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ORIGINAL ARTICLE

Health-care practices performed at assisted living facilities: pursuing the paths back to society*

PRÁTICAS DE CUIDADOS PRODUZIDAS NO SERVIÇO DE RESIDÊNCIAS TERAPÊUTICAS: PERCORRENDO OS TRILHOS DE RETORNO À SOCIEDADE

LAS PRÁCTICAS DE CUIDADOS OFRECIDOS EN EL SERVICIO DE RESIDENCIAS TERAPÉUTICAS: RECORRIENDO LOS CAMINOS DE RETORNO A LA SOCIEDAD

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ABSTRACT

The objective of this exploratory study was to understand the perspective of professionals working at assisted living facilities about the healthcare practices performed in the mental health service. Data collection was performed using an observation form, field journal, and a semi-structured interview script, which was conducted with 10 professionals working at the facilities. It was found that the care provided at the facility was humanized and valued the uniqueness of the individuals living there, as well as their values and beliefs, seeking to (re)establish the individuals' social relationships and encourage them towards self-care. It is observed that this form of care has been achieving (re)socialization and valuing the lives of those experiencing psychic distress.

KEY WORDS

Mental Health.
Mental health services.
Assisted living facilities.

RESUMO

Esta pesquisa objetivou buscar a visão dos profissionais do Serviço de Residências Terapêuticas, sobre a prática de cuidado produzida neste dispositivo de atenção à saúde mental. Para isso, optou-se pela abordagem qualitativa, exploratória e analítica. Os instrumentos para a coleta de dados foram: formulário de observação sistemática, diário de campo e roteiro de entrevista semiestruturada, realizada com 10 profissionais atuantes nas residências. Como resultado, foi encontrado que o cuidado na moradia se dá de modo mais humanizado, valorizando a singularidade dos moradores, seus valores e crenças, tentando (re)estabelecer as relações sociais dos indivíduos e estimulá-los para a prática do autocuidado. Percebe-se que esse modo de atenção vem alcançando uma (re)cidadanização e valorização da vida dos sofredores psíquicos.

DESCRITORES

Saúde mental.
Serviços de saúde mental.
Moradias assistidas.

RESUMEN

Esta investigación objetivó buscar la perspectiva de los profesionales del Servicio de Residencias Terapéuticas, sobre la práctica del cuidado ofrecida en este dispositivo de atención a la salud mental. Para esto, se optó por el abordaje cualitativo, exploratorio y analítico. Los instrumentos para la recolección de datos fueron: formulario de observación sistemática, diario de campo y guión de entrevista semiestructurada, realizada con 10 profesionales actuantes en las residencias. Como resultado, fue encontrado que el cuidado en la residencia se ofrece de modo más humanizado, valorizando la singularidad de los residentes, sus valores y creencias, tratando de (re)establecer las relaciones sociales de los individuos y estimularlos para practicar el auto cuidado. Se percibe que ese modo de atención viene alcanzando una (re)ciudadanización y valorización de la vida de los que sufren psíquicamente.

DESCRIPTORES

Salud mental.
Servicios de salud mental.
Instituciones de vida assistida.

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INTRODUCTION

There are many sides to the same trip: a new train departs

In the context of the Unified Health System (SUS), basic health care emerges as the means to construct a new policy and production of services, going beyond the hegemonic-medical model and becoming the place where health practices are executed, particularly in the mental health area, through the Psychiatric Reform and Anti-Asylum movements[1].

In Brazil, the Psychiatric Reform started at the same time as the health movement, at the end of the 70's. However, the continuation of the fight to reform mental health follows its own course, marked against an international background of innovations against the subjugation of asylum violence[2], with its organization based on the principles of the Italian deinstitutionalization experience in psychiatry and its criticism against the asylum, aimed at the deconstruction of the asylum model.

In 1978, when the Movement of Workers in Mental Health (MTSM in Portuguese) emerged, accusations start to appear against violence in asylums, the capitalization of insanity, the preponderance of the private care network, as well as collective criticism against classic psychiatry and the hospital-centered model in care for patients with mental disorders[3].

For these extra-hospital services to provide new mental health care, the relation they offer needs to be committed to necessary ethical, policy and epistemological ruptures.

The legal beginning of the reform in Brazil takes place with the proposal of Bill 3657/89, which proposed the regulation of rights for persons with mental disorders and the progressive substitution of asylums in the country[2]. Nevertheless, Law 10216, known as the Psychiatric Reform Law, was only approved on April 6, 2001, after going through Congress for twelve years. This law guaranteed the process of progressive substitution of beds in psychiatric hospitals by a community psychosocial care network.

Based on this need, Mental Health Programs were created to put the new extra-hospital care model in practice, which consisted of strategic and controlled services: the Day-Hospital, beds in General Hospitals, Psychosocial Care Centers (CAPS), Halfway House Services, Protected Houses, Going Back Home Program and a Mental Health Emergency Unit, which are regulated by Resolution 224/92 of Brazilian Ministry of Health, guided by SUS principles[4].

For these extra-hospital services to provide new mental health care, the relation they offer needs to be committed to necessary ethical, policy and epistemological ruptures, understanding and creating the understanding that mental patients have their own identity and wishes, are fully capable of directing their lives and should be seen as fathers, mothers, sons, intellectuals, farmers, black or white, instead of being seen as incapable, a burden, sick persons, who cannot take responsibility for their attitudes[5].

Nevertheless, reducing beds and overcoming the recurrent condition of *hospital residents* which many mental patients are relegated to implies the establishment of housing alternatives for those who will be discharged, whether on account of the support they need to ensure their stay outside hospitals or on account of difficulties for reintegration with their families.

These houses appeared in Brazil in the early 90's, originated from innovating initiatives for extra-hospital housing structures[6], which had the function of empirically showing the feasibility of replacing the beds of *residents* in psychiatric hospitals by houses in the community. Their strategic importance was emphasized at the II National Mental Health Conference in 1992, which produced important support so that the initiative could be incorporated as an SUS policy[4].

Current policies have been trying, with special attention in recent years, to achieve the effective deinstitutionalization and reintegration of people with severe mental disorders in the community. To achieve this, they have relied on the full support of Substitute Therapeutic Services, especially Halfway Houses (HH), established by Ministry of Health Resolution 106/2000, aimed at articulation with the Unified Health System (SUS). Besides this document, other policies support the HH Service: Federal Law 10216/2001, which determines on the protection and rights of people with mental disorders; Federal Law 10708/2003, which institutes rehabilitation aid for patients discharged from psychiatric institutions; Resolution GM 2068/2004, which institutes financial incentive for cities to establish HH; and Resolutions 52 and 53/2004, which establish a program for the progressive reduction of psychiatric beds in the country[6].

These houses are not precisely health services, but rather spaces to reside, to live, articulated to the psychosocial care network in the city, and which must be linked up with the Psychosocial Care Center (CAPS), according to the criteria of Resolution 106/2000[4].

When a person is admitted to a HH, this is the beginning of a long rehabilitation process, which should aim for the progressive social inclusion and personal emancipation of these persons, after all, their main purpose is to provide housing, reside and live in the city.

Therefore, each house should be considered unique, and should be organized according to the needs, preferences and habits of its residents, always considering that these houses have their treatment centered on the humanistic model, aimed at offering enriching experiences to turn these people increasingly capable of facing the challenges of life[3].

In this context, this study aimed to get to know the point of view of HH professionals on the care practice produced in these houses, supported by the substitute mental health and community care network.

METHOD

This is an exploratory and analytic study with a qualitative approach. One of the arguments that support the use of qualitative study research is its special approach to study small groups, aimed at understanding the context the phenomenon occurs in, besides allowing to observe several elements inside this context. Hence, it is appropriate to analyze care practices in HH Services.

This study was developed in Campina Grande (with a population of about 370,000 inhabitants) - located in the interior of the state of Paraiba, due to the fact that this city is experimenting with and putting in practice measures for the deinstitutionalization of people with long-term psychiatric hospitalization[7]. This process began when the Ministry of Health established the National Hospital/Psychiatry System Assessment Program 2003/2004. One of the results of that assessment was the declassification and de-accreditation of eight hospitals in the country, one of which was located in Campina Grande and attended to much of the mental health demand in the geopolitical region of the administrative area of Borborema/ PB. The intervention occurred with the de-hospitalization of 176 patients in April 2005 and ended in July of that year, with the de-accreditation of the hospital from the SUS network.

As actors in the present research, there are 10 team professionals of the six HH in Campina Grande: 01 coordinator, 02 reference technicians and 07 caregivers. The identification of the interviewees was defined as: *Prof*. (for professionals interviewed) and *nº* to identify the participant, following the order in which the interviews were held.

Before data collection, a meeting was set up with the HH professionals to present the researchers, the study proposal and its purposes and the method. Then, the professionals were invited to participate in the study. After this first occasion, the authors contacted the professionals interested in cooperating and, by phone, they scheduled a place and date to conduct the interview, which generally occurred at the HH.

Data collection covered a period of four months, from January to April 2007, and was conducted by means of systematic observation, interview and a field diary. Systematic observation covered the entire period of field work, based on a script guided by goals for capturing interpersonal relations established in the houses. To do so, the researcher visited the houses as follows: on each day of the week, the researcher would go to a house where he remained for a period, morning or afternoon. At these moments, informal dialogues were established between the researchers, residents and professionals, so as to explore the context the houses were involved in, observe the relations established in daily routine, get to know the lifestyle of the residents and the work dynamics of the professionals. A relation of mutual trust and respect was then established.

This observation guided the application of the semi-structured interview script, which addressed the professionals' point of view on the therapeutic experience in the halfway house. The field diary was elaborated during daily data collection routine and recorded contacts with the interviewees, how they related to the residents and their tasks in the house, as well as the researcher's impressions, preliminary analyses and other necessary information, such as the dynamics of everyday routine in the houses and the care practices performed there.

To treat the content – the *corpus* – of the interviews, the statements were submitted to thematic content analysis[8], resulting in 05 categories, illustrated with statements and extracts from what the professionals said, namely:

1) There are several factors to discuss in mental health;

2) This care service in halfway houses started in time. Better late than never!;

3) Daily routine at the houses lies within their limits;

4) The difficulty I find in the houses is that we do not have much time… to be a caregiver;

5) The team's perspectives towards the users should not be different, because it is paramount to speak the same language.

Each category addressed specific issues the professionals discussed in the interviews: 1) presents the representations elaborated regarding mental health; 2) exposes the perception about care delivery to mental disorder patients through HH; 3) presents everyday life at the houses, the relationships established among residents, professionals and the community in everyday experience; 4) deals with the difficulties faced at the houses, such as insufficient time for caregiving, lack of professional qualification, lack of support and family engagement; 5) identifies the professionals' perspectives on the users: autonomy, social reintegration and work.

The development of the study followed the rules of the Helsinki Declaration, from 1965, in its 2000 version, and the guidelines of Resolution 196/96 by the National Health Council[9], which sets the guidelines for research involving human beings. Before starting data collection, the project was approved by the Research Ethics Committee at the State University of Paraiba (Protocol 0211.0.133.000-06).

RESULTS AND DISCUSSION

The line of the psychiatric reform process in Campina Grande

According to the Ministry of Health[10], after a detailed diagnosis of the hospital, the deinstitutionalization proposal was elaborated, built together with the actors involved in

the intervention process: the intervening team (indicated by the Ministry of Health), the representatives of the Campina Grande Health Department and the State Coordination of Mental Health in Paraíba.

Among the adopted measures[10], a plan of discharge was elaborated and carefully put in practice, which required articulations with families and health services from the patients' place of origin. Within less than 2 months, this plan reduced the number of *patients/beds* (total of 138) in the hospital, remaining only 38 subjects who could already be considered *residents*, since they had been there between 02 and 30 years. Shortly after, these patients were transferred to the Reference Center in Mental Health, currently the Psychiatric Emergency Unit and, then, gradually, in a planned way, and after evaluating each case, they were accommodated in Halfway Houses.

The city of Campina Grande was then included in the Going Back Home Program and started to receive financial incentives from the Ministry of Health to set up Psychosocial Care Centers (CAPS) and Halfway Houses. Articulation was then established between the mental health network and the Mobile Emergency Care Service (Serviço de Atenção Móvel às Urgências – SAMU)[10]. In about a year, this city managed to change its mental health care style, going from the hospital-centered model to the psychosocial care model[7].

In the current scenario, the city has an extensive network of substitute services: 01 CAPS II, 01 CAPS III, 02 CAPSi (children), 01 CAPSad (alcohol and other drugs), 01 Psychiatric Emergency Unit, 01 Center for Culture and Leisure, 09 mini mental health teams in the Basic Family Health Strategy (FHS) Units, 06 Halfway Houses and 41 accredited users in the Going Back Home Program[11].

Initially, three houses were opened in September 2005, which followed some criteria, such as: behavior of the users, diagnosis, age group, gender, aggressiveness level, among other factors experienced in daily routine, and were named according to the residents' gender: Female Halfway House I, Female Halfway House II, and Male Halfway House I. Due to the need to create new houses, three new HH were opened in May 2006, also following the same criteria and named: Male Halfway House II, Male Halfway House III and Coed Halfway House (for both men and women).

Nowadays, halfway houses articulate with the substitute network as follows: in daily routine, the residents go to the CAPS of reference of their house, which is defined by the territory criterion: male house I (08 residents), female house I (08 residents) and male house III (07 residents) have the support of CAPS II; whereas male house II (07 residents), female house II (07 residents) and coed house (07 residents) are supported by CAPS III. They go to these centers twice a week to participate in workshops, interact with other users, develop artistic work and do physical exercise. HH residents as well as other mental health network users go to the Psychosocial Care Center for leisure and professional qualification – computing, handicraft and recycling courses – and it also allows these users to be in contact with the community, as it is open to the public. Whenever the residents of these houses need exams or a medical appointment, they are sent to the Basic Family Health Strategy Units, outpatient clinics and general hospitals. In order to recover the presence of family members in the houses' everyday routine, the mini mental health teams, which are inserted in the Family Health Strategy, perform psychotherapy activities with the residents' families. In case one of the residents has a crisis, the professional team of the house contacts the Psychiatric Emergency Unit and, after discussing the case, they decide whether the subject will be treated in loco or taken to the emergency unit. In case they decide for the latter, the SAMU is contacted to transport the patient from the house to the emergency unit.

It is worth highlighting that this articulation is put in practice to deconstruct/construct the scenario of mental health practice, creating a new citizenship and ethics[3], which should mainly focus on promotion, protection and rehabilitation.

This articulation is put in practice to deconstruct/construct the scenario of mental health practice, creating a new citizenship and ethics.

Among the categories found in the analysis of the statements, the points that refer to the care practices produced in the HH were selected and are presented as follows.

If we look back, we will see that there are significant changes

After experiencing almost two centuries of isolation of the *insane* person and insanity, the world can see the inefficiency of psychiatric hospitals and asylums to treat mental disease. This awakening aroused the construction of new ways of care, aimed at producing health without leaving the social context of the city, in other words, as a substitute for the hegemonic, medical-centered, mechanic, Flexnerian-inspired model, which is still predominant in health practices[1].

Nevertheless, the deconstruction of this hegemony has already begun in the mental health area, through the establishment of the substitute service network, which creates new fields for health practices and new possibilities in care production, such as home care for people with mental disorders. This is represented by HH Services, with greater possibilities to include and produce citizenship for these people[12] since, first of all, they are accommodations, houses, intensifying the production of life and health.

For some actors in our research, the way in which these houses assist their users is more humanized.

> The thing about this work proposal is the human question. So, on the other side (hospital) the technical part was more obvious and, in this model, we can see it is something more humanized (Prof., 1).

> In the past, everything was stuck like a... it is a good thing that nowadays they are seeing it with a different look (Prof., 4).

Humanizing is, first of all, considering the individual needs and wishes of each person, offering the necessary conditions for the person to be the subject of his story[13]. This new focus – psychosocial – breaks with the segregating and onerous model of psychiatric institutions, which more similar to an industrial assembly line, in which tasks and, what is even more critical, subjects are fragmented and chained like any product in a common production line.

For this reason, humanization is an important factor to be considered in mental health services, as it is an essential pillar in the construction of the new comprehensive, efficient and impartial care model, through the establishment of a bond among professionals, users and families[13].

Another representation about the care proposal offered in the houses is the *care giving* conception.

> Ah, it was very good. Mainly there, at hospital X, there were no conditions there... it was really precarious, and it improved 100% for them here (Prof., 6).

> At the hospital, they were abandoned. Besides the loneliness, there were the accommodation and hygiene conditions. The care improved a lot here (Prof., 8).

The statements indicate the lack of care to people with mental disorders in the asylum model, and confirm that the quality of care practice offered by HH is better.

According to the Ministry of Health[10], even though the houses are still recent in the country, they are already consolidated in mental health care practice, thus constituting a substitute modality for psychiatric hospitals. This happens because care practice in the house involves the entire singular context of the user (his home, space, belongings, neighbors, partners), which allows for the production of a closer and individualized look[12].

Concerning the professionals' performance, it was observed that this new conception of work (the house) has provided teams with means to manage care in a way that is less technical than at the hospital, and more subjectified[12], that it, closer and more involved with the user's whole individual, family and social context.

The platform of this station is life in this place: experience in the Halfway Houses

One of the main characteristics of our society is the lack of security in group life. Individuals' emotional isolation and the need to belong to a group go deep, hence causing vast frustration about not achieving these belongings. These feelings are even more observed in subjects with mental disorders, since their history has already been marked by abandonment, stigmas and exclusions[14].

The new context of citizenship for subjects with mental disorders only becomes concrete when they can have real rights of citizens, not being excluded, forced, discriminated, but helped in their suffering and allowed to be the subjects of their wishes and projects, as the Psychiatric Reform proposes[15].

Due to the segregation and exclusion of people with mental disorders, the main purpose of activities at the HH is to promote social reintegration, providing them with autonomy, through the process of psychosocial rehabilitation, re-learning the daily and social activities necessary for living in a community[12]. Therefore, the universal ways of dealing with problems like love, friendship, religion and entertainment are considered resources of high therapeutic value[7], as observed in the next statement:

> At the moment they go to the CAPS, there is music, a swimming pool, a physical education teacher, drawing (Prof., 6).

The interaction between the caregiver and the user is another very influential factor in the recovery and rehabilitation of people with mental disorders[11], because it allows professionals to understand the concrete and material difficulties of what it means to live this experience, having the opportunity to see users holistically, conceiving them as complex beings.

> We always take them to the church, to the square, to the mall, to go shopping, to the bank, to the INSS (National Institute of Social Security), to spend the weekend with their families, those who have one and those who want to (Prof., 3).

However, besides competence, this work demands that professionals be able to let go of the power they subjectively have over the resident, based on the principle that each person is responsible for deciding and solving his own problems[16]. This peculiarity allows each component of the house, whether user or professional, to have his own value and function, each of them contributes as they can, helps to fight the fears, the frustrations, thus facilitating the overcoming of daily obstacles of life in society.

It can be perceived in the statement below that it is about reinventing life in its most common aspects, since these users are mainly deprived of the routine of the city[17].

> People from the street already know their names. In the afternoon, I let them stay outside, I open the door and we go out. People pass by, and they talk to everybody. The boys from across the street also play with them. It is a happy moment (Prof., 8).

This type of care offers the subjects a routine that is more dynamic, with the opportunity to exercise their independence, participating in and doing housework, price quotations, payments, as well as other activities that may arise in their everyday, as the following statement indicates:

> ...there is one user who washes the dishes after lunch. He washes them better than I do. There is one who cleans the table, and another who wants to sweep the house. Another one sweeps the front part of the house everyday; and then he gets to talk to the neighbors. There was one who was

> really lazy: he would only sleep. Nowadays, he helps me a lot (Prof., 7).

It is acknowledge that this mental health care modality comprises several actors and services, breaking with the traditional models proposed by the biomedical approach and correlating with the social, economic, cultural and political dimensions, which the substitute mental health care service network is inserted in[2].

Upon arrival, the slight difference between giving a hand and chaining a soul

During everyday routine at these houses, educative work is done to encourage users towards self-care activities, activities subjects start and execute for their own benefit, to maintain life, health and wellbeing. Some users already assume this task integrally, and others partially:

> This kind of activity, more related to the body, like brushing the teeth and taking a shower, most of the times, they do it by themselves, which is a great advance, because they left the hospital. They couldn't do it... this was a fact, we had to teach them as if they were a child, how to brush their teeth, wash their hair, clean their ears. This kind of thing was very slow, but most of them can do it by themselves today (Prof., 3).

> It is very difficult, but we tell them to brush their teeth and they do it. Some take a shower by themselves, but others don't. Some will only take a shower if we tell them to... they are very lazy (Prof., 10).

According to these statements, at the time the users entered the houses, they had to be encouraged to re-learn self-care *as if they were a child*. That happens because, in asylum care, the therapeutics has little or no consideration for the existence of the subject, which implies non-investment in the mobilization of users as participants in treatment, based on the hypothesis that the only thing that works is, basically, the medicine[13], thus creating a typical scene in psychiatric hospitals, in which patients are *drugged*, left to hang around or drag themselves through the corridors of the institution, generally alone, since they have already lost their bond with relatives and friends.

Nevertheless, the houses have been able, as far as possible, to overcome this stigma, as observed in the relations of friendship that start to arise between the residents:

> They are friends, they talk a lot. Sometimes they are just not in a good mood, sometimes they even get irritated at me, but they don't fight or argue (Prof., 7).

> Living together is common, even because they already did it at hospital X... and today they are in the house with less people. Thus... they are very familiar to one another (Prof., 3).

This social experience is a factor that should be encouraged in society, due to the social imaginary that insanity is still incurable and dangerous, conceptions that are hard to revert overnight since, until the end of the XVIII century, *insane* people were treated as prisoners[3].

It is also important to consider that the psychiatric hospital or asylum was based on a group of representations and knowledge, allegedly neutral and scientific, which confirmed the insane person as dangerous and incapable. In the Brazilian matrix of social relations, there was the prevalence of this inhuman logic of the *strange*, which contains the difficulty to recognize the other, to accept him as different and equal[18].

The importance of these houses in the re-socialization and therapeutics of people who were discharged from asylums is beneficial. They have to play their important educative and referential function to the residents, who have their fantasies and fears reduced as they get to be in touch with the social context[6].

The fact that patients with mental disorders leave the hospital to experience the social context represents not only a political-administrative attitude, but also a theoretical-practical action that reorganizes the participation, understanding and discussion about the users, together with mental health technicians, towards the progress of the Psychiatric Reform process, as evidenced in this statement:

> Three users participated in the Going Back Home Program in Brasilia. They stated their opinion there and got home really happy (Prof., 7).

In order to implement actions to guarantee dignified care to people with mental disorders, several concepts about insanity and mental suffering that are still rooted in society need to be confronted and deconstructed. This is the only way for mentally ill persons to be seen as subjects with rights who need care, without necessarily losing their freedom and autonomy.

FINAL CONSIDERATIONS

It takes attitude to get to the next station!

In the SUS scope, since the 90's, public policies have focused on the overcoming of mental health care practices to put in practice a care network that replaces psychiatric hospitals as exclusive care institutions. Therefore, care to persons with mental disorders has been re-structured in terms of basic care, thus allowing for the promotion of alternative models, centered in the community and inside its social networks.

In this context, the houses – as accommodations inside the city – have a care logic that is produced in the house, or from it, whether on the street, at the supermarket, at the movie theater, at school, or at several places of the subject throughout the territory, because the focus of this care modality is connected to the promotion of a chance to rescue the life of people with mental disorders, a chance to acknowledge them as subjects, granting them citizenship and paralyzing the disobjectification the asylum institution expresses.

However, this home-inspired care practice cannot be quantified, because it is a subjective system that cannot take the risk of being reduced to numbers, since it is related to inhabiting and (re) inhabiting a space that had been taken from these people. This *residing* transcends and precedes the psychiatric institutions and carries a symbolic meaning, which places the subjects between life, freedom and segregation, inside the same social space – the city.

This peculiarity of the Service of Halfway Houses allows each resident to have his own value and function. Everyone contributes as they can, everyone helps each other face their fears, frustrations, thus facilitating the overcoming of daily obstacles in life. Therefore, care stops being exclusion in spaces of violence and mortification, to become the creation of concrete possibilities of sociability and subjectivity.

Therefore, living the daily routine of the city allows these people, who used to stand at the edge of the story, to become authors of their own life, moving from sick persons towards other roles: of citizens, persons who have rights, consumers, producers, subjects.

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