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THE UNVEILING OF HUMAN RIGHTS VIOLATIONS IN RESIDENTIAL THERAPEUTIC SERVICES.

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ABSTRACT. The aim of the study was to analyze the practices of care to residents in seven therapeutic's residential's services of an municipality of Minas Gerais State, Brazil, and the views of caregivers linked to these practices. Fifteen caregivers were interviewed by triggering question and issues related to assistance and Therapeutic Residential Service's functioning. The interviews were recorded, transcribed and categorized into themes. The data showed human rights violations practices: physical, verbal, psychological and sexual violence and neglect of care by carers and technicians responsible for the services. These practices have proven to be influenced by the social conception of madness associated with lack of understanding and intelligence, lack of autonomy, lack of reason, exclusion, discrimination and isolation. We found a lack of training and continuing education to caregivers and lack of monitoring and supervision of the practices that occurred in these services by the federal, state and municipal's levels. The Association that manages the service is not committed to the care's quality, the County Health Department was silent and there was no support by the technicians responsible for the service and by the staff of the Psychosocial Care Center. There is a lack of investment in interventions to change the social conception of madness by the psychiatric reform movement. Identified, yet, legislation's gap about the Therapeutic Residential Services. The Residential Therapeutic Services surveyed maintained madhouse's practices and characteristics of total institution, instead the psychiatric's reform and National Mental Health Policie's proposals.
Keywords: Mental Health Services; human rights; violence.

O DESVELAR DE VIOLAÇÕES DOS DIREITOS HUMANOS EM SERVIÇOS RESIDENCIAIS TERAPÊUTICOS

RESUMO. O objetivo do estudo foi analisar as práticas de assistência aos moradores de sete Serviços Residenciais Terapêuticos de município de Minas Gerais e suas concepções, segundo as propostas da reforma psiquiátrica, da Política de Saúde Mental brasileira e de outros autores. Foram entrevistados 15 cuidadores por meio de questão disparadora e questões relacionadas à assistência e funcionamento do Serviço Residencial Terapêutico. As entrevistas foram gravadas, transcritas e categorizadas em temas. Os dados mostraram práticas de violações de direitos humanos: violência física, verbal, psicológica e sexual e negligência de cuidados por parte de cuidadores e responsáveis técnicos pelos serviços. Essas práticas mostraram-se influenciadas pela concepção social da loucura, associada à falta de compreensão e inteligência, de autonomia, à ausência de razão, à exclusão, à discriminação e ao isolamento. Verificamos falta de capacitação e educação permanente aos cuidadores e de acompanhamento e fiscalização federal, estadual e municipal das práticas que ocorriam nesses serviços. A associação que gerenciava os serviços não se comprometeu com a qualidade da assistência, a Secretaria de Saúde do Município foi omissa e não verificamos o suporte de responsáveis técnicos dos serviços e equipe do Centro de Atenção Psicossocial. Há falta de investimento em intervenções para mudança da concepção social da loucura pelo movimento da

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reforma psiquiátrica. Identificamos, ainda, lacuna na legislação sobre os serviços residenciais terapêuticos. Esses serviços pesquisados mantinham práticas manicomiais e características de instituição total, contrárias às propostas da reforma psiquiátrica e da Política Nacional de Saúde Mental.

Palavras-chave: Serviços de Saúde Mental; direitos humanos; violência.

EL DESVELAR DE VIOLACIONES DE LOS DERECHOS HUMANOS EN SERVICIOS RESIDENCIALES TERAPÊUTICOS

RESUMEN. El objetivo del estudio fue analizar las prácticas de la atención a los residentes en siete servicios residenciales terapéuticos de una ciudad de Minas Gerais y sus puntos de vista, de acuerdo con las propuestas de la reforma psiquiátrica, la Política de Salud Mental de Brasil y de otros autores. Se entrevistó a 15 cuidadores mediante la activación de emisión y cuestiones relacionadas con el cuidado y funcionamiento del Servicio Residencial Terapéutico. Se grabaron las entrevistas, transcritas y categorizados por temas. Los datos mostraron que hay prácticas de violaciones de derechos humanos: físicas, verbales, psicológicos y sexuales y también hay falta de cuidado de los cuidadores y técnicos responsables de los servicios. Estas prácticas fueron influenciadas por la concepción social de la locura asociada con la falta de comprensión y con la inteligencia, la falta de autonomía, la falta de la razón, la exclusión, la discriminación y el aislamiento. Hemos encontrado una falta de capacitación y educación continua para los cuidadores y hay falta de seguimiento por la supervisión de los niveles federal, estatal y local que se han producido en estos servicios. La Asociación que gestiona los servicios no están comprometidos con la calidad de la atención. El Departamento de Salud del condado se quedó en silencio y no había técnicos de soporte responsables por el servicio del Centro de Atención Psicosocial. Hay una falta de inversión en las intervenciones para cambiar la concepción social de la locura por el movimiento de la reforma psiquiátrica. También identificó fallas en la legislación relativa a los servicios residenciales terapéuticos. Los Servicios Terapéuticos Residenciales encuestados examinaron las prácticas de manicomio guardados y las características totales de la institución, en contra de las propuestas de la reforma psiquiátrica y la Política Nacional de Salud Mental.

Palabras-clave: Servicios de Salud Mental; derechos humanos; violencia.

Introduction

The rights to standard adequate living, including food, housing, and health, are considered to be basic human rights, without which any individual is incapable of reaching full development and of exerting citizenship. These and other rights became legalized in 1948 with the Declaration of Human Rights, at the United Nations Organization (Ventura & Brito, 2012).

Violations to human rights, such as violence, punishments, mistreats, and negligence in assisting people with psychic suffering, have been and still are present in everyday life of mental health services all over the world (Drew et al., 2011), including in Brazil. Those labeled insane, label given to those who are deviant to standard social norms, were maintained in psychiatric hospitals, place of control and social segregation, where patients were submitted to torture and violent forms of treatment. Psychiatric hospitals removed humane characteristics from the patient and operated upon him the process of reification (Castel, 1978; Goffman, 2013; Foucault, 2013).

In Brazil, the movement called psychiatric reform, since the decade of 1970, seeks to change such realty. One of the advances achieved by this movement, mainly with respect to the protection and to the rights of people in psychiatric suffering, came about with legal support from ordinances from Health Ministry and with legislation in National Congress (Ministério da Saúde, 2004). At the same time, there happened a change in the paradigm of assistance in the area of Mental Health, now based on concepts of subjectivity, integrality, sheltering, bond, dignity, autonomy, and justice (Dutra & Rocha, 2011).

Assistance, which used to be offered only at hospitals, has been offered in services or in equipment inserted in the community, aiming at being integrated in social networks available in a community, always focusing on the individual's dignity, on human and civil rights (Ministério da Saúde, 2004). One of the services which replaces psychiatric hospitalization, Residential Therapeutic Services (RTSs),

were created by the ordinance 106/2000, with the goal of providing housing options to former patients who were admitted into the hospital for a long time, during which they lost their families, in order to be socially reinserted and rehabilitated (Ministério da Saúde, 2004). In spite of the advances RTSs represent regarding the process of deinstitutionalization proposed by psychiatric reform, there still are many challenges to overcome, such as unprepared and unqualified professional who work in RTSs, lack of supervision of these professional, lack of planning, little financial resources, absence of community help, stigmatization of former patients, lack of preparation of these patients to deal with daily chores (Vidal, Bandeira & Gontijo, 2008; Sprioli & Costa, 2011; Furtado et al., 2013). Furthermore, there are insufficient services to replace psychiatric hospitals, such as Centers of Psychosocial Attention (CPAs) and RTSs. Even in these new services it is observed practices similar to those of psychiatric centers, such as control, imposition of routine and norms, and vertical relation of power with users (Mângia & Ricci, 2011; Pereira & Costa-Rosa, 2012; Alves, Silva, & Costa, 2012).

The creation of services to replace psychiatric hospitals does not guarantee that the former model will be replaced. Planning strategies and legal imposition do not guarantee there will happen any changes in practices related to psychiatric hospitals. It is necessary for there to be a deconstruction of social knowledge about “madness” which is influenced by its historic origin and is associated to dangerousness, incapacitation, animal-like behavior, which contribute to creating fear, disseminating violence and discrimination towards people in this condition (Bressan, 2014). However, the types of violence these individuals suffer are not mentioned in scientific papers. Our findings reveal that the RTSs considered in this research maintained the same type of violence and disrespect of human rights. This is a serious and alarming matter that should be dealt with by the Brazilian psychiatric reform movement. What is more, there are gaps in the law that should be revisited, just as the lack of federal and local supervision of the practices that happen in RTSs.

The present study aims at analyzing assistance practices towards residents of RTSs and the caretakers’ conceptions connected to such practices.

Method

Participated in the study 15 caretakers from seven different RTSs located in a city of the state of Minas Gerais, Brazil. The criteria adopted for inclusion were: being interested and accepting to participate in the study by signing the Free Consent Form, and having worked at the RTS for at least 6 months. Initially, there were 28 caretakers for the interview; of this group, 23 matched the aforementioned criteria, but only 15 were interviewed. Interviews ceased when the objectives of research were met. Additionally, one member of the local committee of de-hospitalization was interviewed providing information about the history of the RTSs in the city.

The caretakers chose the place where the interviews could be conducted. Nine interviews were conducted in the house of the caretaker, and the other six during their work time at the RTS.

The RTSs at that city were created in October 2008, to provide housing former patients from the city’s psychiatric hospital, which had lost its license. At that time, there were 8 RTSs, with 64 residents. Due to death of some residents, 1 RTS was closed, remaining 7 RTSs with a total of 46 residents. Five of these therapeutic residences are assigned to attend men, and two are assigned to attend women. The majority of the residents were more severely psychosocially impaired, some of them displayed aggressive behavior, and some elder residents were more dependent on the caretakers. A minority of the residents was independent. In visiting the houses, they had their front gate closed with a lock.

At the beginning of the implementation o RTSs, it was created an Association of family relatives and of users of the services of Mental Health, because it was believed that it would serve a gadget in the community to offer support, guidance, and guarantee of rights to relatives and users of RTSs. Although the members of the Association were users and relatives of the individuals suffering from psychic damage, there was no active participation of these members in the activities proposed in association to this profile.

In 2009, this Association compacted with the City Hall to manage RTSs, as responsible for the maintenance of the houses and for the hiring of caretakers and of general services. In total, there were

28 caretakers who worked sifts of 12 hours every 26 hours for seven days a week, that is, four caretakers in each house, and 7 professionals of general services, one for every RTS, who worked 44 hours per week, from Monday to Saturday. Other members of the RTSs' staff were hired by the City Hall: one psychiatrist, one nurse, one biomedic, and one psychologist. The last three of these, with the position of responsible technicians (RT), were responsible for capacitating and overseeing the work of caretakers and other helpers, and were also responsible for articulating with the residents and the staff the Singular Therapeutic Project.

The data was collected through scheduled phone interviews – the day, time, and place were chosen by the caretaker. The interviews happened during the months of October and November 2012, and were conducted by this researcher, experienced nurse in the area of Mental Health. The interviews lasted about an hour and a half each, and were initiated by the following triggering question: "I would like you to tell me your experience: how is it to you the care for residents of the therapeutic home?" This question opened the gate for other themes to be approached as the interview progressed. If the interview did not flow easily, other themes were suggested, such as assistance offered to residents, and the functioning of the RTSs, as stimuli to bring about answers and data that could be of our interest. The caretakers are referred to by numbers in this paper, respecting the ordering of the interviews.

This study received authorization to be developed in the seven RTSs by the Secretary of Health; and it obtained approval by the Ethics Committee at the Federal University of São Paulo under the report number 19653. We secured all ethical procedures in the conduction of this study, respecting the guidelines and norms for research with human subjects established by the CNS Resolution 466/2012 (Resolução Nº 466, 2012). One member of the local committee of de-hospitalization, although not a caretaker, provided information about the history of RTSs and gave consent to the use of this information.

The interviews were recorded and fully transcribed. Then, they were categorized according to their themes, according to the steps proposed by content analysis (Bardin, 2011): 1) pre-analysis – reading of the discourses to apprehend the general idea; 2) exploration of the material – meaningful spans of discourse (meaning units) were highlighted and separated to aid categorization; 3) treatment of results, inferences, and interpretation – grouping of meaning units which formed subcategories of thematic categories. The analysis, and the interpretation of the data were realized according to the theoretical framework of psychiatric reformation, of Mental Health National Politics, and of authors who approach the issue of assistance in Mental Health.

Results and Discussion

Of the 15 subjects interviewed, the majority (10) were women who worked at the RTSs for more than 3 years; the age of the subjects varied between 23 and 57 years old; 12 had completed high school, and 2 had not completed elementary school; 6 were technicians in Nursing; and 12 had never worked in a psychiatric hospital.

The results presented in this paper are four subcategories sheltered under the supercategory of "madhouse practices". The for subcategories are: cowardly violence against the user; users report violence from caretakers; negligence of caretakers and responsible technicians; and death: suffering to some, and distrust to others. The data shows disobedience to the principle of the movement of psychiatric reformation and to the current legislation, revealing a notorious amount of and diverse forms of violence against the residents of RTSs.

Cowardly violence against users

The following reports show forms of violence some caretakers used against residents: "… the caretaker would put the chair people would only go to the bathroom when they [caretakers] wanted to" (C8); "… on Sundays and holydays [the caretaker] is by himself, and leaves the boys [the residents] locked up, there has cases when the caretaker left us with no food, did not make lunch, … they {the residents] do not say anything, they're like children…" (C14).

> *… [the caretaker] attack for real, … lock outside the house, … lock [the resident] outside their rooms, who end up pooping and peeing [in the bedroom] … [the residents] would stay outside [in the yard], didn't matter if it was sun or raining, then she [the caretaker]… would give them a bath with the hose… this guy had a cut in his head… they hit me, broke a wood spoon in my head… you're a nigger, the leftover of an abortion!... a person from the Association [said that].. verbal aggression, it happen all the time… [A male caretaker] almost broke another resident's arm… we had to go to the shower, or we'd get beaten up, … they held us in our beds with stripes… they're Nursing technicians, they brought from [the hospital], … two services, they brought it in their backpacks…. (C7)*
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> *… this [female] caretaker, if the boys disobeyed her, she would leave them with no cigarettes, no coffee, no food… He [resident] was walking with difficulty, the caretaker asked and he said with all the words: [speaking softly]: [this male] caretaker had sex with me… it is a serious complaint to… for no one to take action (C13)*

Madness used to be, and this data confirm it still is, punished, not in asylums, but in RTSs, even though it may be held harmless in the discourse outside the institution (Foucault, 2012). This data show the caretakers' conception about madness associated to the lack of comprehension and intelligence, to the absence of autonomy, of reason, to exclusion, to discrimination, and to isolation.

The torture and punishment that happened until mid 18th century for everyone to bare witness, and, therefore, to be frightened of, started to be conducted in private places, in order for no one to see them. However punishment were still widely known, because the power to punish by means of an authority system became institutionalized. Instead of public local spectacles, punishment practices became more discrete and subtle in institutions considered to be "custodial organization", such as hospitals, quarters, schools, and convents (Foucault, 2013). The same seems to have happened with violence towards individuals with psychic damages, which as common in madhouses, and now, in a more discrete manner, in places such as RTSs.

In previous research conducted with people with psychic suffering in 18 countries of medium or low income about the types of human rights violations they were submitted to, the results were alarming, similar to the ones found in this study. The most common type of violation of human rights described by subjects included: exclusion, marginalization, and community outcast; deprivation of rights to obtain employment or to perform activity that would generate income; physical abuse and violence; difficulties to get access to general Services or Mental Health Services; among others. Among the places where people suffered the most from these types of abuse, Psychiatric institutions and Mental Health services were two of them (Drew et al., 2011).

According to Goffman (2013), violence is found in total institutions. In being admitted into one of them, the individual is a victim of abasement, of degradation, of humiliation, and of desecration of the self. The self is systemically mortified, although sometimes non-intentionally. Beyond the deformations of the self, there is a personal disfiguration, caused by mangling and mutilation, direct and permanent, such as body marks or loss of a member. Verbal or gestural desecration is common practice in these institutions by professionals and managing staff, such as referring to an individual by obscene names, cursing, pointing out their negative qualities, or talking about them with other interns as if they were not present. Another common type of violence in total institutions that contribute to personal degradation is when the individual is forced to have sex against their will. Treating the other with kindness would be a waste with lunatics.

In our study, the data revealed that physical, verbal, sexual, and psychological forms of violence against residents of RTSs, manifested in isolation, disrespect, discrimination, punishment and penalties. These violent practices happened independently of the professional formation of the caretaker and other members of the staff. This indicates that madhouse violent practices remain due to the shared social conception about madness and practiced exerted for centuries, with their deep roots in social imaginary, because historically the mad person was always been considered to lack reasoning abilities, and to act on their animal instincts, therefore dangerous, incapable and child-like (Foucault, 2013).

Therefore, the violation of human rights is a problem brought forth by Psychiatry and maintained by society and by Mental Health professionals in their practices and conceptions, because the madhouse

framing is inside us and we take it wherever we go. A solution proposed by the reformation would be to invest in strategies to change people's mind setting (Marcolan, 2014). In prioritizing the psychosocial rehabilitation and social reinsertion of the excluded, psychiatric reformation is limited for being carried out with no critical thinking or for making no radical rupture in social foundations, which are anchored in the rejection and in the exclusion of people who suffer from psychiatric disorders, and for principles being disrespecting the principles by local authorities and other levels of government (Alverga & Dimenstein, 2006).

Another possible reflection about the existence of these practices is the precarious work conditions, revealed in low salaries, which leads more caretakers to having more than one job. What is more we do not agree with the reduced number of caretakers per RTS, given the high level of dependency residents have on caretakers and it is outraging the lack of professional capacitation, of supervision, and of support by professionals of the RTSs and fo the CPAs, who are responsible for providing necessary technical support to the RTSs, according to the resolution 3.090/2011 (Portaria n. 3.090, 2011).

The lack of professional training, and of permanent education of the caretakers can be observed in the following portion of discourse: "… when a new caretaker is admitted, there should happen but it doesn't… instruction…" (C1); "… when we start the job… we have to stay with another caretaker." (C10); "… no course… in 3 years there hasn't been one course, it's been a long time… but then, never again" (C11) .

Poor professional training has been pointed out in several studies (Sprioli & Costa, 2011; Mângia & Ricci, 2011; Furtado et al., 2013) as one of the main points of fragility of the RTSs, just as the fact that the caretakers' actions are a consequence of the knowledge cumulated through personal experience, based on individual's experiences and moral values, which are quite often contradictory, leading to the adoption of their own parameters and routine, just as happened in the RTSs where we conducted our research.

Our study has also verified the solitary performance of the caretaker, as have other studies (Mângia & Ricci, 2011; Furtado et al., 2013). They are in need a multidisciplinary team working with them in specific projects of rehabilitation in which they can anchor their practice. For this reason, the assistance provided by RTSs is in accordance with a tutorial model, based on the offer of basic cares, with impoverished and ritualized routines.

Furthermore, the problem with the legislation on RTSs should be noted. In the resolutions 106/2000 and 3.090/2011, which are dedicated to RTSs, there are no mentions regarding the level of professional training for the position of caretaker. According to the resolution 106/2000 (Ministério da Saúde, 2004), technical and professional staff responsible for aiding in the supervision of the activities in the RTSs should be formed of a physician and of two other professionals with high school degree, with experience and/or training in psychosocial rehabilitation, who will perform the job of caretakers, since they have been responsible for offering direct assistance for the residents in the RTSs.

The resolution 3.090/2011 mentions the caretaker as a professional of direct assistance, however it does not mention the necessary degree of professional training. The caretaker, then, is a little known employee and who has received little mention in the literature in the area of Mental Health, and also little recognized in RTSs' legal regiments. We have found a paper (Vidal, Bandeira & Gontijo, 2008) which describes professionals with high school degree, mentioned in the resolution 106/2000, as caretakers and direct auxiliaries in the reinsertion of the residents (work, leisure, education, among others, proposed in the resolution 3.090/2011 as the focus of the staff in RTSs. Other authors () describe that the required training for a caretaker is to elementary school, but, when they start the job, they should receive capacitation to assit the residents. Thus it is necessary to review distribution of caretakers in RTSs, considering the quality and the level if specificity of the assistance, including the actions that need a professional legally capacitated to prescribe medication, to perform physical rehabilitation, and other services.

The present study has verified that the level of professional training the caretakers was high school, but not all caretakers underwent capacitation courses when they started working at the RTSs. Only the caretakers who were at the RTSs for a longer period of time had received this additional training.

Users report violence from caretakers

The following data show that the residents themselves reported violent actions against them to other caretakers and to other RTSs: “it is useless to want to do something… they tell on everything…. the woman [caretaker] slapped me in the face, …” (C3); “members of the staff assault, hit, the responsible has arrived…, they talk, it’s like that, the word of a lunatic or of a drug addicted is worthless, …, that’s why things are the way they are. But they talk, most of them…” (C14).

We agree with Mateus e Mari (2013) about the lack of supervision to verify if professionals who provide services outside the hospital, such as CPAs and RTSs, are respecting human rights. When a resident reported to the RTS they had been assaulted in some form, the professional would not pay attention, because according to the social conception incorporated in the RTS, “the words of a lunatic or of a drug addicted are worthless”, as a reported. This reaction shows one again that historically grounded conceptions about madness are still present in our social environment among professionals of Mental Health, regardless of their professional training.

The 3rd National Confernce on Mental Health (CNSM) already recommended that supervision organs (local and federal) should guarantee that replacement services did not reproduced the same madhouse logic (Ministério da Saúde, 2002). According to the law 8142/1990, social control is attainable if representatives of the users and of relatives, health professionals, and other become more actively involved with Town, State and Federal Health Councils, and in some cities with the managing council of the unity. The Association did have a representative in the Town Health Council, but the reports of violence addressed to him, mainly by neighbors of the RTSs, did not reach the council. This shows that social control in the RTSs we studies was not effective. We agree with Oliveira and Conciani (2009) that there are representatives in the Council who aim at their own interest and do not prioritize the reports.

Furthermore, associations of users and relatives of people with psychiatric disorders, and organizations of different entities also have an important role in guaranteeing mental health patients’ human rights (Drew et al., 2011). As mentioned before, the aforementioned Town Association was created by members who represented users with psychiatric disorders and their relatives, but did not act to their benefit; they were responsible for managing distribution of the financial resources to the RTSs.

In choosing to outsource the management of financial resources, the Secretary of Health wavered the responsibility of management, supervision and hiring of the caretakers and technicians, going against the ideals foresaw at the National Conferences on Health and Mental Health, which defend a public management of the services connected to public health system (SUS) and of the admission of new staff. Therefore, the management of the RTSs, which is of responsibility of the Association, considered Social Organization in Health (SOH), did not guarantee the best quality of assistance provided to the residents. Rather, this study shows that that the Association did not respect the basic principles of psychiatric reformation, in guaranteeing human dignity, autonomy, rehabilitation, and reinsertion of residents in society; barely did it guarantee the basic human rights.

The critique against SOH is related to attending the demand of users as a justification to its hiring, and the quality of the service is outcast (Mazzaia, 2014). In our understanding, this Association should be disconnected from the management of financial resources, be extinct, reformulated, or even, created another to assume its role in supporting, supervising and guiding the community, guaranteeing, therefore, that the complaints of the users and relatives would be met in services of Mental Health.

It is still necessary to consider that the process of implementing the RTSs we researched happened quickly, with deficiencies and with a political agenda behind it, in order to solve the problem of housing for former patients of psychiatric hospitals in town. The planning of actions, and the transition process from the hospital to the RTSs would consist of the preparation of these former patients and of the local community to receive them, and of the criteria to select the staff, such as attributes and profile necessary for the job, were not considered. Also, the process of permanent capacitation of the employees, which could contribute to a better quality of assistance of the residents in the RTSs, was not a priority.

Negligence of caretakers and responsible technicians

The following excerpts of discourse are from reports on the negligence of caretakers and of responsible technicians regarding cares for residents: "… only if we call [the responsible technicians]. Many times they deal with it over the phone… don't pay much attention" (C2); "… it has been a year that I don't have a meeting" (C8).

> *…died chocking in a piece of bread… it is negligence… they [RT] put hot towels [regarding aggression of the caretakers]… he was since this morning, it was 2 in the afternoon, …. The reference should send someone more qualified… Mr. X was all dirty, had defecated on himself, urinated, … open ulcer, … I took him to the front, but no one took action… the Association in management, I think that…. aggression, providence should be immediate… [the caretaker] sleeps profoundly, even snores and may even ring the telephone,… most of the general services is convenient to the situation… (C7)*

> *… today they hire anyone… people who use drugs… in the other house, the residents had lice… if they [RT] were more present and read the reports, …. he thin, didn't eat, complained about pains in the back and in the chest… he complained so much we went and said something, RT took him to a consultation… performed the sputum exam, tuberculosis… RT didn't bring me my meds that night… forgets (C13)*

> *… they didn't do anything and the person who did something went after the caretaker who threatened them, they wait at the service door to hit, … there's no way around it because most of the caretakers, I am afraid of them… specially in the night shift. There are those [caretakers] who use drugs,… drink, … throw parties in the residences, … gives extra medication to put residents to sleep,… have sexual relation in the house during the night, has the boyfriend or girlfriend over to sleep… in the night shift… they left the boys [residents] sleeping, partied all night long, and returned in the end of the day (C14)*

Institutional violence, generated by professional in the area of Health, includes discrimination, mistreats, violence, negligence, refusal to provide care, induction of bad states and avoidable deaths, lack of supervision or partial supervisions of the poor conditions of care provided by competent organs, or even cover ups of negligent actions (Nunes & Torrenté, 2009). All these facts were found in our study.

Negligent attitudes of the caretakers are illicit actions utilized by staff members in order to scape from what the organization expects them to do. These are considered as secondary adjustment in total institutions. Usually, in order for them to be committed by a staff member, they need to be outside the bosses' and patients' scope of supervision (Goffman, 2013). This is possibly the reason why residents were excessively medicated so they would sleep and did not witnessed the parties thrown in the residence; the residents were locked up in their bedrooms or in the yard so the caretaker could sleep in their shift.

It is inadmissible the fact that the RTs cover these negligent actions, mistreats, and violence from caretakers, just as the reluctance to fire these caretakers after these happenings. The management should preserve the stance to zeal with ethical compromise. What is more, the lack of in loco supervision and staff meetings contributed to the perpetuation of practices violating human rights. Staff meetings, practically inexistent in the RTSs investigated, are of paramount importance for the members to debate singular therapeutic projects, strategies to put them in action, and to reflect on new practices regarding the organization of new services, guided by the principle of integrality (Bonfada, Cavalcante, Araujo, & Guimarães, 2012). This strategy could be inserted in the RTSs investigated aiming at improving the quality of assistance offered to the residents and at avoiding violent and negligent practices.

Another important aspect to become integrated to standard practices in the RTSs investigated is supervision. This action promotes the guidelines of the work, and the continuity of the actions in the agenda (Sprioli & Costa, 2011). Institutional supervision of professionals in Mental Health services was

proposed at the first CNSM (Ministério da Saúde, 1988) and reiterated in the third edition of the conference (Ministério da Saúde, 2002), in affirming that the replacement services of Mental health has clinical and institutional supervision, with permanent discussion of the users' therapeutic projects.

The 3rd Mental Health Conference, in 2001, proposed that the foundation and the creation of indicators and of a evaluation system of the policy and of the Mental Health Services were necessary to effectuate the reorientation of the assistance model. In this sense, follow up, intervention, and reorientation in Health practices are necessary, aiming at a consolidation of the principles of the public health system (SUS) and of psychiatric reformation. This was not verified in our study.

All measures mentioned above, such as staff meetings, in loco supervision, institutional supervision, indicators for evaluations, were not fulfilled by different responsible agents involved in providing assistance to residents in RTSs, starting with the RTs, professionals from CPAs, who were responsible for providing technical support, Association, City Hall, and local supervision committees. This only shows the lack of commitment of professionals, of services, and of governmental levels with the principles of the psychiatric reformation.

Death: suffering to some, and distrust to others

Considering the 18 deaths in a period of 5 years in the RTSs – from October 2008 to August 2013 – almost 4 death per year, some caretakers show sadness and suffering, and other suspect that these deaths were results of negligent action, since they happened in the night shift: "When I lose a patient it messes with me… I consider them my children… the reason for sudden death… it is like they have been living for a long time, isolated from their families, a lot of medication, … sadness" (C1) ; "… it seemed like I had lost a son… I suffered a great deal… it caused anxiety, I had to take relaxing pills" (C2) ; "… [he] arrived at the hospital, an hour or so later he had a heart attack, …" (C5) ; "… I think I should talk, X died because of this… it can be a diagnosis that can be avoided…" (C7); "… we are having an outbreak of tuberculosis, … X passed away and there is another one on treatment for this" (C1).

Possible causes of death reported by the caretakers were: continuous use of psychiatric medication, sadness for separation from relatives, heart attack, and tuberculosis. These last two were also pointed out in a study by Garcia (2012) as most frequent causes of death in madhouses in the area of Sorocaba-SP. In a similar fashion, in our study there was no adequate investigation about the deaths. The complaint of the caretakers is that it was difficult to access to the diagnosis of the cause of death. For example, the report on the death by chocking in the previous subcategory.

The data shows that the principles of Mental Health policies based on the Caracas Declaration were not being respected. These principles concern the respect to resources, to assistance, and to the legislation that should preserve personal dignity, and human and civil rights of the individual suffering from psychiatric disorder, and to promoting the organization og community services of Mental Health that guarantee their fulfillment (Ministério da Saúde, 2004).

The violation of human rights in extra-hospital institutions goes by unnoticed, and, to the movement of psychiatric reformation, the most important thing seems to be closed beds in psychiatric hospitals and their replacement for other gadgets in attention to Mental health, such as RTSs, among others. What seems to be forgotten is the creation of a legislation of services that will replace madhouses, which does not guarantee by itself that the madhouse model be overcome.

Besides supervision and evaluation of Mental Health services, and of social control as measures to control the violation of human rights of individuals with psychiatric disorder, it should be taken into account that the ignorance and false beliefs about these people are reasons why violations of human rights occur. Usually, these individuals are seen as violent, dangerous or unpredictable, for this reason they have their rights violated. These negative attitudes are performed not only by general population but also by Health professional, and by politicians responsible for the present legislation (Drew et al., 2011).

These strategies were more effective in the long term, to the deconstruction of madhouse culture in the community, it is to favor the increase of knowledge of the population regarding their mental sufferings and the possible treatments, considering the new focus on Mental Health, by means of

instructive campaigns in which the population have contact with the individuals and their testimony. Such contact propitiates the perception of the human dimension of the other, and it has been identified as a significant factor in the reduction of stigmatizing attitutes, in allowing the demystification of the dangerousness and unpredictability associated to these individuals with psychic suffering. The development of action partnering with segments in sports, culture, leisure, among which these individuals can be inserted, are also good strategies in enabling the contact and in reducing the stigma and discrimination (Pimentel, Villares, & Mateus, 2013).

Further suggestions to reduce the violations of human rights count with the participation of the individuals themselves, and their relatives, and Mental Health professional, to identify the main areas in which could happen these instructive campaigns about Mental Health, discrimination, and promotion of human rights. These campaigns should be continuous and should start in schools (Drew et al., 2011).

Our suggestion to Health professionals is to conduct specific instructive trainings offered by social authorities of the State. To the individuals with psychic suffering, our suggestion is support of advocates, of community services, of social assistance, of the other Health professionals, and of peers in order to encourage the establishment, and the strengthening of organizations that fight for the rights to citizenship. These organizations and their users should take part in the evaluation and supervision of Mental Health services, more specifically with respect to the practices of violation of human rights, through regular inspections of these services. Users' complaints about the service, as well as their relatives' complains should be considered, allowing and encouraging them to freely and securely come forward about violation in human rights (Drew et al., 2011).

As we have verified in the data presented in this study, no action was taken to eradicate madhouse practices, which violate human rights of individuals with psychic suffering, in Mental Health services investigated here.

Final considerations

This study revealed some madhouse practices such as violence, and negligence towards the residents of the RTSs investigated. These practices, which violate human rights, were related to the influence of the social conception and of the caretakers position regarding madness, associated with poor comprehension and intelligence, lack of autonomy, absence of reason, exclusion, discrimination, and isolation. This is a serious and alarming matter that should be dealt with by the movement of Brazilian psychiatric reform, strategizing to change the social conception about madness.

Among the factors that contributed to the occurrence of these practices is the lack of federal and local supervision. The City's Health Secretary exhumed itself from any responsibility in managing and supervising RTSs, and has assigned this responsibility to a local Association of people who have their relatives using Mental Health services, which, in turn, has hired caretakers and technicians with no qualifications for the job. The Association did not oversee the permanent education of the professionals who work there and did not supervise the practices that take place in the RTSs.

The RTSs did not fulfill their role and the professionals from the CPAs did not offer technical support, violating the legislation regarding the RTSs. What is more, there are gaps in the law about reformations related to RTSs that need to be revisited, such as making explicit mentions as to the professional qualifications of the caretakers. Given these reasons, the caretakers, alone in their professional duties, having their misconceptions about madness, based their practices in their own moral values.

Beholding this scenario, we conclude that the investigated RTSs, which should replace psychiatric hospitals and their asylum practices, served, in fact, as new services with he physical structure of a house, but maintained the same madhouse practices, that is, RTSs are the new madhouses. The matter regarding the violation of human rights grew in us serious concerns, at the time the data was collected. The results of this research were presented at a meeting in the beginning of 2013 to the Coordination of Mental Health of the city, given the change in management. Since then, there has happened a restructuring of the RTSs. It has been promoted capacitation courses for caretakers, and

violent practices have been supervises by new personal hired at the RTSs. We do not have any data after these changes.

The limitation of this study regards its generalization. We suggest that future studies should be undertaken in order to bring forth new reflections and proposals, aiming at construing a more humane assistance committed to the principles of the psychiatric reformation: rehabilitation, social reinsertion, autonomy, human rights, and citizenship. This study can only point out to the fact that a reform needs to be effectively implemented in al l regions of Brazil. The proposals need to become a reality in order to change the hard and cruel reality of madhouse models still present in much equipment, including in the replacements of psychiatric hospitals.

References

Alverga, A. R. & Dimenstein, M. (2006). A reforma psiquiátrica e os desafios na desinstitucionalização da loucura. *Interface, 10*(20), 299-316.

Alves, D. S., Silva, P. R., & Costa, N. R. (2012). Êxitos e desafios da reforma psiquiátrica no Brasil, 22 anos após a declaração de Caracas. *Medwave, 12*(10). Recuperado em 1 de outubro, de 2014, de: http://www.mednet.cl/link.cgi/Medwave/Revisiones/RevisionTemas/5545.

Bardin, L. (2011). *Análise de conteúdo*. Lisboa: Edições 70.

Bonfada, D., Cavalcante, J. R. L. P, Araujo, D. P., & Guimarães, J. (2012). A integralidade da atenção à saúde como eixo da organização tecnológica nos serviços. *Ciência & Saúde Coletiva, 17*(2), 555-560.

Bressan, V. R. (2014). Estratégias de desinstitucionalização. *Psique Ciência & Vida*, São Paulo, 103, 50-53.

Castel, R. (1978). *A ordem psiquiátrica: a idade de ouro do alienismo*. Rio de Janeiro: Edições Graal.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin L. & Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *Lancet, 378*(9803), 1664-1675.

Dutra, V. F. D. & Rocha, R. M. (2011). O processo de desinstitucionalização psiquiátrica: subsídios para o cuidado integral. *Rev. enferm.* UERJ, *Rio de Janeiro, 19*(3), 386-91.

Foucault, M. (2012). *História da loucura na idade clássica* (9a ed.). São Paulo: Perspectiva.

Foucault, M. (2013). *Vigiar e punir: nascimento da prisão* (41a ed). Petrópolis: Vozes.

Furtado, J. P., Tugny, A., Baltazar, A. P., Kapp, S., Generoso, C. M., Campos, F. C., Guerra, A. M. C., & Nakamura, E. (2013). Modos de morar de pessoas com transtorno mental grave no Brasil: uma avaliação interdisciplinar. *Ciência & Saúde Coletiva, 18*(12), 3683-3693.

Garcia, M. R. (2012). A mortalidade nos manicômios da região de Sorocaba e a possibilidade da investigação de violações de direitos humanos no campo da saúde mental por meio do acesso aos bancos de dados públicos. *Revista Psicologia Política, 12*(23), 105-120.

Goffman, E. (2013). *Manicômios, prisões e conventos* (8a ed.). São Paulo: Perspectiva.

Lei nº. 8142, de 28 de dezembro de 1990. (1990, 28 de dezembro). Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Brasília, DF.

Mângia, E. F. & Ricci, E. C. (2011) “Pensando o Habitar”: trajetórias de usuários de serviços residenciais terapêuticos. *Rev Ter Ocup Univ São Paulo, 22*(2),182-190.

Marcolan, J. F (2014). A assistência psiquiátrica no Brasil. *Psique Ciência & Vida*, São Paulo, 103, 38-41.

Mateus, M. D. & Mari, J. J. (2013). O sistema de saúde mental brasileiro: avanços e desafios. In M. D. Mateus (Org.), *Políticas de Saúde Mental*: baseado no curso políticas públicas de saúde mental, do CAPS Luiz R Cerqueira (pp. 20-55). São Paulo: Instituto de Saúde.

Mazzaia, M. C. (2014). Reforma psiquiátrica a passos lentos. *Psique Ciência & Vida*, São Paulo, 103, 42-45.

Ministério da Saúde (2002). *3ª Conferência Nacional de Saúde Mental: cuidar sim, excluir não – efetivando a reforma psiquiátrica com acesso qualidade, humanização e controle social* (relatório final). Brasília: Conselho Nacional de Saúde.

Ministério da Saúde. Secretaria Nacional de Programas Especiais de Saúde (1988). *1ª Conferência Nacional de Saúde Mental* (relatório final). Brasília: Centro de Documentação do Ministério da Saúde.

Ministério da Saúde. Secretaria-Executiva, Secretaria de Atenção à Saúde (2004*). Legislação em saúde mental: 1990-2004.* Recuperado em 19 de setembro, de 2014, de http://bvsms.Saúde.gov.br/bvs/Públicacoes/legislacao_mental.pdf.

Nunes, M. & Torrenté, M. (2009). Estigma e violências no trato com a loucura: narrativas de centros de atenção psicossocial, Bahia e Sergipe. *Rev. Saúde Pública, São Paulo, 43(supl. 1),* 101-108.

Oliveira, A. G. & Conciani, M. E. (2009). Participação social e reforma psiquiátrica: um estudo de caso. *Ciência & Saúde Coletiva, 14*(1), 319-331.

Pereira, E. C. & Costa-Rosa, A. (2012). Problematizando a reforma psiquiátrica na atualidade: a saúde mental como campo da práxis. *Saúde Soc, 21*(4), 1035-1043.

Pimentel, F. A., Villares, C. C., & Mateus, M. D. (2013) .Estratégias de combate ao estigma na saúde mental. In

M.D. Mateus (Org.), *Políticas de Saúde Mental*: baseado no curso políticas públicas de saúde mental, do CAPS Luiz R Cerqueira (pp. 306-321). São Paulo: Instituto de Saúde.

Portaria n. 3.090, de 23 de dezembro de 2011. (2011, 23 de dezembro). Altera a Portaria nº 106/GM/MS, de 11 de fevereiro de 2000, e dispõe, no âmbito da Rede de Atenção Psicossocial, sobre o repasse de recursos de incentivo de custeio e custeio mensal para implantação e/ou implementação e funcionamento dos Serviços Residenciais Terapêuticos (SRT). Brasília, DF: Ministério da Saúde. Recuperado em 1 de outubro, de 2014, de http://bvsms.Saúde.gov.br/bvs/Saúdelegis/gm/2011/prt3090_23_12_2011_rep.html.

Resolução n. 466, de 12 de dezembro de 2012. (2012, 12 de dezembro). Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções: Nº 196/96, Nº 303/2000 e Nº 404/2008. Brasília, DF: Ministério da Saúde, Conselho Nacional de Saúde. Recuperado em 2 de outubro, de 2014, de http://conselho.Saúde.gov.br/resolucoes/2012/Reso466.pdf.

Sprioli, N. & Costa, M. C. (2011). Cuidar em novo tempo: o trabalho de cuidadores com pacientes psiquiátricos em moradias. *Revista Latino Americana de Enfermagem, 19*(5), 1155-1162.

Ventura, C. A. A. & Brito, E. S. (2012). Pessoas portadoras de transtornos mentais e o exercício de seus direitos. *Rev Rene, 13*(4), 744-754.

Vidal, C. E., Bandeira, M. & Gontijo, E. D. (2008). Reforma psiquiátrica e serviços residenciais terapêuticos. *Jornal Brasileiro de Psiquiatria, 57*(1),70-79.

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