Who are the residents of therapeutic residential services? Profile of de-institutionalized patients with mental disorders

Quem são os moradores de residências terapêuticas? Perfil de usuários portadores de transtornos mentais desinstitucionalizados

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ABSTRACT This article aimed to characterize the sociodemographic and clinical profile of residents of Therapeutic Residential Services (TRS). A cross-sectional, census-based study was carried out with 190 TRS residents from Recife (PE), Brazil. Data collection occurred on an individual basis in TRS. Most of the residents are men, unmarried, elderly, illiterate and with history of various and long-term psychiatric hospitalizations. The iatrogenic conducts practiced in the hospital have left important sequels in several aspects of the life of users and have become a social debt that is yet to be paid by society.

KEYWORDS Assisted living facilities. Home care services. Mental health services. Mental disorders. Deinstitutionalization.

RESUMO *Este artigo teve como objetivo caracterizar o perfil sociodemográfico e clínico de moradores de Serviços Residenciais Terapêuticos (SRT). Trata-se de um estudo transversal, censitário, com 190 moradores de SRT de Recife (PE), analisando as variáveis de perfil sociodemográfico e o histórico psiquiátrico. Observou-se que os moradores se caracterizam, em sua maioria, por homens, solteiros, idosos, analfabetos e histórico de múltiplos e longos internamentos psiquiátricos. Conclui-se que as condutas iatrogênicas praticadas no hospital deixaram sequelas importantes em diversos aspectos da vida dos usuários e tornaram-se numa dívida social que ainda precisa ser paga pela sociedade.*

PALAVRAS-CHAVE *Moradias assistidas. Serviços de assistência domiciliar. Serviços de saúde mental. Transtornos mentais. Desinstitucionalização.*

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 DOI: 10.1590/0103-1104201711416

Introduction

Established through Ordinance nº 106/2000 of the Ministry of Health, Therapeutic Residential Services (TRS) can be conceptualized as:

> Homes or houses inserted in the community, intended to care for people with mental disorders, egresses of long-term psychiatric hospitalizations, who do not have social support and family ties, and who enable their social insertion. (BRASIL, 2000, P. 1, FREE TRANSLATION).

These devices were created to contribute to the reduction of beds in psychiatric hospitals occupied by 'hospital residents' who, despite having the clinical profile to reside in the community, had family and social ties compromised or even disrupted due to the perverse association between mental disorder and long years of confinement and distancing from their peers (SILVEIRA; SANTOS JUNIOR, 2011).

According to data of the Ministry of Health, in december 2014, there were 610 TRS implanted in the Country with 3.470 residents. Pernambuco has 58 TRS, of which 31 are in Recife (BRASIL, 2015).

It is undeniable the importance of the TRS for the implementation of the Brazilian Psychiatric Reform and de-hospitalization of those with few or no social ties. Despite the existence of such devices in an official way 15 years ago, there is evidence, in the scientific literature, of few studies about the real profile of the residents of these services. A study carried out in Piauí with 11 residents of two TRSs showed a profile composed of men, with an average age of 45 years and with elementary education. In Rio de Janeiro, research carried out in records with 66 residents of three TRSs showed a predominance of the age group from 41 to 60 years old and the presence of comorbidities such as hypertension and smoking (ALVES *ET AL.*, 2010; BRASIL, 2005; LAGO *ET AL.*, 2014).

In depth investigations of the profile with significant samples of the population are relevant to show what real characteristics that this group, so far little studied, has. This way, one can contribute to the elaboration of care plans and public policies focused on the real characteristics that these residents present. In the face of these issues, the objective of the study was to characterize the sociodemographic and clinical profile of TRS residents, living in Recife (PE).

Methods

Descriptive, cross-sectional study. It has as scenery the 31 TRSs in operation, until march 2015, in the municipality of Recife (PE).

The study population was the 229 residents of both sexes, residing in TRS until july 2015 in said municipality. Residents who were hospitalized or out of town during the period of data collection were excluded; residents unable to participate in the study due to physical or mental illness and who did not have a legal curator appointed or that the conservator could not be contacted during the period of data collection. The sample was of the census type because of the size of the population and the singularities that surround their clinical and psychiatric histories.

As a result of death (5), hospitalizations (2), removal of the resident of the city during data collection (3), refusal of the participant (13) or his/her legal curator (16), the final sample corresponded to 190 residents.

A structured instrument was used for the data collection, elaborated based on the 'Basic Attention Notebook nº 19' of the Ministry of Health and in the model of form for outpatient form of the Nucleus of Attention to the Elderly (NAI), a university service of the Federal University of Pernambuco (UFPE) that provides multiprofessional care to the elderly. For this study, socioeconomic and family profile variables were analyzed: age, sex, marital status, income, education,

guardianship, history of family abandonment, street situation, loss of personal documents prior to TRS and family contact after change to the TRS. With regard to the psychiatric profile, the following variables were analyzed: number of hospitalizations in a psychiatric hospital during life, time of the last hospitalization in psychiatric hospital, time of residency in TRS, hospitalization in a custodial hospital and psychiatric treatment, besides the psychiatric diagnoses prevalent in medical records.

The data collection was carried out through an interview, using a structured questionnaire, through a pact with the coordination of the TRS and with the technical teams of each residence and the respective reference Centers for Psychosocial Attention (Caps). Initially, by management requirement, the data collection took place individually, in a reserved place in the Caps, after the invitation of participation in the research by the TRS technical team and clarification of the terms of the study. On the day and time scheduled, a vehicle of the city hall would make the round-trip transfer of this resident to his/her reference Caps, where the interview would be held.

During the first moment, it was evidenced that part of the population presented difficulties of locomotion, clinical and psychiatric issues that made difficult their transfer or they even refused to leave home. Due to such issues, the research team was authorized to conduct data collection at TRS facilities in these specific cases. Such a change did not disturb the progress of the research. On the contrary, it helped to reduce the number of losses. To minimize memory-related biases and incomplete responses, a triangulation of the data was done with the confirmation of the data, by consulting the medical record available at the Caps, as well as the validation of the information by the responsible caregiver.

For data analysis, a database was built in the Epi Info program, version 3.5.2, by means of double typing, later validation and correction of the divergent values. The database was exported to the SPSS software, version 18, in which the analysis was performed. To evaluate the sociodemographic, clinical, psychiatric and functional capacity profile, the percentage frequencies were calculated and the frequency distributions were constructed.

This article is part of the project entitled 'Therapeutic Residency Services: demands for nursing care', which meets Resolution nº 466/12 and that obtained approval from the Research Ethics Committee of the Health Sciences Center of the Federal University of Pernambuco, through the CAAE: 37085914.0.0000.5208 and opinion number 859.731.

Results

The largest part of the study population was composed of men (64.7%), singles (82.6%), illiterate (43.7%), with income between one and less than two minimum wages (70.6%), aged 60 years or more (33.2%), minimum age of 25 years and maximum of 89 years, with an average of 54.05 years (standard deviation, SD = 13.33). The proportion-comparison test was significant for all sociodemographic factors assessed (p-value <0.001), except for age, in which the chance of belonging to any of the four age groups was identical (*table 1*).

Table 1. Sociodemographic characterization of residents of Therapeutic Residential Services of Recife (PE), 2015

Characteristic	N= 190	%	p-value[1]
Sex			
Male	123	64,7	<0,001
Female	67	35,3	
Age* (in full years)			
25 – 44	43	23,4	0,084
45 – 53	40	21,7	
54 – 59	40	21,7	
≥ 60	61	33,2	
Minimum		25	
Maximum		89	
Mean ± Standard deviation		54,05 ± 13,33	
Marital status			
Single	157	82,6	<0,001
Separated/divorced	23	12,1	
Widowed	6	3,2	
Married	4	2,1	
Education			
Not educated	83	43,7	<0,001
Literate	18	9,5	
Elementary School complete/incomplete	67	35,3	
High school complete/incomplete	13	6,8	
Higher education	9	4,7	
Income (Minimum Wages)			
No income	47	24,7	<0,001
<1 MW	8	4,2	
1 ├ 2	134	70,6	
2 ├ 3	1	0,5	

* 6 residents did not have documents and did not know how to report their life stories.

[1]p-value of the Chi-square test for proportion comparison.

Regarding the family profile of TRS residents, 55.8% reported, at the time of the interview, to maintain contact with their relatives. The history of mental disorder in the family was present in 14.2% of the residents. Family abandonment occurred in 30.5% of the cases, and 26.3% of the residents had a previous history of street situations. The guardianship was present in 22.1% of the population.

The psychiatric history (*table 2*) showed that 41.6% of the residents had between 3 and 10 psychiatric hospitalizations during their lifetime. At the last hospitalization, the length of stay in the psychiatric hospital ranged from 5 months to 40 years with an average time of 9.48 years (SD=8.409). Most residents had between 1 and 5 years of TRS (55.8%). The proportion-comparison

test was significant for all factors evaluated (p-value <0.05), indicating that the psychiatric profile described is significantly more frequent in the study population. The hospitalization, in a custodial hospital and psychiatric treatment, was present in 8.9% of the residents. The report of absence of documents on admission or loss during psychiatric hospital admission occurred in 32.6% of the cases.

Table 2. Psychiatric profile of residents of Therapeutic Residential Services of Recife (PE), 2015

Characteristic	N= 190	%	p-value
Number of hospitalizations			
1	48	25,3	<0,001
2	27	14,2	
3-10	79	41,6	
> 10	36	18,9	
Time of last hospitalization* (years)			
≤ 2	39	21,1	0,002
2 ├ 9	72	38,9	
≥ 10 years	74	40,0	
Minimum		5 months	
Maximum		40 years	
Mean ± Standard deviation		9,48 years ± 8,4	
Time of TRS (in full years)			
≤ 1	29	15,3	<0,001
1 ├ 5	106	55,8	
> 5	55	28,9	
Minimum		2 months	
Maximum		12 years	
Mean ± Standard deviation		5 years ± 2	

Note: 5 residents had the indication to reside in a TRS by the reference Caps, thus, they did not have a hospitalization in a psychiatric hospital.

Regarding psychiatric diagnosis (*table 3*), the group of schizotypal disorders, schizophrenia and delusional disorders (isolated diagnosis) was more prevalent (57.4%). The most prevalent disorder was residual schizophrenia (isolated or associated with other disorders), which was present in 51.6%; and paranoid schizophrenia (isolated or associated with other disorders) in 15.3% of the total sample.

Table 3. Psychiatric diagnoses of residents of Therapeutic Residential Services of Recife (PE), 2015

Description of diagnostics	N	%
Schizophrenia, schizotypal disorders and delusional disorders	109	57,4
Schizophrenia + Psychiatric comorbidity	22	11,6
Intellectual disability	12	6,2
Intellectual disability + Psychiatric comorbidity	14	7,2
Other Mental Disorders	6	3,1
Other double, triple or quadruple diagnoses	27	14,5
Total	**190**	**100**

Discussion

Initially, it is important to emphasize that the public to whom this study refers has a history of several rights violations, including integral care. Thus, it was important to look at the uniqueness of the experience of long-stay hospitalization in a psychiatric hospital with a subsequent housing in a therapeutic residence to highlight all these demands. However, when consulting the available scientific literature, a small number of quantitative studies that analyzed who are the people who live in these spaces were highlighted. Facing this gap, in many moments, it was necessary to compare the results found with other prevalences evidenced in the brazilian and northeastern population, with censuses performed in psychiatric hospitals throughout the Country and with the analysis of the profile of users of Caps.

The higher prevalence of single men, evidenced in the TRS of Recife, could also be found in other studies performed both in Piauí and Rio de Janeiro residences as well as in psychiatric hospitals. This distribution by sex is not observed in the demographic profile of the city of Recife where the female population corresponds to 53.87%. Epidemiological analyzes of the prevalence of mental disorders between genders show that women are more vulnerable to mental disorders, with an emphasis on anxiety and depressive symptoms, eating disorders and the sequelae of gender violence situations (ALVES *ET AL*., 2010; CAYRES *ET AL*., 2015; GOMES *ET AL*., 2002; LAGO *ET AL*., 2014; MELO *ET AL*., 2015; ROSA; CAMPOS, 2012).

The impact that the mental disorder exerts, in the domestic daily life, is related to the position that the patient occupies in this family. Culturally, man plays the role of financial provider of the house, while the woman, despite having double work days, still exercises the function of caretaker of the house, family and members, sick or not (ROSA; CAMPOS, 2012; SANTIN; KLAFKE, 2011).

This way, the family that receives this mental disorder bearer at home after long periods of psychiatric hospitalization presents different expectations between the genders, based on the cultural scene. The predominance of male patients in psychiatric hospitals may be related to the expected performance of the user, by his family, in the role of financial provider. This expectation may be frustrated as a result of the mental disorder presented by the user. Among women, even with some commitment, it is still possible, in many cases, the performance of simpler domestic activities, culturally accepted as sufficient social performance (FRAZÃO, 2007).

A study carried out in the municipality of Lorena, São Paulo, with 5.830 medical records of users of mental health outpatient clinics and Caps, showed an average age of 47.9 years and

a predominance of female sex among the users of the outpatient clinic and 41 years old and a higher prevalence of male sex among those who attend the Caps (PEREIRA *ET AL.*, 2012).

In the present study, relating to the age group, older people were predominant, which diverges from the results of other studies in which there are reports in the hospital setting of a higher prevalence of young adults or those younger than 50 years (⅔ of the population). It is important, however, to evidence that the prevalence of users of productive age (from 18 to 59 years) was significant (66.8%). High prevalence of persons of economically active age in psychiatric hospitals or the Psychosocial Care Network (Raps) services (such as outpatient clinics and Caps) results in an increase in the need to grant financial benefits due to temporary incapacity for public coffers (GOMES *ET AL.*, 2002).

An ecological study conducted with secondary data from the Ministry of Social Security, between 2008 and 2011, showed that mental and behavioral disorders are the third biggest reason for granting benefits. The reduction of the productive force can generate important costs to the State, and social exclusion can further aggravate the suffering of the group. In addition, by the age of 18 years old, the beginning of the economically active age, the user can still attend the school environment and learn to carry out their social and work practices. Besides the mental disorder, which, in a way, already contributes to establish a difficulty in interpersonal relationships, the isolation caused by the long periods of hospitalization strengthens the commitment of social order.

Other studies carried out in psychiatric hospitals in Ceará, São Paulo and Rio de Janeiro found a higher prevalence of persons aged between 40 and 59 years (51.2%) or more than 50 years (62.2%), with emphasis between 50 and 59 years (26.7%), suggesting that in addition to chronic mental disorders, the aging process and the health burden will also reach these TRSs (CAYRES *ET AL.*, 2015; GOMES *ET AL.*, 2002; MELO *ET AL.*, 2015).

The rapid aging process evidenced in the Country, highlighted in these services, presents challenges to the health system as: greater number of elderly people with needs for treatment and control of chronic non-communicable diseases, prevention of grievances and health promotion, independence and mobility. The World Bank report, of 2011, showed that health expenditures will increase considerably due to the increase in the number of elderly people in the brazilian population and the frequency of use of health services, related to chronic comorbidities (FISCHER, 2014; SILVA JÚNIOR).

The strengthening of the Family Health Strategy and the expansion of its coverage are considered strategic for the care of the elderly in the community. In addition to the strategies already considered here, it is necessary that the health professionals, caregivers and reference technicians involved in the daily life of this resident are prepared and able to respond to this emerging demand. A study conducted in Botucatu (SP), showed that higher-level professionals involved in elderly care recognize the increase in the brazilian population and, at the same time, the unpreparedness to meet their demands for care, demonstrating that, sometimes, this assistance is provided in a technical and fragmented way, centered on the biomedical model (SILVA JÚNIOR; FISCHER, 2014; VASCONCELOS; GOMES, 2012).

The lack of remunerated activity among the residents of the TRS of Recife was also observed in 82% of inmates in the psychiatric hospitals of Ceará. It is noteworthy that this reality still occurs in the TRS, since the work could be an important tool for the reinsertion and search for autonomy by this resident (MELO *ET AL.*, 2015).

Although the residents did not exercise remunerated activity, 75.3% of them had income. Of these, 70% received one and less than two minimum wages, which

corresponds to the value of the benefit of continuous benefit; and R$ 412,00 related to the Back-Home Program grant (PVC), (social benefits that are part of the brazilian social assistance policy and mental health policy, respectively). It should be pointed out that PVC is one of the main strategies used to strengthen and contribute to the implementation of the deinstitutionalization process, considering that it is a public policy of social inclusion instituted by Law nº 10.708, dated july 31, 2003, which provides rehabilitation assistance for people with mental disorders coming from long-term hospitalization, in order to provide financial support and help in the construction of the autonomy of the graduates of psychiatric hospitals after a long stay (BRASIL, 2011).

A qualitative study performed among users of Caps of Recife showed that this group had difficulty in drawing up a life plan that did not include retirement or benefit already received. In Brazil, the maintenance or withdrawal of the benefit is performed by an expert who evaluates the psychiatric situation of the beneficiary (FRAZÃO, 2007).

Solidarity economy is a viable solution to the problem. It expresses a new mode of production, through cooperation in collective undertakings and articulated solidarity chains. This form of production is an alternative that stimulates the financial autonomy while it considers the human being in its integrality, developing its potentialities. Among the initiatives, stand out the income generation workshops and the cooperatives that act in the inclusion of the person with mental disorder in the ambit of the solidarity economy. These devices are important instruments in the implementation of the Psychiatric Reform by realizing the social inclusion of users, increasing autonomy and broadening access to income (BRASIL, 2010).

Currently, formal work is difficult to access for a considerable portion of the population, with or without mental disorders. The competitiveness present in companies and the labor market produces a mass of excluded, without access to employment opportunities. Mental disorder is not necessarily an impediment to the search for work, but it is known that the vacancies today are insufficient. In addition to the presence of the disorder, the population that is a resident of TRS in the municipality of Recife still has a low educational level and a high number of psychiatric hospitalizations during the life (between 3 and 10), which contributes to this group having difficulties in effectively participating in the labor market, without recourse to the principle of equity through the benefit of a differentiated condition of access and permanence (FRAZÃO, 2007).

To overcome these problems, strategies were created to reintegrate the mentally disordered person into the formal labor market, to combat stigma and raise this population to the same level as other workers in rights and duties. For example, there is the Labor Management Project, carried out in a pioneering way in Brazil in the city of Nova Friburgo (RJ), which seeks to ensure access to the person with a disorder in the labor market, fulfilling a differentiated working day and with salaries compatible with time worked. Psychology trainees accompany these employees to serve as job managers and receive the back of mental health services (SALIS, 2013).

Regarding the tutelage of this resident, the guardianship was present in 22.1% of the population of TRS residents in Recife. A census conducted in 53 psychiatric hospitals in the state of São Paulo showed that 38% of the residents were curated, and 64.9% of them received financial benefits. The curate, in most cases, has contact with his relatives. This fact raises the discussion about the relationship of this family with the resident and of the role that the income of this family plays in the domestic daily life of their family of origin (CAYRES *ET AL.*, 2015).

If on one hand guardianship represents responsibility for the decisions and care of

the incapacitated person, on the other hand, in many cases, curators transfer that responsibility for day-to-day care to TRSs, in fact only taking responsibility for financial decisions. These issues may arise from the erosion of family relationships, the financial cost and the lack of expectation of this group in relation to the future of the patient, which brings conflicts, mismatches and directly affects the therapeutic process (FRAZÃO, 2007).

The care of the family member with mental disorder in the home environment implies, sometimes, the renunciation of paid work and involves increased costs with transportation for treatment and feeding (often associated with an increase in the appetite of the user due to the use of the psychotropic drug). The opposite is also evident in practice. A study carried out at a Center of Reference in Mental Health of Teresópolis (RJ) with users and relatives showed that the benefit received by this user gives him/her the status of provider of family income, being his/her fundamental money for the survival of the family. Generally, this provider presents difficulties to administer its finances and, consequently, does not have financial autonomy for personal expenses. During the study, the authors observed that, sometimes, the family adopts the benefit of the user as the main family benefit, but 'outsources' the care of this patient to the psychiatric hospital or TRS (LIMA; NOGUEIRA, 2013; ROMAGNOLI, 2001).

Studies have identified the absence rate of family ties in psychiatric hospitals varying between 39.5% and 74.4%. It should be pointed out, therefore, that the prevalence found in TRSs was very close, which shows, thus, that, despite the change of scenery, family rapprochement is still fragile and that further studies and investments are necessary for understanding and possible reversal reality. Census carried out in the psychiatric hospitals of São Paulo also evidenced that the weaknesses of family ties worsen as the length of hospital stay lasted (CAYRES *ET AL.*, 2015; GOMES *ET AL.*, 2002; MELO *ET AL.*, 2015).

The history of absence/loss of documents during hospitalization in this study permeated 32.4% of TRS residents. Similar reality was reported in a psychosocial census conducted in São Paulo in 2008, in which 21% did not have documents, which was reported in the TRS, by their managers and professionals, as a frequent problem and related to other sectors such as the Judiciary (FURTADO, 2006).

Much more important than discussing who is responsible for the absence of these documents is the need to seek solutions for the regularization of the situation of recovery of the conditions of citizens of the former inmates of psychiatric hospital, since the possession of the civil document provides access to other citizenship rights linked to protection, social security and health policies (CAYRES *ET AL.*, 2015).

In São Paulo, for example, a 'citizenship project' was created with the purpose of retrieving the original documentation or withdrawing the Late Birth Certificate, promoting the rescue of life histories, identities and bonds and subsidizing access to benefits (CAYRES *ET AL.*, 2015).

The education of the residents was lower than the national average of years of study, with a prevalence of illiteracy of 43.7% in the TRS. The National Sample Survey of Households of 2011 evidenced that the percentage of out-of-school brazilians was 11.48%, three times lower than the rate identified in this study. A study carried out in two TRSs also found an illiteracy rate that was higher than the national average, but still lower than that of the present article (36.4%), with a higher prevalence of elementary education (54.5%). Studies performed in psychiatric hospitals have identified rates of 50% and 66.7% (IBGE, 2011; LAGO *ET AL.*, 2014).

The mean time of the last hospitalization in psychiatric hospitals was 9.5 years, in which 38.4% had 10 years or more of hospitalization. The predominance of this period

was evidenced in psychiatric hospitals in São Paulo (75.5% of inmates) and in Rio de Janeiro (36.5%). It is important to emphasize that the largest portion of TRS residents in Recife has a history of 3 to 10 hospitalizations in psychiatric hospitals during their lifetime. It is highlighted, also, that long periods of hospitalization may worsen the clinical manifestations of psychiatric illness (ALENCAR; AGUIAR, 2009; CAYRES *ET AL.*, 2015, GOMES *ET AL.*, 2002; MELO *ET AL.*, 2015).

Regarding the psychiatric diagnosis, in the reality of the residents of Recife, residual schizophrenia (51.6%) was the most prevalent, followed by paranoid schizophrenia (15.3%). Schizophrenia is the most frequently reported disease in the articles on clinical-psychiatric profile of psychiatric hospital residents, with a prevalence of 41% in Ceará, 43.1% in São Paulo and 53.6% in Rio de Janeiro. A study carried out with 1.444 patients with psychotic disorders of Caps of the state of Sergipe demonstrated a prevalence of 75.3% of schizophrenia. The literature indicates that the disease occurs in 1% of the world population. Over time, the most exuberant positive symptoms (delusions and hallucinations) tend to decrease in intensity, while the more residual negative symptoms (affective dullness and bizarre behaviors) may become more evident (CAYRES *ET AL.*, 2015; GOMES *ET AL.*, 2002; MELO *ET AL.*, 2015; SILVEIRA *ET AL.*, 2011).

Residual schizophrenia is, in many cases, the late stage of evolution characterized by the persistent presence of negative symptoms, such as psychomotor retardation, hypoactivity, affective dullness, personal neglect, social isolation and speech poverty. The presence of a high percentage of cases of residual schizophrenia corroborates the high disease time found in residents of TRS.

Conclusions

The study evidenced that the socio-demographic and psychiatric profile of TRS residents in Recife (PE) is composed mainly of men, singles, elderly, illiterate, with income between 1 and 2 minimum wages, with a history of between 3 and 10 psychiatric hospitalizations during life and in the last hospitalization they spent more than 10 years. The most prevalent diagnosis is residual schizophrenia.

The identification of the profile of this population is strategic to guide the interventions adjusted to the reality experienced and the history of illness of these users. The biopsychosocial sequels brought about by the high number of psychiatric hospitalizations during life and by the long duration of the latter need to be studied in depth in order to respond to a historical social debt that brazilian society has with this population.

In addition to the issues secondary to the period of confinement, these residents have an important percentage of elderly people in their composition. Aging generates a series of repercussions for the health system, especially when it involves coexistence with chronic diseases. It is suggested that the team that performs the daily care in these services emphasizes in their practice, besides the care for the chronic mental disorder and the social reinsertion, the clinical aspects related to the aging.

There is a need for further research into the family relationships of TRS residents who directly question the actors involved. Failure to receive this user in the family may be related to the fact that living with this person imposes on the family structural reorganization, changes in routines, experiences of feelings, memories and emotions that consciously or unconsciously discourage the process of family reintegration. It is essential that work be continued with these families to rebuild the broken or fragile ties and that, as far as possible, the resident can gradually make the journey 'back home'.

In order to overcome the limitations caused by the lack of personal documents or the loss of the identity of the subject, it

is recommended to make agreements with public bodies in the local reality, which make it possible to withdraw the second copy of the documents or search in the registries, with a view to the resumption of their citizenship and the implementation of the process of Psychiatric Reform by the residents. In addition, it is also recommended that trainings or capabilities be developed that address TRS and Raps workers; handling this population based on the identified profile, especially, paying attention to the age component, regarding the management of chronic comorbidities, the promotion of health and the prevention of grievances.

The Psychiatric Reform advocates the rehabilitation of this user to the maximum of his/her role as the most important flag of this process, be it through access to work, income, community centers and/or family, to enable the possibility of return of this resident to his/her community. The elaboration of interventions for the recovery of weakened family ties is, therefore, important for the management with this group.

This study presents as limitations the fact that it was carried out in only one municipality, excluding the residents who did not have legal curator named and that part of the triangulation of the data was performed by means of medical records, which in some cases were incomplete information.

The study brings, also, among the contributions, a description of the TRS residents' profile of a brazilian capital that historically presented the largest number of hospitals and psychiatric beds in the Northeast. Despite advances in the deinstitutionalization of patients with severe psychiatric disorders evidenced in Recife in recent years, it is necessary that the progress of de-hospitalization step even further into the state, by bringing patients back to the hometowns and communities of origin before hospitalization psychiatric hospital in the state capital, still considered a major medical-assistance center for various specialties, including psychiatry.

Contributors

It is hereby declared for the proper purpose that all authors of this article have participated in the steps listed below:

(a) a substantial contribution to the conception and planning or to the analysis and interpretation of the data;

b) significant contribution to the drafting or critical revision of the content;

c) participation in the approval of the final version of the manuscript. ■

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Received for publication: March, 2017
Final version: July, 2017
Conflict of interests: non-existent
Financial support: non-existent