

Between past and future: what the everyday lives of beneficiaries of brazil's Back Home Program teach us about the program

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Abstract *This study investigates the everyday lives of six beneficiaries of the Programa de Volta para Casa (the “Back Home Program” - PVC) with the aim of analyzing its effects and identifying lessons that can be applied to help improve and ensure the continuity of the deinstitutionalization process in dialogue with the current political, social and economic reality. Using participant observation and narratives, we conducted a qualitative study in two cities that have been implementing the PVC over the last 15 years. The results were organized into the following core themes: the participants - who they are and how they live; the challenges of being back in the city; using money and the challenge of shifting towards social capital; and the guarantee of rights. The findings of the hermeneutic-dialectic analysis show that the beneficiaries have moved away from a situation of zero contractuality and ruptured affective relations towards one of access to goods and services, housing and free movement in public spaces, limited by urban violence, lack of money for leisure activities, aging, precarious housing conditions, and lack relations of trust and solidarity with ordinary people living in the neighborhood. Making the city an enabling environment and promoting actions in coordination with other sectors such as housing, income, employment, security and justice are steps of resistance in the face a regressive political, economic and social landscape.*

Key words *Deinstitutionalization, Mental health, Personal narrative, Citizen participation in science and technology*

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Introduction

The *Programa De Volta Para Casa* (or the “Back Home Program” - PVC), regulated by Law 10708/31 July 2003¹, is an avant-garde initiative that emerged from Brazil’s mental health reform. This psychosocial rehabilitation assistance program pays monthly benefits to people discharged from long-term care in psychiatric institutions. One of the characteristics of the program is that it requires personal identification to open a personal bank account, thus contributing to the recovery of personal documents such as birth certificates and individual taxpayer identification numbers and, consequently, the personal history of individuals who had their life denied.

The PVC is the only program of its kind to make direct payments to beneficiaries. With regard to deinstitutionalization processes in other countries, assistance is generally provided in the form of services and programs. The Italian program, *budget di salute*, is probably the initiative that most resembles Brazil’s PVC, as it also aims to address the financial needs of people who have been discharged from psychiatric institutions. However, the main aim of the Italian program is to fund personalized projects². It is similar to the Brazilian program insofar as it is oriented towards the individual, but does not make direct payments to beneficiaries.

Given the PVC’s unique characteristic, it is surprising that it has been little studied among the strategies developed under Brazil’s mental health reform³. Studies highlight the PVC’s impact on the everyday lives of beneficiaries and the challenges related to accessing the program.

Studies include experiences in Fortaleza⁴ and Belo Horizonte⁵ that demonstrate the contribution the PVC makes to the dehospitalization of long-stay patients. The findings show that the program helps beneficiaries exercise citizenship because it guarantees the civil right to have personal documents – which patients did not have while hospitalized – the right to come and go as residents of a city rather than a psychiatric hospital, the right to have a voter registration card, and the right to access this public policy⁴. These studies conclude that the PVC helped restore various rights⁵.

With regard to the PVC’s contribution to psychosocial rehabilitation actions, Lima⁴ suggests that engaging beneficiaries’ as a central element of treatment planning remains a challenge, due to the technical team’s lack of knowledge of the program. The author also highlights the need to

monitor how the benefit is used in order to ensure the exercise of citizenship. An analysis of the PVC implementation process in Ribeirão Preto⁶ from the perspective of managers describes a different scenario in which the mental health team helps beneficiaries manage the money received from the program. The team calls the program “assisted citizenship”, insofar as it combines protective actions with the promotion of autonomy tailored to the user’s needs.

Many of the beneficiaries of the PVC are also residents of therapeutic residential care homes (TRCHs), which provide alternative accommodation for a large contingent of people who have been discharged from psychiatric hospitals and have experienced ruptures in family and community ties⁷. Studies exploring the use of the benefit report that beneficiaries use the money for leisure activities, home improvements, purchasing furniture and paying for services not provided by Brazil’s national health service, the *Sistema Único de Saúde* (SUS), such as dental prostheses^{5,6}.

In a TRCH in Salvador, part of the benefit is used collectively to pay joint costs that are not covered by facility funding. The remainder is provided to the beneficiaries on a weekly basis and managed by the TRCH carer⁸. In contrast, beneficiaries living in a TRCH in a town in Greater São Paulo regularly go to commercial establishments (markets, restaurants, delicatessens, supermarkets, banks, beauty salons, shopping malls, etc.), cultural and leisure spaces (beaches, fishing, museums and art galleries, churches, football stadiums, cinemas, etc.), and health services⁹.

The most recent studies of the PVC are fruit of a national evaluation coordinated by Fiocruz Brasília with the support of professors from universities in five states. Guerrero et al.¹⁰ highlight the individual benefits that beneficiaries receive from the PVC when it is implemented in coordination with local services, such as the promotion of social inclusion and citizenship and strengthening of bargaining power. In addition, a study undertaken by Bessoni et al.¹¹ analyzing narratives constructed during a national evaluation reported that the combination of different strategies emerging from Brazil’s mental health reform (the PVC, psychosocial care centers and TRCHs) facilitated:

*the establishment of affective relationships, getting around the city and consumption of goods and services, consequently, increasing capacity for expression, communication and critical positioning. It was possible to observe new spheres of bargaining engendered by receiving money*¹¹ (p. 40).

There are 4,520 beneficiaries of the PVC in Brazil¹². Despite the benefits of the program, the figures show that a significant number of eligible people have yet to be registered in the program. According to a national inspection of psychiatric hospitals in 2019¹³, 14% of beds are occupied by residents, meaning that there are approximately 3,639 potentially eligible beneficiaries living in psychiatric hospitals.

These figures show that although progress has been made on the mental health reform front, a lot remains to be done. One of the pathways to strengthening mental health services is the expansion of the Psychosocial Care Network (PSCN), through the creation of the PVC and its amplification during the 2000s. However, a number of changes have taken place in Brazil's political landscape, starting in 2016 with the impeachment of President Dilma Rousseff: the judicialization of health care, contributing to delays in PVC benefit payments; the approval of constitution amendment 241, capping public spending on health and education for the next 20 years¹⁴; and the election of a far-right president.

Moreira *et al.*¹⁵ highlight the challenges this context poses for Brazil's mental health reform, resulting in the strengthening of the hospital-centric model and unsustainability of public health and social policies. It is therefore vital that evaluations of government programs identify gains, advances and challenges from the perspective of beneficiaries when deciding program continuity and expansion.

The aim of this article is to reflect on the effects of the PVC on the everyday lives of beneficiaries. We therefore identify what needs and demands must be met to ensure that beneficiaries maintain their liberty and how the lessons learned from the PVC can be applied to help improve and ensure the continuity of the deinstitutionalization process. Finally, we discuss the findings in the context of the current political, social and economic reality.

Methodology

This article is the fruit of two convergent studies in municipalities with certain similarities: both are medium-sized and have regional referral psychiatric hospitals, meaning they were pioneers in the implementation of the PVC. Although in different regions of the country (the Northeast and Southeast), both municipalities have played a powerful role in the deinstitutionalization pro-

cesses. Another point of convergence is that both studies were qualitative and explored the social reality and everyday life of beneficiaries of the PVC, or in other words, an existence that provides the possibility of living in freedom after years of confinement and isolation in psychiatric hospitals.

According to Minayo, qualitative research is the study “of interpretations that human beings make with regard to how they live, construct their artifacts and themselves, feel and think”¹⁶ (p. 57). The techniques used in the studies were participant observation – which permits an understanding of a “variety of situations or phenomena that is not obtained from questions”¹⁷ (p. 60) – and narrative, which according to Koosah *et al.*¹⁸, is an important instrument for mediating life authorship and comprehending the challenges of care and knowledge production within the context of Brazil's mental health reform. Koosah *et al.* point out that, unlike the hierarchical relationship that is commonly established between the researcher and the researched, the encounter between individuals who have been discharged from long-term stays in psychiatric hospitals and a group of researchers reflects the complexity of human encounters.

Constructed after four participant observation encounters, the narratives of each participant show who they are, how the money empowers participants and how participants relate with people and the neighborhoods in which they live. In this method, the words of social actors, in this case the narratives transcribed by the group of researchers, are situated within a context in order to be better understood.

For the purposes of this article, each researcher revisited the narratives to select extracts that help reflect upon the relationship between fundamental determinants (socioeconomic and political conjuncture) and the perceived daily demands and needs of beneficiaries, thus prompting reflections on the continuity of the program and achievement of its objective: psychosocial rehabilitation. Three narratives were randomly selected from each study without using predefined criteria in order to minimize bias.

The narratives were then reread by another researcher to validate the selection. Using dialectical hermeneutics as a theoretical framework^{14,19}, the extracts were analyzed together and used to illustrate core issues that emerged in the encounter between the historicity of these people's experiences and the theoretical underpinnings.

The study protocols were approved by the research ethics committee (approval numbers 3.243.147 and 2.064.899).

Results and discussion

The results were organized into five core themes: the participants - who they are and how they live; the challenges of being back in the city; using money and the challenge of shifting towards social capital; and the guarantee of rights.

The participants - who they are and how they live

The analysis of the transformations is based on a brief presentation of each individual, losses during hospitalization, and how they are currently living.

Estevão is a black man of average height with short curly gray hair. He was born in the state of São Paulo and has lived on the coast since he was a baby. He was hospitalized for a long time, but does not know exactly how long, though he knows that it was “a life, a long time”. He lost his father’s and grandmother’s house to cousins who still live there. He is 61, lives alone and attends the psychosocial care center (PSCC) on a daily basis to, in his own words, “enjoy myself”: play guitar. He is known for his friendly and kind nature. He goes to the bank every month to withdraw his benefit, which he uses for household expenses. He spends any money that is left over in the bakery, paying with his debit card because he thinks it is dangerous to carry money around in his pockets. He uses change to buy the odd cigarette. His latest purchases were his glasses and cellphone.

Janaína, 54, is a calm and soft-spoken Gemini. She is suspicious at first, but likes talking about herself. She identifies as a jambo-colored brown girl. She has been hospitalized a number of times due to relapses, which make her lose consciousness. She said that she escaped from the last hospital “without being cured and it’s been almost two years since I was last hospitalized”. She attends the PSCC on a daily basis to have her meals, because she does not cook much at home. She used to do crafts classes, but prefers to watch television now. She has a cellphone companion to listen to the hymns she used to hear when she used to go evangelical church on Sundays.

Wando lived on the street, in school and various hospitals, spending five years in the last one. He is 61 and lives by himself in a rented house, which he calls “the most beautiful thing, with speakers”. He walks around the neighborhood with an Aiwa personal stereo and flash drive listening to Roberto Carlos, his favorite singer. He

goes to the PSCC on a daily basis to eat and goes home by bus, “come rain or shine”. He is punctual in withdrawing his benefit, paying the rent and water and electricity bills. He uses the money to pay for groceries, preferring to buy in local stores because it is cheaper.

Ninha was hospitalized for 27 years. She had three children during this period, but does not know their whereabouts. She also has two brothers, with whom she has little contact. She immediately understood the study objectives, helping to suggest and explain where to find potential participants, revealing that she has wide knowledge of the everyday life of the other beneficiaries and the city. A member of the dance group and income generation project, she accepted to participate as long as it fitted in with her schedule “because I do a lot in the morning at home and in the afternoon around town”.

Linda, 68, lives in a TRCH and has been hospitalized several times since she was a child. She only remembers her last hospitalization, which lasted seven years. She has two children and three grandchildren, who she meets only on some holidays and at the end of the year. She spends most of her time with the other home residents, especially Lí, her friend since she was hospitalized. Linda had poor health and died two months after the end of the field work.

Zé, around 50, is black and always likes to be well dressed. In and out of hospital, the last facility he was admitted to was a therapeutic community, which he left after seven years to live in a TRCH. He is sure that his date of birth was recorded incorrectly. Before being hospitalized, he was married twice and had a daughter, but has lost all family ties. He has only had one formal job. According to Zé, it was drink that caused the problem. Despite being scared, mainly of getting lost, he likes going on trips with the other residents, going to a restaurant in the city and having ice cream.

Now that we have presented the protagonists, below we describe the needs and demands identified in the narratives, helping to understand the challenges of maintaining deinstitutionalization and psychosocial rehabilitation. This process modifies the psychiatric loop²⁰, constituted as a social model centered on the individual’s life in pursuit of constant and daily social inclusion, in contrast to the limited and misguided approach criticized by Venturini²⁰ and Pitta²¹, which proposes a process of dehospitalization or humanization of care in asylum-style spaces as a learning process.

The challenges of being back in the community

The six stories show that the rupture of affective relationships that existed before long periods of hospitalization was definitive for all participants. When resuming their life, the participants were able to create new ties of friendship and partnerships with both workers and people attending PSCCs or residents of TRCHs. For some participants it was possible to choose their assigned carer at the PSCC, an unlikely occurrence in times of institutionalization. Like other city dwellers, freedom provides the possibility to interact, be with others as an option, and notice common interests with other people, out of free will and not obligation as in closed institutions. Wando and Janaína mention the establishment of other ties, with old work friends and the church, respectively.

Estevão, Janaína and Wando live alone, meaning that they go to town every day. They follow similar routine itineraries: home to the PSCC, grocery store, bank, shops in general, and walks around the neighborhood. The walks and stops on the way are for common activities that ordinary people living in the city perform: shopping and paying bills. For Linda, Zé and Nina, who live in a TRCH, going to town appears to be less frequent and more varied. Nina, in particular, seems to have a broad social exchange routine, selling her products on the street in the mornings.

Although relatively broad, the expansion of these itineraries is limited by different boundaries: “the money doesn’t go very far, on the day I receive the ‘back home’ I go to the beach, just to look.” (Estevão); “someone might pick on me on the way, if someone comes up to me and says give me 10 reais otherwise you don’t pass, what do I do? I have to give them the 10 reais (...) I don’t like going out, I’m afraid someone will do something mean to me (...) hit me” (Wando). Linda has diabetes and tends to have swollen legs, meaning that steep streets are a problem for her. Nina worries because the streets are quiet and has heard there have been muggings and Zé does not tend to go out by himself because he might get lost or fall over and not be helped, like Janaína: “I’m afraid to walk alone around the city; what if I fall over and lose consciousness?”

As Campos⁶ concludes, violence, lack of money for leisure activities and physical limitations that come with aging appear to be obstacles to social interaction, and consequently one of the

main factors hampering psychosocial rehabilitation among people aged over 60. The history of social isolation and stigma suffered by people discharged from long-term hospital care may explain the fear participants feel of establishing new social relations. They seem to feel more susceptible to violence or to not receiving help when they need it.

It is important to highlight that these obstacles are not related to limitations resulting from psychic suffering, but rather to being old and having been deprived of their liberty for much of their adult life in a society with high rates of violence and deep inequalities.

According to Venturini²⁰, deinstitutionalization really takes place when individuals are granted civil, social and individual skills and abilities and the city becomes a set of scripts, exchanges, and itineraries established by each individual involving other people. Effective deinstitutionalization consists of transformations and social exchanges with the people living in the city.

Money and the city

Two questions emerged from the participants’ experiences of using money: the different support strategies beneficiaries use to access and use the money; and the predatory relationship that people and/or institutions such as banks and stores establish.

The first question concerns the relationship between health professionals and the beneficiaries. The beneficiaries may use a range of strategies to access the money. Care workers may look after the beneficiary’s personal documents, card and password to ensure they are not lost or stolen; withdraw the money for the beneficiary or go to the bank with them to make the withdrawal or teach them how to use the ATM; look after the money to help the beneficiary control spending; calculate how much has been spent and what is left over for other expenses, informing the beneficiary how much they have saved and if there is enough balance for larger purchases; and assess spending priorities based on the balance.

For beneficiaries living in rented housing, the relation with the PSCC appears to be one of constant bargaining. Wando leaves his cards and personal identification documents in his patient records and on the 20th of each month, he reminds his assigned carer that it is the day to go to the bank. They walk three blocks from the PSCC to the bank. Wando knows what to do when he gets there: punch in the password, put the money

in his wallet while still inside the bank, and go directly to pay his debts. Janaína explained that after the PSCC team taught her to withdraw the money, she started going to the bank by herself. Each month she makes a supermarket and pharmacy list and when she receives the benefit, she immediately goes shopping. When there is money left over, she goes to the clothes store. Estevão looks after his documents and cards, makes his own withdrawals and pays for shopping with his debit card. As he has lost his documents a number of times, he keeps copies in his patient records.

Part of the money received by residents of the TRCH is paid into the kitty to cover shared expenses. Linda does not go to the bank. Instead, she prefers that her assigned carer looks after her card and password and makes withdrawals. Zé does not usually go to the bank to make withdrawals and explains how he uses the benefit: “There’s money for putting away and money for spending. Before I didn’t have any to put away, now I put away a lot and spend little”. He uses his savings to purchase things like furniture, CDs and a CD player. He also pays for medical appointments when he cannot get them on the SUS. Nina maintains her autonomy in accessing the money and receives help with financial control. One of the carers at the TRCH looks after her benefit and gives her small amounts throughout the month to get her nails done in the beauty salon, pay her private health insurance and buy ice pops, for example. With this help, she managed to save enough money to buy a camera, cellphone and fan. She concludes, “the money from ‘Back Home’ really helps (...) if the person doesn’t receive the money, he/she is left with nothing. All broke (...) wants to support him/herself but can’t.”

Life in the city poses risks. In this regard, the second question that stood out in this core theme was the predatory relationships between people and/or institutions and the beneficiaries, which are exemplified by the following events and accounts.

During one of his walks to the bank with his carer to withdraw his benefit, Wando was approached by a man who offered him a place in a therapeutic community for the treatment of *alcoholism*. Despite Wando’s refusal of the offer, the man followed them insisting on the benefits of the community.

Janaína was unable to buy a television because of her credit score. She explained that she had never taken out a bank loan, but she is in

arrears with a department store credit card and owes around R\$4,000. She also mentioned a neighbor who taught her to make bank transfers so she could lend him money. Zé told us under his breath of a robbery at the TRCH. Two men took all the money from the safe (R\$100) that the residents had pooled together to cover joint expenses, “but they didn’t hurt anybody”.

Estevão was surprised that he had nothing in his account when he went to the bank. The manager explained that it was because he had been making a R\$100 monthly payment to a savings bond that he took out after the manager had explained that it was important to save money. Estevão did not understand how saving money was a good choice if he was unable to pay the rent and asked to cancel the bond. He was surprised and worried that he could only withdraw the money in one year’s time.

These extracts highlight the challenges of being back in the city. Residents living in TRCHs (guaranteed free housing) are able to go further without getting into debt, unlike Wando, Janaina and Estevão, who live alone and, despite receiving a disability living allowance, find it hard to make ends meet.

The pride of the accomplishment of living alone is the consequence of a shift from an experience of zero contractuality²² as residents of a psychiatric hospital to some level of contractuality as city residents. The findings help understand how this policy directly addresses the needs of individuals who have lived long periods of exclusion and isolation.

After pride, the desire for better housing is a common feeling, which can be seen in the remarks about housing conditions: “messy with old stuff, no window, leaky” (Wando), “dirty and messy” (Janaína), “it’s small, not everything fits, it’s impossible to clean” (Estevão). This feeling is only possible when individuals experience contractuality and become aware that they are socially excluded because they do not access basic rights such as the right to adequate housing, defined by the constitution as having proper sanitation facilities that ensure adequate living conditions.

Venturini²³ highlights that to advance the process of deinstitutionalization, it is necessary to know the city and the resources and needs of the neighborhood where these individuals live in order to enable active socialization, involving the integration of social networks and institutions. Lima⁴ recommends that the PVC should offer more than the restoration of rights, contribut-

ing to the creation of new rights stemming from access to public policies in other sectors, such as education, housing and employment. Venturini²⁰ suggests that efforts should focus on promoting social cohesion, developing the social capital of the community in the form of relations of solidarity and trust.

The transition from money to social capital

The transition from money to social/affective capital appears to be a challenge. Being back in the city provides an opportunity to establish encounters with the other in public spaces; however, it is in the private space at home that the encounter is transformed into a more intimate relationship. The precariousness of housing may be a factor that hampers the establishment of new affective ties between beneficiaries of the PVC and ordinary people living in the neighborhood.

Gender differences may also be a challenge to promoting this shift. The three men, Zé, Wando and Estevão mention resorting to prostitution in the past and present to have sexual relations. They talk openly about sexual experiences, while Janaína wants to date and get married, Ninha has a boyfriend, but does not want to get married, and Linda does not touch on the subject.

The six person's life stories include normal everyday cultural activities, ranging from the free profession of faith and participation in religious services to the acquisition of musical goods (CDs and CD player, for example) and playing guitar. However, the participants do these activities at home by themselves or in the PSCC. The precariousness of housing and the exercise of sexuality and culture are different facets of a common question: the barriers to and possibilities of establishing relations that extend beyond those with health professionals or the restoration of family connections to include local residents, neighbors and people who frequent the same public spaces of interest. Sharing care, incorporating these individuals into the world of production and intensifying efforts to promote new values when it comes to interacting with people who have experienced severe psychic suffering²⁰ are possibilities for shifting from money towards social capital.

The “back to the city” program: social capital and the guarantee of rights

Based on the above observations, from a deinstitutionalization perspective and consider-

ing the current change in direction of public policy in Brazil towards neoliberal strategies characterized by necropolitics, the redesign of this program should focus on investing in social capital and guaranteeing rights. Delgado²⁴ lists some measures that demonstrate the resurgence of regressive politics: the weakening of primary care with the dismissal of community health workers from family health teams; increased cost of psychiatric hospitalization and provision of places in therapeutic communities; lack of incentives for the creation of new PSCCs; and the return of specialized outpatient clinics.

Zé and Ninha have subsidized private health insurance, which they use to bypass problems in accessing public services for the treatment of cancer and tests to diagnose a tumor, respectively. Given their age, both should be a priority in the local health center, but report that they only manage to keep their examinations up to date when they pay for private services.

Ninha also challenges the capitalist mode of production. First, because she does household chores, and second because she participates in an informal income and employment generation program in her city, making products and selling them at different points around the city. She does this because she has the autonomy to get around the city, knows the neighborhoods and feels good getting around the city at any time of the day. Although informal and low paid, this is her work.

Some of the participants are in debt, one with their bank. With the possibility of making purchases with a credit card and using online banking services, they find it difficult to keep monthly spending within their means. Even when using traditional money management techniques such as keeping money in a safe at home, we found reports of robberies. It is therefore important to adopt protective measures to avoid exploitation and invest in addressing urban violence.

In this regard, Rotelli²⁵ suggests that the question is not only asylums, but also madness as a social product. According to Rotelli, the fight was always against a combination of scientific, legislative, administrative and cultural apparatus and power relations structured around what was regarded as an “illness”, but is actually a mode of social structure. The development of a program that seeks to promote transformation on this scale also requires the construction of new values and forms of social interaction in order to promote a more radical structural transformation that engenders a new order. This construction is by no means linear or progressive and can there-

fore give rise to both advances and regressive steps.

Considering that walls can be rebuilt, it is necessary to show what has been possible and point out what can be expanded. Intersectionality is an area that requires investment. The experiences described above exemplify the need for networking, both within the health sector as well as to promote cooperation between other sectors such as housing, income, employment, security and justice.

The use of narratives to obtain a deeper understanding the participants' stories appeared to be a necessary alternative to hear people who are directly involved in the deinstitutionalization process. The use of dialectical hermeneutics as a theoretical framework allowed us to analyze the historicity of these stories and at the same time take them as ahistorical narratives that make it possible to point to distinct paths to a possible and uncertain future in pursuit of new horizons.

Final considerations

Being included in the program reclaimed civil registration and the right to live in society. Access to goods and services seems to be contingent on territories and established social relations. Restoring these two aspects allowed participants to go beyond the simple receipt of benefit, with the development of autonomy and contractuality and the establishment of new relations being the main indicators of living a dignified life in freedom.

These narratives show that inhabiting the city is a process of rehabilitation, as suggested by Venturini²³. The challenges are those present in the way of life in urban peripheries: violence and precarious employment, housing, leisure and culture.

At individual level, aging is aggravated by living in social isolation, posing numerous challenges. These challenges are present in the power play of relations of support – established mainly with health professionals and sometimes other people, involving a low level of affection and intimacy – and relations of exploitation, primarily with financial institutions. These relations can mean that participants are less likely to attain social capital and the guarantee of human rights.

From the point of view of program management, there are a number of challenges in developing and expanding the PVC. With regard to development, it is important that care teams create strategies to help beneficiaries manage their money and look after their documents only when defined jointly as part of the individual treatment plan. With regard to expansion, the small number of beneficiaries may be a reflection of the sluggishness of the deinstitutionalization process and relative lack of knowledge of strategies to access rights, such as the possibility of late registration to obtain personal identification documents and open a bank account. In such cases, the designation of a local point of reference for the program, as provided in the program regulations, or deinstitutionalization team, as provided by Ministerial Order 2840/14²⁶, can help tailor the program to the real needs of this group.

There are points of resistance and coping amidst the challenges imposed by the dismantling of the system by the federal government. Further studies with service users should be undertaken to help inform decision-making on public investment in social welfare. In addition, it is important to invest in the diffusion of rights in order to enhance the continuity of processes such as psychosocial rehabilitation.

Collaborations

The three authors contributed to study conception and writing the manuscript and revising it critically for important intellectual content.

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