

FIFTEEN YEARS ON: RESIDENTIAL TREATMENT SERVICES AND ORDINANCE 106/2000

QUINZE ANOS DEPOIS: SERVIÇOS RESIDENCIAIS TERAPÊUTICOS FRENTE À PORTARIA 106/2000

QUINCE AÑOS DESPUÉS: SERVICIOS RESIDENCIALES TERAPÉUTICOS ANTE LA ORDENANZA 106/2000

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ABSTRACT

Introduction: Residential treatment services (RTSs), instituted by Ordinance 106/2000, offer housing to those discharged from psychiatric hospitals in the process of deinstitutionalization and must follow certain legal requirements, with the aim of promoting psychosocial rehabilitation. **Objective:** describe and analyze 11 RTSs in the state of *São Paulo*, Brazil, based on Ordinance/GM (Minister's office) No. 106 of February 11, 2000. **Method:** quantitative-descriptive study using a self-administered questionnaire to collect data from a key professional from each service. The data were organized according to information core and analyzed using descriptive statistics. **Results:** the RTSs studied comply with most of the determinations in aspects related to functioning and organization, such as: being public in nature, registered with the SUS, part of the mental health network and number of residents per household; on the other hand, regarding state and municipal monitoring visits, the state carried out just over half and municipalities, fewer than that; more than half of the houses were outside the community; many did not receive financial aid to which they were entitled. **Discussion:** the RTSs require more monitoring by state and municipal authorities, providing opportunities for improvements to the functioning of the services; houses outside the community hinder community living - the aim of psychosocial rehabilitation; all users are entitled to BPC-LOAS (Social Care Benefits), promoting greater financial autonomy. **Conclusion:** adjusting aspects that still do not comply with the ordinance could improve services, especially in the search for psychosocial rehabilitation.

Keywords: Assisted Living Facilities; Psychiatric Rehabilitation; Mental Health; Psychiatry.

RESUMO

Introdução: os serviços residenciais terapêuticos (SRTs), instituídos pela Portaria 106/2000, oferecem moradia a egressos de hospitais psiquiátricos no processo de desinstitucionalização e devem seguir as determinações legais, com o objetivo de promover a reabilitação psicossocial. **Objetivo:** descrever e analisar 11 SRTs do estado de São Paulo, Brasil, a partir da portaria/GM nº 106 de 11 de fevereiro de 2000. **Método:** estudo quantitativo-descritivo que utilizou como instrumento de coleta um questionário autopreenchido por um profissional-chave de cada serviço. Os dados foram organizados de acordo com os núcleos de informação e analisados de forma estatístico-descritiva. **Resultados:** os SRTs estudados cumprem a maior parte das determinações nos aspectos relacionados ao funcionamento e organização, como: serem de natureza pública, cadastrados no SUS, integrados à rede de saúde mental e número de moradores por casa; por outro lado, quanto às visitas de acompanhamento estaduais e municipais, o estado realizava pouco mais da metade e os municípios, abaixo disso; mais da metade das casas situava-se fora da comunidade; muitos não recebiam auxílio

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financeiro a que tinham direito. **Discussão:** os SRTs precisam de mais acompanhamento das autoridades estaduais e municipais, oportunizando melhorias de funcionamento para os serviços; as casas fora da comunidade dificultam o convívio comunitário e o objetivo de reabilitação psicossocial; o BPGLOAS pode ser recebido por todos os usuários, fomentando mais autonomia financeira. **Conclusão:** a adequação dos aspectos que ainda não correspondem aos instituídos pela portaria pode aprimorar os serviços, principalmente na busca pela reabilitação psicossocial. **Palavras-chave:** Moradias Assistidas; Reabilitação Psiquiátrica; Saúde Mental; Psiquiatria.

RESUMEN

Introducción: los servicios residenciales terapéuticos (SRT), instituidos por la Ordenanza 106/2000, en el proceso de desinstitucionalización y con el objetivo de promover la rehabilitación psicossocial, ofrecen alojamiento a pacientes que recibieron alta de internación psiquiátrica. Esos servicios deben cumplir con los requisitos legales. **Objetivo:** describir y analizar 11 SRT en el estado de São Paulo, Brasil, ante la Ordenanza / GM No. 106 del 11 de febrero de 2000. **Método:** estudio cuantitativo-descriptivo con datos recogidos a través de un cuestionario autoadministrado por un profesional clave de cada servicio. Los datos se organizaron de acuerdo con los núcleos de información y se analizaron de forma estadísticamente descriptiva. **Resultados:** los SRT analizados cumplen con la mayoría de las determinaciones en aspectos relacionados con el funcionamiento y la organización, tales como: ser de carácter público, registrado en el SUS, integrado en la red de salud mental y cantidad de residentes por hogar; por otro lado, con respecto a las visitas de seguimiento estatales y municipales, el estado realizó algo más de la mitad y los municipios por debajo de eso; más del 50% de las casas estaba fuera de la comunidad; muchos no recibían la ayuda financiera a la que tenían derecho. **Discusión:** los SRT necesitan más monitoreo por parte de las autoridades estatales y municipales, con miras a brindar oportunidades de mejora en el funcionamiento de los servicios; las casas fuera de la comunidad obstaculizan la vida comunitaria y el objetivo de la rehabilitación psicossocial; el beneficio BPC de la ley LOAS puede ser recibido por todos los usuarios, promoviendo mayor autonomía financiera. **Conclusión:** la adecuación de aspectos que aún no se corresponden con los establecidos por la ordenanza podría mejorar los servicios, especialmente en la búsqueda de rehabilitación psicossocial. **Palabras clave:** Instituciones de Vida Asistida; Rehabilitación Psiquiátrica; Salud Mental; Psiquiatria.

INTRODUCTION

Residential treatment services (RTSs) assist the social reintegration of mental health service users into city life. The service arises from the deinstitutionalization process, following the Psychiatric Reform movement and National Mental Health Policy legislation, guaranteeing care outside of institutions.¹

RTSs represent both inclusion and housing for those discharged from psychiatric hospitals who have been excluded for years and who, by law, have received their freedom. This service was officially instituted by the Ministry of Health, through Ordinance 106 of February 11, 2000. This legal instrument defines the structure, organization and functioning of said services, and highlights that its main aim is psychosocial rehabilitation.¹ There are two types of regulated RTSs and their users are entitled to receive two types of government financial aid, if they meet the requirements.

Type I RTSs are living facilities for those with mental disorders undergoing deinstitutionalization. Each home accommodates a minimum of four and a maximum of eight residents and there must be a reference caregiver for each home. The professional to be incorporated must be decided by the technical team, according to the care needs of each group.¹

Type II RTSs are homes for people with mental disorders and a high level of dependency and who, especially due to physical impairment, require specific and intensive full-time care, with daily and personal technical support. Each home can accommodate between four and ten residents and must have five caregivers working in shifts, as well as a Nursing technician there every day.¹

All RTSs must be public, but may work in partnership with non-governmental organizations (NGOs) of various natures, such as health or social work NGOs; they can also be organized by individuals, along the lines of host families; they must be integrated into the Unified Health System (*Sistema Único de Saúde - SUS*) service network and technically linked to the nearest outpatient service for supervision of the service.¹

Another requirement is that the state and municipal departments monitor, supervise, control and evaluate the services. To ensure quality and proper functioning, they need to be properly registered with the SUS. Moreover, the RTSs must be located outside hospital grounds, preferably in the community.¹

Regarding the two types of financial aids, these can be cumulative and, to receive one or both of them, the user must meet SPECIFIC requirements. In order to receive the aid known as Back Home - "*De Volta Para Casa*" (PVC), the individual must have been discharged from a psychiatric hospital or from a psychiatric custody and treatment hospital and have a referral for inclusion in a municipal social reintegration program, having spent at least two years hospitalized. This aid lasts for one year and can be renewed if necessary.²

To obtain Ongoing Provision of the Organic Social Assistance Law (*Lei Orgânica de Assistência Social - BPG-LOAS*), in the amount of a minimum wage, it is not necessary to have contributed to Social Security. It is intended for the elderly over 65 years old and/or for citizens with long-term physical, mental, intellectual or sensory disabilities, provided that the family income is less than a quarter of the minimum wage in effect.³

More than a decade after the RTSs Ordinance was instituted,¹ research on treatment residences has focused on the experience,

perception of professionals and users regarding the service.⁴ It is also necessary to assess its main objectives and values, so that the services do not simply reproduce mental asylums.⁵ This study aims to contribute to assessing mental health services by describing and analyzing 11 residential treatment services in the state of *São Paulo*, Brazil, based on Ordinance/GM 106 of February 11, 2000.¹

This article is part of a larger piece of doctoral research, carried out at the *Escola de Enfermagem de Ribeirão Preto* of the *Universidade de São Paulo* (EERP-USP), titled "Residential Treatment Services: from deprivation to freedom", which analyzed 11 RTSs in the state of *São Paulo*, Brazil, based on Ordinance 106/2000 and the theoretical framework of psychosocial rehabilitation, which produced a documentary video on some of the residents' memories, with a view to bringing together and demystifying their daily lives, available on Youtube titled "Residential Treatment Services - Documentary: ... at home" (*Serviços Residenciais Terapêuticos - Documentário: ...em casa*).

METHOD

This article presents the quantitative data from that doctoral research. It is a quantitative-descriptive study carried out in 11 RTSs in the state of *São Paulo*, Brazil, during the month of October 2015. These services were chosen based on a survey carried out at the *São Paulo State Department of Health* (*Secretaria de Estado da Saúde de São Paulo - SES-SP*), Brazil, of all existing RTSs in the state. There were 45 municipalities with RTSs, totaling 49 RTSs, as there were municipalities with more than one of these services.⁶

The inclusion criterion was to have been in regular operation for at least 10 years. Of the 49 RTSs, 26 met the criteria. A list of services that met the inclusion criteria was drawn up and RTSs selected at random. Data collection started with the first service drawn and, thus, successively, up to a total of 11, using saturation sampling. There were no refusals to participate.

Eleven professionals (one from each service) were included in the study. For this selection, the criteria were: a) to be service technicians (nurse, doctor, psychologist, social worker, occupational therapist, among others); and b) that the professional monitor all the houses that made up the RTS, being familiar with the project and the history.

Thus, the persons responsible for the RTSs were asked to indicate a professional who met these criteria. The group of professionals chosen to answer the questionnaire was composed of: five coordinators, two nurses, one psychologist, an administrator and two technicians responsible for the service. These professionals monitored all the RTS homes, the routine of caregivers and residents.

To collect the data, the professionals chosen from each RTS were contacted to schedule the day and time. The visit was made, the objectives of the study explained and the questionnaire

delivered. This was prepared by the researchers and consisted of 28 closed questions addressing the main aspects indicated by the Ordinance as essential to the functioning of the service, especially those related to psychosocial rehabilitation.

For the purposes of this article, we took the parts of the questionnaire focusing on the main characteristics of the law, namely: compliance with legal requirements (public nature, SUS registration, integration with mental health service networks, number of residents per household); municipal and state visiting routines (monitoring, supervision, control and evaluation); location (within or outside the community); main characteristics of residents (sex and age group of adult/elderly); and whether they received BPC-LOAS and/or PVC.

The questionnaire was tested beforehand with a professional connected to the same type of service, in order to observe possible flaws in the instrument and make any necessary adjustments and alterations, after which it was considered ready for use in the study.

Of the 11 questionnaires, seven were completed by the respondents on the premises of the RTSs and four at other locations according to the participants' preference. The responses to the questionnaires were organized in Microsoft Excel® spreadsheets according to the information core to be analyzed with descriptive statistics.

This study was discussed and approved by the Ethics Committee for Research Involving Human Beings, at the EERP-USP, under protocol number CAAE: 27369614.9.0000.5393.

RESULTS

In the 11 RTSs investigated ($n = 11$), there were 130 houses, of which 66 (51%) were type I and 64 (49%) were type II. Of these, 78 (60%) were for male residents, 34 (26%) for females and 18 (14%) were mixed.

As can be seen in Table 1, most RTSs complied with the following legal requirements: being public in nature, having SUS registration, integrated into the mental health service network, having a maximum of eight residents in type I RTS and a maximum 10 residents in type II RTS.

Regarding the state or municipal visiting routines, the former carried out the monitoring, supervision and evaluation at more than half of the services, the latter fulfills just over half of the monitoring visits, as shown in Table 2.

Most of the RTS homes were type I and were located outside the limits of the community (on psychiatric hospital grounds or on farms), of type II, half were within the community and the other half outside, as shown in Table 3.

A total of 654 residents were studied and the majority were male, did not work, were discharged from psychiatric hospitals and received the PVC and/or Ongoing Provision of the Organic Social Assistance Law (BPC-LOAS), as can be seen in Table 4.

Table 1 – RTSs complying with legal requirements in the state of São Paulo, Brazil, 2015 (n=11)

Legal requirements	RTSs	
	Number	Percentage (%)
Public	11	100
SUS registration	10	90.9
Integrated with a mental health care network	11	100
Maximum 8 residents (type I)	10	90.9
Maximum 10 residents (type II)	11	100

Table 2 – Routine visits by the state and municipal departments to the studied RTSs, showing quantity and percentage of RTSs in compliance, in the state of São Paulo, Brazil, 2015 (n=11)

Visiting routine in compliance		SRTs	
		Quantidade	Percentage (%)
State	Accompaniment	6	55
	Supervision	6	55
	Monitoring	4	36
	Evaluation	7	64
Municipal	Accompaniment	5	45
	Supervision	4	36
	Monitoring	6	55
	Evaluation	2	18

Table 3 – Number of houses and percentage according to type and location of the RTSs studied (n = 11), in the state of São Paulo, Brazil, 2015 (n=130)

Location	Type I	Type II	Total	Percentage of grand total (%)
In the community	29	32	61	47
Outside the community	37	32	69	53
Total	66	64	130	100

Table 4 –Residents’ main characteristics in the RTSs studied, in the state of São Paulo, Brazil, 2015 (n=654)

Residents’ main characteristics					
Sex	N	%	Age Group	n	%
Female	222	34	Adult	329	50
Male	432	66	Elderly	325	50
Working	N	%	Origin	n	%
No	627	96	Psychiatric Hospital	498	76
Yes	27	4	Other institution	156	24
BPC-LOAS	N	%	PVC	n	%
Receive	483	74	Receive	379	58
Do not receive	171	26	Do not receive	275	42

DISCUSSION

According to Table 1, overall, RTSs have complied with the legal provisions of article 5 of the ordinance, which establishes rules and criteria for including these services in the SUS.¹

Only one (9.1%) of the services did not comply with the legal determination regarding SUS registration and thus did not receive financial resources, such as R\$ 10,000.00 incentive for each RTS implemented. This incentive should be used for home repairs, purchase of household items and furniture.⁷

Regarding the number of residents per home, in one (9.1%) of the RTSs, one of the type I houses of which it is comprised, did not comply with the maximum limit of eight people, while the type II services respect the limit of 10 residents.

Even though the treatment residences had collectivist characteristics, resembling student halls of residence, where several residents, with different histories, can meet and live together, there is something that unites them and intimacy needs to be preserved. Thus, the importance of each type I home having a maximum of eight residents, type II having a maximum of 10 and a maximum of three people to a room. Otherwise, the idea of “[...] a protected place is lost, where the pressure of the social body on the individual body is removed, where the plural of the stimuli is filtered or, in any case, it should be, in theory”.⁸

Regarding state and municipal visits, as per article 12 of the ordinance, the visiting routine is important to ensure quality and the smooth functioning of the services.¹ Table 2 shows failures in support from state and municipal health departments in all directions: accompaniment, supervision, monitoring and evaluation routines. The numbers related to the State Secretariat’s visit routines make this clear: accompaniment 55%, supervision 55%, monitoring 36% and evaluation 64%; as do those of the Municipal Secretariat: accompaniment 45%, supervision 36%, monitoring 55% and evaluation 18%.

This lack of routine visits affects the RTSs, as it is through the feedback and adjustments proposed based on such visits that services can reflect on their work and ensure quality care. It is noteworthy that only four legally determined routines were being complied with in more than 50% of the RTSs.⁹

It does not make sense to comply with bureaucratic and structural determinants such as those described in Table 1, if there is no discussion or monitoring of evaluation and supervision. There is the risk that, without routine support from teams in line with the assumptions of the Psychiatric Reform, these services will not go beyond the mental asylum/institutional logic and will not fulfill their effective role of social inclusion, the aim of psychosocial rehabilitation.¹⁰

Table 3 shows that, of the residences surveyed, 53% were set up on the grounds of psychiatric hospitals, on farms or far from daily community life. According to paragraph 5 of article 2 of the legal document¹, RTSs should preferably be part of the community

and care for and enable their residents to be part of the community and of society. The location facilitates contact and the construction of social support networks, as well as access to cultural, social, leisure and health resources.^{11,12}

Pierre Mayol,¹³ when studying neighborhoods, conducting a socio-ethnographic analysis of everyday life, shows how important it is in constructing identities, in the development of intersubjective relationships and internalization of what he calls “convenience” of subjects’ actions, a series of symbolic benefits¹³ rooted in the cultural traditions of users of the space. The resident needs to circulate within the neighborhood to create bonds and affective ties.^{9,12,14}

Having the RTS in the community/neighborhood is a very important aspect of the residents’ psychosocial rehabilitation, making it a place for new experiences, good and bad adventures experienced by people who walk the streets of the community, and these experiences strengthen and transform the resident and the community, as both have been deprived of this relationship for a long time.

The neighborhood is the place in which we move around without the need for complex means of transport, just a walk is enough to be immersed in the complex web of relationships it provides.

“The neighborhood also figures as the place where social ‘engagement’ is manifested or, in other words: an art of living with partners (neighbors, traders) who are connected to you by the concrete, but essential, fact of proximity and repetition.”¹³ Thus, little by little the subjects take on their social roles, being recognized in this intermediate space between the public (city) and the private (home). This process is extremely important for the residents of the RTSs, people who have come from a condition of identity erasure, isolation and subjugation and, now, seek to resignify themselves.

Regarding the receipt of BPC-LOAS and PVC benefits, described in Table 4, it is necessary to clarify who is entitled to them and whether the users of the services analyzed here are classified under what is determined by law.

Article 1 of Ordinance 106 of February 11, 2000, in its sole paragraph, specifies that RTSs are intended for “[...] people with mental disorders, discharged from long-term psychiatric hospitalization, without social support or family ties”, and the sole paragraph of article 2-A sets out that “long-term hospitalization will be considered uninterrupted hospitalization of two years or more”.

However, the document entitled “Treatment residences: what they are and what they are for”, published by the Health Care Secretariat, Department of Programmatic and Strategic Actions of the Ministry of Health (*Secretaria de Atenção à Saúde, Departamento de Ações Programáticas e Estratégicas do Ministério da Saúde*), opens up the possibility of receiving “people being monitored at Psychosocial Health Care Centers (*Centros de Atenção Psicossocial - CAPS*), for whom housing problems are identified, by the referral team, as especially strategic in its therapeutic project”, as

well as “homeless people with severe mental disorders, when part of special therapeutic projects monitored at CAPS”.⁷ These had not necessarily undergone long-term hospitalizations.

As a requirement for receiving the PVC is having undergone more than two years of hospitalization, it is impossible to state that the high number of residents who did not receive it (42%) was due to this requirement, as there is a gap in the questionnaire applied, in that it did not collect data on length of stay or type of referral to the service.

On the other hand, any person with a disability is entitled to receive BPC-LOAS, this condition being defined in paragraph 2 of article 20 of Law 8.742, of December 7, 1993, as: “long-term physical, mental, intellectual or sensory impairment, which, in interaction with one or more barriers, can obstruct full participation and effective in society on equal terms with others”.²

Furthermore, in accordance with the head provision of article 20 mentioned above, the person must prove they “do not have the means to support themselves”, with no mention of minimum hospitalization time. Thus, with the exception of those residents who were working at the time of the study, 27 (4%), everyone else was entitled to the benefit. However, 26% of the total residents did not receive BPC-LOAS. This fact is closely related to the psychosocial rehabilitation of service users.

We must highlight that receiving the benefits and being able to manage them is extremely important in constructing greater autonomy, “[...] considered the basis for deinstitutionalization, together with the cultural transformation of society. Otherwise, we fall into *assistencialism* that merely tries, unsuccessfully, to remedy the effects of years of exclusion”.¹⁵

Financial “empowerment” of RTS resident means respecting their rights as citizens and as subjects in a position to develop quality of life, integrated into the community. This promotes reintegration into common life under the principles of psychosocial rehabilitation. As an example, Pina and Mezzina¹⁶ report on the Italian experience, in which users of mental health services, in addition to managing their own financial resources, also play a fundamental role in public investment decisions that benefit them, attesting to their centrality in the care and power of decision.

CONCLUSION

RTSs are of great importance for Psychiatric Reform and are of extreme relevance for those who have suffered and who still suffer from the inhumane treatment imposed on those diagnosed with mental disorders. Unlike places where rights are violated, RTSs appear to reclassify lives, create new subjectivities, empowerment and the chance to be free.

According to statistical data, regarding aspects of functioning and organization (Table 1), there was excellent performance in complying with legal requirements.

As for visiting routines (Table 2) for accompaniment, supervision, monitoring and evaluation, the statistical data reveal a gap. These are important measures that should be complied with and need to be better structured to meet demand and, thus, offer better quality support to RTSs, in order to prevent them from becoming a mere reproduction of the classic psychiatric institution.

As for the location of the houses (Table 3), the data show a gap between the real and the ideal: houses that are on the grounds of psychiatric hospitals, away from the city, take away the right to come and go and make access to daily social interaction more difficult, as with a conventional institution.

The data also show that there were residents who did not receive BPC-LOAS (Table 4), to which everyone who is included in the project is entitled.

The BPC-LOAS and PVC benefits play an essential role in the psychosocial rehabilitation process, as they make it possible to meet basic desires and needs that are part of daily life in relation to food, clothing, health care and personal hygiene, leisure and culture, providing autonomy for residents. It is the responsibility of the mental health service to which the RTS is connected to arrange for its receipt.

It is possible to consider the importance of this service as a bridge, beginning to shift paradigms and change prejudices toward these people, giving dignity and freedom for all. The data presented and discussed here do not add up to all the complexity of the services, but they do contribute to constructing better routes and paths.

Therefore, adapting those aspects not yet in line with what is established in the ordinance can improve the functioning of services, contributing to their quality and to even more coherent psychosocial rehabilitation.

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