

THERAPEUTIC RESIDENTIAL SERVICE: THE USER'S PERSPECTIVE

Serviço residencial terapêutico: o olhar do usuário

Servicio terapéutico residencial: la mirada del usuario

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ABSTRACT

Objective: This paper studied the daily life of residents of Therapeutic Residential Services (TRS) discharged after long-term psychiatric internments. The objective was to describe the residents' social reintegration process of residents, considering the TRS model. **Methods:** This is a qualitative study, whose subjects were residents of TRS. Data analysis followed the principle of thematic content analysis. **Results:** The therapeutic project envisioned by the staff of the Therapeutic Residential Service is in accordance with the recommendations in the epistemological paradigms of Psychosocial Rehabilitation. **Conclusion:** The interviews revealed the experience of living outside the mental hospital, showing the reconstruction of this subject as a social being, in practical terms, with some residents who circulates through the neighborhood, talks to neighbors, while others argue with peers and are intolerant of colleagues.

Keywords: Deinstitutionalization; Assisted Living Facilities; Mental Health.

RESUMO

Este estudo teve como objeto o cotidiano de moradores de Serviços Residenciais Terapêuticos (SRT) egressos de internações psiquiátricas de longa permanência e, como objetivo, descrever o processo de reinserção social dos moradores considerando o modelo de SRT. **Métodos:** Trata-se de um estudo de natureza qualitativa, cujos sujeitos foram moradores de SRT. A análise dos dados seguiu o princípio da análise de conteúdo temática. **Resultados:** Constatou-se que o projeto terapêutico vislumbrado pela equipe do Serviço Residencial Terapêutico aproxima-se do preconizado pelos paradigmas epistemológicos da Reabilitação Psicossocial. **Conclusão:** As entrevistas permitiram a aproximação da vivência fora do manicômio, sendo possível perceber a reconstrução desse sujeito enquanto ser social. Em termos práticos, tem-se um morador que circula pelo bairro, conversa com os vizinhos, mas também há aquele que discute com os pares, é intolerante com os colegas.

Palavras-chave: Desinstitucionalização; Serviços Residenciais Terapêuticos; Saúde mental.

RESUMEN

Objetivo: Este estudio tiene como objeto el cotidiano de habitantes de Servicios Residenciales Terapéuticos (SRT) oriundos de estancias psiquiátricas de larga permanencia y como objetivo, describir el proceso de inserción social de los habitantes considerando la plantilla de SRT. **Métodos:** Se trata de un estudio cualitativo, cuyos sujetos eran los residentes de SRT. El análisis de los datos siguió el principio de análisis de contenido temático. **Resultados:** Se constató que el proyecto terapéutico previsto por el equipo del SRT se acerca del preconizado por los paradigmas epistemológicos de la Rehabilitación Psicossocial. **Conclusión:** Las entrevistas permitieron el acercamiento de vivir fuera del hospital psiquiátrico, siendo posible percibir la reconstrucción de ese sujeto mientras un ser social, en términos prácticos, se tiene un habitante que circula por el barrio, habla con los vecinos, pero también hay aquel que discute con los pares, es intolerante con los compañeros.

Palabras-clave: Desinstitucionalización; Instituciones de Vida Asistida; Salud Mental.

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INTRODUCTION

Experience in the mental health area and the existing theoretical construct about the theme have demonstrated the changes that have happened across decades in the treatment of mental patients, some of which were superficial and others effective, capable of influencing public policies and the core of society.

In that sense, the Brazilian Psychiatric Reform contributed, first by changing the precarious conditions in psychiatric hospitals, and then through the services offered in replacement of hospitals, through which the territory was experienced as a scenario to rescue subjects who were forgotten in a limited space that was full of rules of conduct.

This territory goes beyond the physical space and is capable of connecting people, of enhancing the exchange of experiences and of constructing a new way to conceive mental patients. This is a live force of concrete relations, the place where lives and subjectivities are reproduced¹.

The services in replacement of asylums, which deal with the territory on a daily base, include Therapeutic Residential Services (TRS) or Therapeutic Residences (TR), which are *homes in the community to take care of mental patients discharged after a long-term psychiatric internment, without social support and family bonds, and which permit their social insertion*².

An alternative model of "normal houses with modulated support" - that is, a residence whose constitution would receive minimal support from the services and where the resident would receive variable and flexible support from the health sector - emerges in response to criticism against the traditional model, which allegedly does not respond to the users' needs and preferences³.

The TRS do not only aim to respond to the housing demands of users who occupied or are still occupying hospital beds without psychiatric symptoms to justify these internments. The proposal complies with the recommendations of psychosocial rehabilitation, that is: rescue of autonomy, social insertion, increased contractual power and resumption of rights.

Most importantly, the idea remains that the existence of the TRS and their implementation only are insufficient to establish deinstitutionalization. The restructuring follows the path of care and the way it is offered or based on what reference it is produced:

The Therapeutic Residence Services respond to the need to construct another social place for madness, by establishing new care dialectics. It should be kept in mind that care also means social inclusion and that there does not exist any reform clinic that isn't also a social inclusion clinic⁴.

In that sense, what is at stake is not just a new address, whether an asylum, a boarding facility or even

the family, in which the subject's situation of guardianship is maintained, but the adoption of an inclusion policy of patients in social life⁵.

Thus, the TRS serve as places where personal histories are intertwined in daily life with the people living at the same home, closest neighbors and the territory. Hence, new histories are experienced, new possibilities are constructed. Each actor will thus subjectively construct his/her own identity and 'his/her own home' in this physical space and the surrounding social universe, according to his/her subjective references and particular life projects⁶.

And it is precisely this construction, intertwined in the experiences permitted by the incursions across the territory, that makes room for the individual's insertion in a wide range of living contexts, in different social scenarios. The individuals, who used to have their physical space and individuality curbed by the asylum routine, start to leave their interior world, live with people, exchange experiences, learn from other people and the surrounding world and, mainly, start to be acknowledged by neighbors, peers and have their rights legitimized.

The inclusion process that permeates the TRS, however, involves a process of deconstruction, in which these devices do not attend to the residents' demand.

In view of the social inclusion proposal of the TRS, in this research, the researchers intend to give voice to TRS residents, as they are the subjects the theoretical actions reflect on.

Hence, this study is focused on the daily life of residents at Therapeutic Residential Services who were discharged after long-term psychiatric internment, justified by the intent to contribute to a broader discussion about the importance of well-planned deinstitutionalization, as an alternative for patients without appropriate family and social bonds.

Thus, the aim was to describe the residents' social inclusion process in view of the Therapeutic Residential Service model.

METHOD

A qualitative study was undertaken, as this type of approach permits understanding the interviewed subjects' discourse and is concerned with covering and deepening the reality and the universe of meanings, aspirations, beliefs, values and attitudes as much as possible, which corresponds to a more intimate (profound space) of human relations, processes and phenomena⁷.

Data were collected through semistructured interviews with the people living at the therapeutic residences. Their statements permitted the reading and analysis of the experiences shared inside and beyond the space of the therapeutic residence. The interviews were recorded with the help of a digital recorder.

These interviews were held at a Therapeutic Residence located in the region of Taquara, in the neighborhood called Jacarepaguá, in the city of Rio de Janeiro, and at the Coordination Room of the TRS. This Residence receives support from a team of the Therapeutic Residence Program organized by the *Instituto Municipal de Assistência à Saúde Juliano Moreira* (IMASJM) in 2000.

The choice of the IMASJM's Therapeutic Residence program as the place of study was due to this institution's trajectory and experience in this kind of device, as its TRS were implemented even before the ministerial decrees and federal laws.

The TRS residents receive technical support from the Segment Team, which is responsible for guaranteeing attendance to residents in the territory. The houses receive weekly supervision by mini-teams, including a referral technician with a higher education degree, a territorial caregiver (supporter and articulator between the residents and the street) and the home caregivers.

The scenario that served as the strategy to approach the residents for a future interview was the Project *Arte e Horta*, an income generation program for mental patients over 18 years of age, which promotes actions that can support their social reinsertion. The Project functions within the IMASJM facilities and includes income generation workshops, namely: Mosaic, Cooking, Canteen, Gardening and Vegetable Growing.

Before entering the residence, I got to know the residents in this Project as, because it was related to houses, the Coordinator felt obliged to serve as the spokeswoman for this discourse and to make sure that, in practice, the TRS resident would take home whoever pleased him, that is, an invitation was needed to get into that domestic space.

The need for this invitation, however, limited the study sample to seven residents, although the TRS Program of the study institution manages a significant number of residences. Not all residents participate in the *Arte e Horta* project though. In addition, not all project participants are TRS residents. Therefore, the criterion used to define the study sample was exactly the researchers' access to the study population.

The TRS where part of the interviews were held was an apartment, located on the first floor of a building in one of the main streets of Taquara, a neighborhood in Jacarepaguá. The apartment is well located, with shops and transportations means in the surroundings, and consists of two bedrooms, a living room, a kitchen, a bathroom and a small porch.

The study subjects were selected according to the inclusion criteria: living in the TRS, accepting to participate in the study, over 18 years of age and not being confined,

that is, not being declared legally incapable, because of the impossibility to sign the free and informed consent form. Anyone who did not comply with the above criteria was considered as excluded.

The study followed the recommendations of National Health Council Resolution 196, issued on 10/10/1996. The participants spontaneously signed the free and informed consent term after having read and received explanations about its content. Their anonymity was guaranteed, being identified as Resident 1 to 7, according to the order in which the interviews were held.

The study was submitted to the Research Ethics Committee at Anna Nery School of Nursing, *Universidade do Rio de Janeiro*, and approved under protocol 8689 on March 27th 2012.

Data analysis followed the principles of thematic categorical content analysis, put in practice in three steps⁷, involving the pre-analysis (floating reading and formulation and reformulation of the objectives), exploration of the material (coding/categories) and treatment and interpretation of the results.

In the second phase, known as the exploration of the material, the reports were organized, so that the collected data could be classified according to their thematic similarity, reaching the following categories: Autonomy, contractual power and relationship between peers and the community.

In general, the choice of the Autonomy category is justified to the extent that it represents the recurrence of themes in the residents' reports, which are: activities of daily living, medication management and administration, incursions across the territory, routine inside the residence. The contractual power was chosen to represent the residents' relation with work and the forms of leisure they experience and express in their statements. And the third category, which is the relationship with peers and the community, represents the relations the residents established inside and beyond the residences, according to the reports.

The third step was the interpretative synthesis, where a dialogue is established between the adopted theoretical framework, the testimonies and their contexts and the research objectives.

ANALYSIS AND DISCUSSION OF THE RESULTS

A profile was outlined of the interviewed residents, considering their age, gender and time of residence in the TRS. The length of their internment before being deinstitutionalized could not be determined, as many of them were unable to specify how many years they were interned, providing imprecise answers in quantitative terms.

The interviewed residents' mean age was 61.5 years, ranging from 42 to 81 years. Concerning gender, three residents were women and four men. With regard to how long they had lived at the residences, this ranged from four to 12 years, with an average length of 8.6 years.

Six out of seven interviewees passed through different psychiatric institutions, one was a street dweller before going to live at a Rehabilitation Center (Resident 2).

CATEGORIES

The residents' statements were divided in recurring categories according to the content expressed: Autonomy, contractual power and relationship with peers and the community.

Category 1: autonomy

It should be kept in mind that the TRS intend to rescue the residents' autonomy that was lost by the hospital's guardianship and by the distancing from the social group. This rescue is possible through social contact with peers, caregivers and the community within the territory, permitting changes in behaviors and in the production of life. Thus, the autonomy was analyzed from within the residency, through the activities the residents perform, and externally, that is, related to activities undertaken during incursions across the territory.

According to the residents' discourse, the routine described does not differ from a house and is not similar to the institutional context: there are no imposed rules of conduct, but the residents' internal organization, each of whom perform the activity according to his/her skills and/or desires:

"Nowadays I wash my clothes for sleeping, for working, for wearing, my bedclothes. I clean the house, wipe the floor, the rooms, wash the bathroom. R. makes the food, lunch, dinner, but there's a caregiver to accompany her. So cleaning the stove, the fridge on the outside, F. does that. (...) The four don't need a servant for everything they do around the house, most of the housework, the domestic services, the four of them are able to solve the problems at home (Resident 2)".

"J. wakes up around 05 a.m. and starts to sweep the floor and remove the dust, I used to do that, then she came to live here and woke up early to sweep, the psychologist found it better to let her do it because she took the initiative (Resident 4)."

Resident 5's freedom of choice was respected by the psychologist, and also by the fellow resident who used to sweep the floor and remove the dust from the furniture, like in another situation in which Resident 4 did not want to continue preparing meat and transferred the task to another resident, according to the report:

"I used to prepare the food because J. couldn't cook, that's when I stopped eating meat, just soy, then I told the psychologist that it didn't make sense for me to prepare meat if I wasn't gonna eat it, then J. agreed to learn and the caregiver taught her to prepare mincemeat, steak, chicken, she does that today. Some things I still make, like fish, beans (Resident 4)."

Thus, the residents' initiatives are considered as part of the process of recovering and encouraging autonomy. In the interviewed residents' discourse, the place they occupy inside the residence can be recognized, as well as the presence of a dialogue and respect for individuality, like in the situation above.

Thus, the residents' experience gains a new meaning to the extent that their discourse is recognized and valued in the management of their own lives, turning them into subjects of rights and desires with their own histories⁸.

The residents' autonomy can also be identified through the recovery of the role of administering and controlling medication times and the commitment to treatment:

"I take a drug that was never canceled, Risperidone, it's been 18 years now. I used to get help, from a nurse, but then there was a time I started taking it myself, today I go to the consult, get the medicine. The psychologist comes at home and brings the paper with the times, we don't forget it, right, because it's a commitment (Resident 2)".

In that sense, the quality of the rehabilitation spaces implies the redistribution of power to the subjects, who need to take active attitudes in their histories and desires, turning them into subjects who produce competency. In that context, the idea of living as inhabiting is not just being in a place, inhabiting refers to the degree of property of the space⁹.

But we perceive that that has not always been the reality, as there used to be an auxiliary nurse at the headquarters of the Residency Program, who was responsible for separating the medicines for distribution at the residences. To enhance the residents' autonomy, however, the dispensary stopped functioning and the caregivers were left in charge of separating and administering the medication¹⁰.

Through the recovery of the role of medication manager, the residents regained their condition as active subjects of their treatment, as opposed to the former reality in which someone controlled the medication for them, as if they were incapable of doing that.

The residents' trajectory across the territory also involves autonomy, the places they visit, independent coming and going, freedom to choose the places where they do their shopping. All of these aspects demonstrate the competency to make choices, which translates the notion of inhabiting the territory, according to the following report:

"For example, I don't buy cigarettes in Taquara because it's very expensive, I buy them in the wholesaling, on Tuesdays, when it's my day of, I go to buy cigarettes from the street vendors in Uruguaiana. (Resident 6)".

The interview with Resident 6 indicates that he exercises the power to choose to buy at the cheapest place, exercising his autonomy, first through the right to come and go, second through his ability to get the bus, go to the center of town, taking over the space he lives in.

Another aspect that was included in the discussion in the autonomy category but which expresses a lot about relationships refers to the relation established inside the residency between the caregiver and the residents. Some residents consider the following about the caregiver:

"Our caregiver is V. and there's the other one who goes to the doctor, to the bank with us. And V. goes out more but when she goes the other one comes, goes shopping with us. If, by any chance, she gave us money we could do it but it's safer, it's better for her to come with us (Resident 1)."

Autonomy equips the individuals to create standards and orders for their lives, according to their ability to cope with situations. This should not be mixed up with self-sufficiency or independence, as some degree of dependence is inherent in human beings, the problem is restricted dependence⁸.

At first, Resident 1's discourse seems to entail the relation of dependence, when she says that the caregiver goes shopping with her. The patient admits, however, that she would be able to go shopping without help. Nevertheless, considering that the other women living at the residency are elderly, help is seen as an aspect of care, in the sense of zeal.

When asked about the relationship with the caregiver, Resident 3 answered: *She's good, she's nice,*

yesterday I gave her money, she went to pay a bill for me, because I came to work. When it's Wednesday she separates the money so that nobody gets all confused.

When asked if he did not accompany the caregiver to pay his bills, Resident 3 justifies that he was working, without explicating whether the caregiver routinely pays his bills. Despite the inquiry, he limited himself to saying that it is part of routine for the caregiver to separate the money so that they do not get confused. In view of his discourse, it should be considered *how to dose how much care should be offered to help in the user's gaining of autonomy*^{2:12}.

Enabling the residents to manage their lives is part of a continuous process, which does not end when they enter the TRS. Thus, the resident is still attended by the team of the Residency Program and is referred to other Mental Health devices like the CAPS for monitoring of individual demands, aiming for psychosocial rehabilitation.

Category 2: Contractual power

The contractual power represents the individual's ability to hold exchanges in daily life, establishing his/her own interests and relations according to the value that is previously attributed to each subject in the social field. The contractual power is present to the extent that the residents' discourse is heard and recognized in the management of their daily life and that they receive the right to actively participate in the conduction of their own life⁸.

The money aspect was included in the contractual power category, as many of the negotiations and exchanges made in daily life are made possible by financial capital.

As regards money, the residents mention that they have a bank account. The majority is able to pay bills at the bank, while some need help from the caregivers or the therapeutic companion:

"We get our money, every month, when we get the money, we pay our part of the house, R\$80.00 for the reserve fund and R\$60.00 for food, buy sugar and things like that, the rest is for us. I get the grant here from APACJUM (Resident 1)".

"(...) I am able to count, separate correctly. If the fan breaks, there's some money here to buy another one or pay an electrician to fix it, if a television, a radio breaks. I take off R\$ 150.00 for the house, pay the bills and the rest is for me, to buy clothes (Resident 2)".

The residents now withdraw small amounts of money directly from the bank. They used to get the money all at once and the amount was centrally stored in a safe at the TRS headquarters, administered by an employee. This change permitted the redistribution of power among the residents and enhanced their ability to exchange and negotiate.

Another discourse that relates to the participants' ability to argue and negotiate is described next:

"I used to pay 80 reais for the house, if there's money from the purchases the municipal government gives we don't need to give that money. With the money that's left I buy medicines, pay a private physician (Resident 7)."

Thus, the resident refuses to pay money for the expenses of the house. Without any further information about the final destiny of this money collected for the house, the resident's initiative to question something established in the rules should be questioned, exercising her ability to negotiate and taking an active stand with respect to the application of the money.

In view of the reports, in general, these individuals' contractual power is strengthened based on the social relations established through work. Considering that the residents participate in the *Arte e Horta* project and perform paid work, they can show the value of their work, expressed by what they produce, and establish relations of exchange based on this value:

"So there (in the Project), I also do the mosaic work, I don't know if you've been able to notice, that I work well. When I take the mosaic work they like it (Resident 2)."

This statement endorses that the value the consumer attributes to the object produced by the work is important for the individual who produces it, from a consumption perspective as well as from the viewpoint of personal accomplishment and increased self-esteem.

Work serves as an indicator of successful social functioning, considering the complex functions required from this social subject, including cognitive and intrapsychic skills¹¹.

In this sense, work is understood as production and related to the exchange of goods, different from what is done inside the psychiatric hospital, where it is seen as therapy itself. Thus, for work to be considered as rehabilitating and reproducing the subjects' contractual power, it needs to lose its therapeutic emphasis.

Category 3: Relationship with peers and the community

All residents presented problems related to family support and, consequently, lack of housing was a common reality before the TRS. Even for those participants who still had contact with their relatives, the statements demonstrate that there is no more room for them at the heart of these families.

In the case of the mad, the exclusion then produced another phenomenon, which material equality alone does not cause: it produced... disaffiliation. This differs from poverty or the privation of material goods because it adds the rupture of bonds and the absence of a future, causing social invisibility^{11:22}.

Disaffiliation involves the loss of work bonds or relations with the community and the family, and is proven in Resident 1's report, who at each internment got more distanced from her children and could not even accompany their childhood.

"(...) I only lived with them when they were children really. Then I even needed Lar X, my children were raised by them. There was a time when I was still interned, they took the kids. After I got better I wasn't allowed to have them anymore, I had no place to live, then I started working and got a place there in the Serrinha slum. Whenever I could I used to go there to the kindergarten in Realengo. Things went on and on and they're all big now, grown (Resident 1)."

The experience of these subjects' internment implied a loss of roles, which are often unrecoverable, such as not participating in the children's in the children's education process. Restarting, however, includes the recovery of the social roles lost and, in that sense, the family enters as a participant in the process, in the sense of rescuing lost bonds and reestablishing the identity of the forgotten subject.

This task is not easy and departs from the principle that, over the years, the families restructure their core and the space of the person who was part of the family context is gradually suppressed by absence and distancing. The technical team that offers support to the residents is responsible for mediating between them and the family.

In this context, the family is a fundamental element in the dehospitalization and rehabilitation process of the individual with a mental disorder, as these people have direct contact and constitute the base of their structure^{12:84}.

As regards the relationship with peers, the interviewees said that they have a good relation with the other residents and with the technical team of caregivers and psychologists who support the residences. One of them acknowledged discord in the relation among the residents:

"[...] There are two there who are kind of mad, there's one who's schizophrenic, who broods that there's something that messed with him or that you messed with his stuff, he makes a mess and then the psychologist comes and talks to him, he gets quiet and comes to apologize, everything's fine. None of us has something against the other, we're not angry, bitter, the medicine cuts that off, you just have to take it (Resident 2)."

Through the negotiation of interests, conflicts can be mediated, guaranteeing their control. The articulation between the residents and different aspects of social reproduction, in the community space, is possible through contact with countless resources that can be mobilized. This mobilization is the essence of the rehabilitation, which permits a personal reappropriation process of the true and symbolic dimensions of the body, space, time, the use of objects and the creation of interpersonal bonds in daily life¹³.

Resident 2's discourse shows that the peer relation has its mishaps but that, through the negotiation of interest, conflicts can be mediated, guaranteeing their control, even if this mediation needs the presence of the reference technician. The interpersonal bonds are present there among the peers in dealing with the other, when one resident says that the medicine cuts off the anger, expressing the existence of bonds through which the residents inhabit the space of the residence with tolerance towards their fellows.

Thus, the relations with the peers take shape and, little by little, the stranger not only becomes part of the social context, but feelings like companionship and mutual help can be observed, as expressed in the following statements:

"As a result of frequent social contacts, friendship develops (Resident 6)."

"They like me there and I like them too, they're all ladies. In August, it has been two years since my roommate, who lived closely, shared the room with me, she died, we got very sad. Then almost a year went by, now there's D. who has been living with us for two years. (Resident 1)"

Concerning the neighborhood, the residents affirmed that they have a good relationship with the neighbors and do not reveal conflicts among them. It has not always been like that though, according to one TRS resident's report:

"When we came to live in this apartment, on the day of the move, they didn't want to let us offload the furniture because they had done a petition for us not to come and live

here. But then the psychologist talked and explained that we had brought everything and that we were able to live there because we used to live at another place in Taquara before. But today, the neighbors are excellent, they invite us for folklore celebrations, birthdays, we exchange presents on special dates (Resident 4)".

The neighborhood's initial position regarding social contact with the mental patients, recently discharged from the asylums, was marked by intolerance. In this context of the asylum apparatus, it is evidenced that isolation also exists outside the psychiatric hospital, through gestures, looks and attitudes that establish limits, intolerances and differences¹.

At this moment of paradigm change and psychiatric reform, the walls of the asylum, which dictate exclusion and isolation, stopped being concrete and moved to the level of relationships, capable of raising barriers against differences, based on the popular imaginary of madness and on the figure of the mad constructed in history, bringing along the apparatus of exclusion by trying to deny them the right to come and go.

In view of these positions, it is clear that "it is not enough to modify the care places if the representations associated with mental illness are not modified, creating a movement that dissociates madness from violence, unproductivity and inability for social articulation^{14:458}.

When asked about the relationship with the neighbors, Resident 6 limited himself to answering that it was good but, according to one resident from the same TRS:

"Sometimes he disagrees with someone because he wants to be sympathetic and tries to start a dialogue but has nothing to say and ends up being misinterpreted, like when he asked the father of a child whether his son was a scoundrel and the father took offense because of the question (Resident 4)".

This excerpt demonstrates that the former intolerance still continues through attitudes that underline the limits. On the opposite, the territory is not hybrid, but conflicts and disagreements can exist sometimes, as the experience in the territory implies the subject's exposure to different contexts, with varying people and situations, which explains the complexity of work in the territory, according to the proposal of the TRS:

(...) as a result of the advancement of the dehospitalization process, many interns who were institutionalized for many years in psychiatric hospitals now start living in residences around the city. Formerly

expelled from social life with their families, with people, in short, from life, the mad are back now. The assisted residences of former interns or the therapeutic residential services in mental health, as they are oddly called by the state bureaucracy, gain a strategic function in the Brazilian psychiatric reform process. We will need to construct these experiences, these spaces, these new forms of coping^{15:10}.

Thus, the housing, the neighborhood, the city is too unstable to permit careless looks, because the configuration of the TRS, without the routine support from a team imbued with the principles of the Psychiatric Reform, easily transforms the neighborhood into a desert, incapable of dismantling the asylum that exists in each of us and of permitting the desired social inclusion.

CONCLUSIONS

The objective of the study was achieved, considering that the interviews permitted closer contact with the experience offered by the TRS and revealed a small part of the residents' trajectory, showing in practical terms how these residents have inhabited the territory and have been able to recover their life, so that they no longer need the hospital's guardianship. Their movements towards social insertion could be appointed.

Nevertheless, much remains to be achieved. One of the aspects that need to be reconsidered in this Psychosocial Rehabilitation process is the approximation between the residents and their families, the recovery of family bonds. Furthermore, continuous assessment is needed, following the daily life at the residences and the care model the caregivers deliver, which a view to keeping the game of differences going, as the territory can reveal itself void of possibilities for the residents.

Thus, it should be acknowledged that the study comes with limitations and cannot be considered a paradigm case. The interviewed residents are part of a structured TRS Programs, whose objectives rest on solid and ideal bases of Psychosocial Rehabilitation. As regards the other programs that underlie the Therapeutic Reform in Brazil, research is lacking to outline a profile. In addition, the interviews were held with TRS residents, and caregivers were not involved in this process at any time, as the residents' perspective was sufficient to achieve the study objective.

In practical terms, through the resident's perspective, in general, a residence was unveiled where each member plays a different role, but where there is respect for people's will and skill to develop daily activities.

The residents walk around in the neighborhood, talk to neighbors and participate in local parties. Others discuss with their peers and are intolerant of their colleagues. Nevertheless, the interviewed residents have truly participated in the social inclusion movement.

As to the observation of the residents in possible scenarios, the researchers consider that the therapeutic project envisioned by the TRS team is in accordance with the legal recommendations and paradigms of the Psychosocial Rehabilitation. This does not mean that the service is considered ideal, as ideal may be unfeasible in practical terms, but the passage from guardianship to freedom is permeated by crossings and the search for this model should be present with a view to constant change.

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