundation of our understanding in the foucaltiano thought which preaches that, in order to include people in the world of life, we necessarily need to destroy internal chains and also external chains that imprison the mad people and their different mode of existence.

♦ Psychosocial Rehabilitation

The thematic phrases pointed out that, within the psychiatric hospital, residents suffered from the lack of rights and care, violence of the treatment, whether physical or psychological. The mental hospital is a

place for being and not for dwelling, and this difference happens in the perspective of exchange of and contractual, concrete and subjective power of homem.[3] Regarding being, the individual has absolutely no perspective of exchange with their place of residence, while dwelling implies a great contractuality and exchange power.

The psychiatric hospital, as a total institution, manages the dimensions of the resident's life leading the person to introduce - during the long years inserted in the context of the institution - a dependent attitude in life in relation to the institution. The deinstitutionalization becomes more difficult due to the integration of the individual into institutional chains.[9]

In the experience of Italian deinstitutionalization, the nursing home is perceived as the place where there is zero possibility of exchange and every effort to overcome this model demonstrates the gap and the violence that the psychiatric hospital causes.[10] In order to create a new model of care and to end the old model, it is necessary to generate and strengthen relations to overcome the relations of power, to expand the space for exchange, to increase the possibilities for social exchange, to propitiate a new relationship network and to modify the ways of being and relating to the environment.[11]

On the other hand, focusing on mental health policies in Brazil today, it was found from the speech of the residents that the majority of users appropriated the house and they see it as a place where they feel hosted, welcomed and accepted. Although most residents enjoy the RTS, there are users who do not like the lack of privacy in the home, because the house not exclusively male or female.

It is important to develop a more accurate view for smaller everyday events of the residents, as they may denote an event full of meaning and make sense to the life of the subjects. For this, it is necessary to embark on daily activities, to restore and give new meanings to the day-to-day actions that reintegrate the macrocosm of users.[11]

One of the thematic phrases draws attention for the resident himself who verbalizes the concreteness of living at this moment in the RTS and literally says that he has been in a psychiatric hospital.

In this direction, we find another study conducted in Brazil that proves this premise of Saraceno, when studying the constitution of the social bond of residents of two RTS, which may or may not boost the resident to build his social network. The study concludes that the social ties of individuals under psychological distress, residents of this service-house called RTS, can be strengthened by placing them on the streets, in local shops in the neighborhood, in the city, and in the community. As fortifying mechanisms, we identify social exchanges between the residents through living together in daily life, in relations of partnership, friendship, affection, and in conflictive relations sometimes, because any relationship of life is guided by conflicts and affections. It is noteworthy that it is the team of professionals who estimulate experiences out of the RTS, which, in our view, contributes to introducing the resident into a life of belonging to the social environment, after the long years within asylums.[12]

The thematic phrases pointed out that the support of the family network to residents was insufficient. Discrimination and denial of the existence of the residents happened among their families, as well as lack of family affection, in the perception of users. Thus, residents feel a strong bond with their families.

The most complex element to be faced and accepted by the family is the difficulty to interact with the person with mental disorder and also to live together with these people, which brings serious damage to the health of their relatives.[3]

The family is of fundamental importance in the intervention to the mental health and one of the factors that influence the feelings of inadequacy and helplessness of the family is the little knowledge and the lack of appropriate concept of the disease. Mental health professionals strengthen their relationship with these family members to understand their anguish. It is the role of the nurse to inform them about the disease and the correct use of medicines. Thus, the nurse is an ally for familiar cohabitation.[13]

The family of mental health users need to express themselves, share experiences, have someone to share their anxieties and gains obtained in the treatment, and discover coping strategies. Providing assistance to family members of mentally ill people means to help with their anguish and denial/acceptance of the disease, since the relationship of the family with a mental health patient is often difficult. By this we understand the difficulties that the mental illness imposes on caregivers and to their own families. This difficulty can translate into abandonment and abuse.

Understanding that living in the community can also help the daily lives of users, a study shows that social networks were important for strengthening the social inclusion of mental health users. It was also perceived that the social changes that occur to accept the differences between people can be the result of reducing the stigma and prejudice against the disease.[8]

Some thematic sentences show that despite a strong desire of residents to have contact with their families and friends, such families do not accept them, reject their existence or even use violence against them. Other thematic phrases point to the RTS as a site where users feel great affection, a site where they feel as their home, something never given by the family. Residents also cited that their social exchanges are hampered because the family feels financially burdened by the the fact that the resident cannot find a formal work and assist in the payment of household expenses.

One study investigated what the family thought about work as a factor that promotes social inclusion of mental health users and about getting involved with the process. Family members perceive the work as a key factor to implement spaces for social and material exchanges, directions and also conservation of their quality of life. Work can be seen as an expression of citizenship and a form of building life, dreams and projects of the mentally ill people.[14]

Residents report that their former jobs did not have, in most cases, a formal character and they have great difficulty getting a formal job. Due to this difficulty and because they did not have a source of income, some residents say they have been driven out from their homes by family members.

Human Rights and Citizenship

Mental health users are part of a set that have their human rights and their freedom violated. They have their civil, political, social and cultural rights denied, because they are a vulnerable group.[15]

It was noticed in the speeches of the subjects that, before RTS, in the psychiatric hospital, they had their rights violated not only by the institution, but also by their families. Greater autonomy and freedom of movement of these users can be observed out of these experiences, although they are subject to tipical day-to-day difficulties in the community. Some residents still speak of the difficulties faced in other ways of being, as in hostels, on the streets. However, it is known that the difficulties faced by people, such as the lack of right to privacy and the violence, are perpetuated in total institutions as a whole.

We understand that freedom, besides being therapeutic, it is a right of every person. Promoting human rights is based on seizing social rights.[16-8] In this sense, the RTS provides residents the possibility of movement in the territory they inhabit, exercising their rights and duties as any other citizen.

The results indicate the need to improve public health policies for mental health users, promoting the social inclusion of these individuals in the community and assuring the respect for their rights to come and go.

CONCLUSION

This study described the demographic profile of the residents of a RTS, located in São Paulo/SP, and understood the representations of the facts of their lives. It was found that most residents were female, nonwhite skin color, single, Catholic, unemployed, without private health plan, with incomplete primary education.

Although this study is restricted to one RTS and, therefore, is limited to a sample of six residents, the results reveal the socio-demographic profile of these users and shows that the RTS is seen by most of them as the place where they live and receive affection, where they are welcomed and accepted by all. Some see the RTS as the home that they never had and, despite all the difficulties of living in this mixed home, which can be seen in this hybrid "service-house", these residents that were completely strangers to each other now interact in the manner that we see in most homes: happy periods, fights, affections.

The family and social networks of these users are quite scarce and regarding work, no one resident works and only a few have motivation to do this. This study indicates that much of what is seen as a characteristic of residents has to do with the long length of stay in psychiatric hospitals, a result of the institutionalization. Thus the study indicates that psychosocial rehabilitation is a necessary process in the life of these subjects.

It is understood that the results cannot be generalized and this is not the focus of qualitative research. However, the study contributes to deepen the knowledge about the characteristics of these residents, and also awakens the need for further investigations because there are issues in this and other services in relation to the everyday lives of these people, their relationships with caregivers, and the experience of living

together, or lack of such experience, in the territory in which they unfold.

We need to consider that the everyday knowledge contributes to nursing care planning in services that are rear for residents of the RTS.

FINANCIAL SUPPORT

● Coordination for the Improvement of Higher Education Personnel - CAPES).

REFERENCES

1. Brasil. Ministério da Saúde. Reforma Psiquiátrica e política de Saúde Mental no Brasil. Biblioteca Virtual em Saúde on line [Internet]. 2005 Nov [cited 2015 May 03]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/Relatorio15_anos_Caracas.pdf

2. Brasil. Ministério da Saúde. Portaria GM n. 3.090, de 23 de dezembro de 2011. Rede de Atenção Psicossocial. Biblioteca Virtual em Saúde on line [Internet]. 2011 Dec [cited 2015 Apr 23]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3090_23_12_2011_rep.html

3. Saraceno B. Libertando Identidades: da reabilitação psicossocial à cidadania possível. 2nd edição. Rio de Janeiro: Te Corá Editora/Instituto Franco Basaglia; 2001.

4. Aranha e Silva AL. A construção de um projeto de extensão universitária no contexto das políticas públicas: Saúde Mental e Economia Solidária. [Livre docência] Escola de Enfermagem da Universidade de São Paulo; 2012.

5. Brasil. Ministério da Saúde. Envelhecimento e saúde da pessoa idosa. Biblioteca Virtual de Saúde on line [Internet]. 2007 [cited 2015 May 06]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/abcad19.pdf

6. Kantorski LP. REDESUL – Redes que reabilitam: avaliando experiências inovadoras de composição de redes de atenção psicossocial. Pelotas; 2011.

7. Vilhena J, Rosa MC. Diagnóstico em saúde mental: por uma concepção não objetivista das representações da loucura. Contextos Clínicos on line [Internet]. 2012 July [cited 2015 May 06];5(1):26-36. Available from: http://pepsic.bvsalud.org/scielo.php?pid=S1983-34822012000100004&script=sci_arttext

8. Salles MM, Barros S. Inclusão social de pessoas com transtornos mentais: a construção de redes sociais na vida cotidiana. Ciênc saúde coletiva on line [Internet]. 2013 July [cited 2015 May 06];18(7):2129-38. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232013000700028&script=sci_arttext

9. Goffman E. Manicômios, Prisões e Conventos. São Paulo: Perspectiva; 1974.

10. Rotelli F, Mauri D. Desinstitucionalização: uma outra via. São Paulo: Hucitec; 2001.

11. Marques ALM, Mângia EF. Ser, estar, habitar: serviços residenciais terapêuticos no município de Campinas/SP. Rev Ter Ocup USP on line [Internet]. 2012 Sept/Dec [cited 2015 May 06];23(3):245-52. Available from: http://www.revistas.usp.br/rto/article/view/55639

12. Cortes JM, Kantorski LP, Barros S, Antonacci MH, Magni CT, Guedes A. O laço social de indivíduos em sofrimento psíquico: contribuições para a enfermagem psiquiátrica. J Nurs UFPE on line [Internet]. 2015 Apr [cited 2015 May 06];9(4):7322-9. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/7343

13. Almeida ACMCH, Felipes L, Dal Pozzo VC. O impacto causado pela doença mental na família. Revista Portuguesa de Enfermagem de Saúde Mental on line [Internet]. 2011 Dec [cited 2015 May 06];(6):40-47. Available from: http://www.scielo.mec.pt/scielo.php?script=sci_arttext&pid=S164721602011000200007&lng=pt.

14. Filizola CLA, Teixeira IMC, Milioni DB, Pavarini SCI. Saúde mental e economia solidária: a família na inclusão pelo trabalho. Rev Esc Enferm USP on line [Internet]. 2011 [cited 2015 May 06];45(2):418-25. Available from: http://www.scielo.br/pdf/reeusp/v45n2/v45n2a16.pdf\

15. Kehl MR. Direitos humanos: a melhor tradição da modernidade. In: Venturi G. Direitos humanos: percepções da opinião pública. 1st edição. Brasília: Secretaria de Direitos Humanos da Presidência da República; 2010. p. 33-41.

16. World Health Organization. Mental health and development: targeting people with mental health conditions as a vulnerable group. Geneva: WHO; 2010.

17. Dudley M, Silove D, Gale F. Mental health and human rights: vision, praxis, and courage. UK: Oxford University Press; 2012.

18. Waidman MAP, Marcon SS, Pandini A, Bessa JB, Paiano M. Nursing care for people with mental disorders, and their families, in Primary Care. Acta Paul Enferm on line [Internet]. 2012 [cited 2015 May 07];25(3):346-51. Available from: http://www.scielo.br/scielo.php?pid=S0103-21002012000300005&script=sci_arttext&tlng=en

Submission: 2015/12/04
Accepted: 2016/10/13
Publishing: 2016/11/15

Corresponding Address

Jandro Moraes Cortes
Universidade de São Paulo
Escola de Enfermagem/EEUSP
Departamento de Enfermagem Materno-infantil e Psiquiátrica
Av. Dr. Enéas de Carvalho Aguiar, 419
Bairro Cerqueira César
CEP 05403-000 – São Paulo (SP), Brazil