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Right to social protection and health among residents of Therapeutic Home Services

Direito à proteção social e à saúde entre moradores de Serviços Residenciais Terapêuticos

Derecho a la protección social y a la salud entre los residentes de Servicios Residenciales Terapéuticos

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This is a qualitative and descriptive study carried out in the second semester of 2017 in a city in the interior of the state of Minas Gerais. It aimed to analyze the exercise of rights that ensure standard of living, social protection and physical and mental health among residents of therapeutic residential services. A semi-structured interview guided by the QualityRights Tool Kit was used to collect data, that were later interpreted with Bardin's content analysis. Ten residents of two therapeutic residences participated. Two categories emerged: "*The right to an adequate standard of living and social protection*"; and "*The right to enjoy a higher standard of living and physical and mental health*". The therapeutic residential service protects its residents from social discrimination and provides sufficient physical structure and resources for a dignified life. The rights to autonomy, inclusion and social rehabilitation are exercised through external practices that generate proximity to the community. Access to health is mediated by the professionals of this service. However, there are gaps in access to leisure and reception of visitors, which shows the need to implement practices that promote proactivity and social inclusion of residents.
Descriptors: Human rights; Deinstitutionalization; Mental health.

Este é um estudo qualitativo e descritivo realizado no segundo semestre de 2017 em uma cidade do interior mineiro, tendo como objetivo analisar o exercício de direitos que assegurem padrão de vida, proteção social e saúde física e mental entre moradores de serviços residenciais terapêuticos. Utilizou-se a entrevista semiestruturada direcionada pelo *QualityRights Tool Kit* para coletar os dados que foram interpretados utilizando-se a análise de conteúdo de Bardin. Participaram dez moradores de duas residências terapêuticas. Emergiram duas categorias: "*o direito a um padrão de vida e proteção social adequado*"; e "*o direito a usufruir padrão de vida mais elevado de saúde física e mental".* O serviço residencial terapêutico resguarda seus moradores da discriminação social e disponibiliza estrutura física e recursos suficientes para uma vida digna. Os direitos à autonomia, inclusão e reabilitação social são exercidos por meio de práticas externas que geram proximidade com a comunidade. O acesso à saúde é intermediado pelos profissionais desse serviço. Entretanto, há lacunas no acesso ao lazer e à recepção de visitas, o que mostra a necessidade da implementação de práticas propulsoras da proatividade e a inclusão social dos moradores.
Descritores: Direitos humanos; Desinstitucionalização; Saúde mental.

Este es un estudio cualitativo y descriptivo realizado en el segundo semestre de 2017 en una ciudad del interior del estado de Minas Gerais, con el objetivo de analizar el ejercicio de los derechos que garantizan el nivel de vida, la protección social y la salud física y mental entre los residentes de servicios residenciales terapéuticos. Para recoger los datos se utilizó la entrevista semiestructurada dirigida por el *QualityRights* Tool Kit, que se interpretó mediante el análisis de contenido de Bardin. Participaron diez residentes de dos residencias terapéuticas. Surgieron dos categorías: *"el derecho a un nivel de vida y a la protección social adecuados"*; y *"el derecho a disfrutar de un mayor nivel de vida de salud física y mental".* El servicio residencial terapéutico protege a sus residentes de la discriminación social y les proporciona estructura física y recursos suficientes para una vida digna. Los derechos a la autonomía, la inclusión y la reinserción social se ejercen a través de prácticas externas que generan proximidad a la comunidad. El acceso a la salud está intermediado por los profesionales de este servicio. Sin embargo, existen lagunas en el acceso al ocio y la recepción de visitantes, lo que demuestra la necesidad de implementar prácticas que promuevan la proactividad y la inclusión social de los residentes.
Descriptores: Derechos humanos; Desinstitucionalización; Salud mental.

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INTRODUCTION

Therapeutic residences (TR), most often occupied by people discharged from long-term psychiatric hospitalizations, are services defined as housing in the community for people with mental disorders who do not have family ties or social support. In Brazil, these services were regulated in the 2000s, through Ordinance No. 106/2000, which provides the creation of therapeutic residences within the scope of the Unified Health System (SUS), regulated by Ordinance No. 1,220/2000, which detailed the financing of these services[1] .

Although they were regulated in 2000, only recently the structure of TRs was intensified, which should not only represent a welcoming space after hospital discharge, as their main goal is to deinstitutionalize and establish a rehabilitation process that ensures the therapeutic character of this service[2] .

From a legal point of view, the stimulus for the creation of these services began in 2004, through Ordinance No. 2068/20041 which was replaced by Ordinance No. 246, in 2005, which provided a financial incentive of ten thousand *reais* - value to be applied in the improvement and/or implementation of RT in municipalities. The transfer is made in a single installment and does not restrict state and municipal budgets, with a goal to consolidate the extra-hospital mental health care network in all units of Brazil[3]. In 2011, Ordinance No. 3,090 classified residential therapeutic services as Type I and Type II and, based on this classification, redefined operating guidelines and financial incentives for each of them[4].

Type I therapeutic residences are intended for people who are in the process of deinstitutionalization. Up to eight people may stay in these types of residences, and they must be referred by a caregiver, monitored by a mental health technical team responsible for establishing individualized therapeutic projects for residents[4]. Both these projects and the care provided by this reference caregiver must be based on the (re)structuring of the residents' social network through work, education, leisure and other existing strategies in the community, which favor the psychosocial rehabilitation of these subjects[4].

Type II therapeutic residences host people (minimum of four and maximum of ten residents) with a higher degree of dependence, usually caused by physical impairments, that require continuous care. In this classification, care is provided by approximately five caregivers (on a work schedule) and a nursing technician, who works daily; these professionals are also monitored by a technical reference team in mental health that establishes a therapeutic project during the process of de-hospitalization of each resident[4].

In this project, the focus should be on adapting to activities of daily living (personal hygiene, self-care, food, and others), training for social skills (communication and others), as well as other actions that enable these people to feel at home, where there are other people who help them to live better and thus (re)build affective bonds. In this classification, the need for adjustments/adaptations in the physical space of the house to better meet the needs of the residents should also be highlighted[4].

From the regulation of Ordinance 3090/2011, it was also established a financial incentive of twenty thousand *reais* for the implementation of both types of TR. However, the monthly financial transfer is different for each classification. In Type I TR, the financial transfer is determined by the number of residents (between four and eight) and, if there are eight residents in the TR, an amount of ten thousand *reais* is transferred monthly. In Type II TR, the financial transfer also varies according to the number of residents; if the residence has a maximum number of ten people, the monthly transfer is twenty thousand *reais*[4].

In addition to the financial stimulus proposed by Ordinance 3090/2011, there are still challenges to be overcome, which focus on the care process, which should value quality of life, regardless of diagnoses and cognitive conditions, which requires a new perspective from professionals who work in therapeutic residences[5].

Ensure social inclusion and avoid social discrimination of TR residents is mandatory, as shown in recent research[6] on the rights to equality and freedom of its residents.

The World Health Organization (WHO) highlights the Quality Rights Tool Kit[7], created to improve the conditions of mental health establishments, according to premises of human rights that include: right to adequate standards of living and social protection, right to enjoy the highest possible standard of physical and mental health, right to exercise legal capacity and right to personal liberty and security, prevention of torture or handling by cruel, inhuman or degrading people and against exploitation, violation and abuse and the right to live independently and to be part of the community.

These rights are important, especially considering the current moment, which proposes to increase funding of beds in psychiatric hospitals and Therapeutic Communities as one of the solutions in mental health[8].

In this context, the fragilities and deficiencies of access to the basic rights of people with mental disorders are disregarded[9], contradicting the assumptions of Law No. 10,216, which provides protection of the rights of these subjects and priority for community treatment[10]. Furthermore, studies on Quality Rights are still recent. In this sense, this article aims to analyze the exercise of rights that ensure standard of living, social protection and physical and mental health among residents of therapeutic residential services.

METHODS

This is a descriptive study based on a qualitative approach[11], developed in a medium-sized city in the interior of the state of Minas Gerais, which has approximately 300 thousand inhabitants, in the first two of the six existing therapeutic residences.

The following inclusion criteria were considered: not presenting cognitive alterations, as assessed by the Mini Mental State Examination, and residing for at least one year in the residence. The established exclusion criterion was: being hospitalized for clinical or psychological complications.

Data were collected from September to October 2017, using a semi-structured interview script built based on the QualityRights Tool Kit[7], which establishes a grouping of specific questions for each of the themes addressed in this investigation (standard of living, social protection, physical and mental health).

The interviews were recorded via mobile phone, lasted an average of thirty-five minutes and took place in the living space of each of the participants (private location chosen by each one of them).

The data obtained were analyzed with content analysis[12]. The interviews were analyzed according to the procedures recommended by Bardin. First, the statements of each representative were analyzed. Next, the points of similarity and difference between contents were listed, as well as what could be highlighted as relevant to achieve the research goals. The results were gathered into categories and discussed based on specific production in the area.

This work was developed after approval by the Ethics Committee for Research with Human Beings at the Escola de Enfermagem de Ribeirão Preto (CAAE: 45903815.3.0000.5393). All participants received clarifications about the research proposals and the established Terms (TCLE and TALE), which were duly signed by guardian and resident, respectively, to formalize their agreement to participate in the investigation.

Seeking to ensure anonymity of the participants, the participants were identified by the letter R (resident), followed by an Arabic number corresponding to the sequence of the interviews.

RESULTS

The TR chosen for the research had eight each, thus making a total of sixteen people. Two people had clinical conditions that led them to hospitalization during the period of data collection, one person had been living in the therapeutic residential services for 8 months and three had cognitive alterations and, therefore, were excluded from data collection.

Ten residents participated in the investigation, seven of whom were male and three female, with a mean age of 49.2 years of age, having lived in the TRS from four to five years, with a predominance of schizophrenia spectrum in the diagnosis doctor.

From the data analysis, two categories emerged: "*The right to an adequate standard of living and social protection*"; and "*The right to enjoy a higher standard of living and physical and mental health*".

The right to an adequate standard of living and social protection

Overall, the participants expressed satisfaction with the home they live in, as four of them described the house as beautiful and most of the others reported enjoying living there:

I like it here, it's beautiful. (R1)
It's nice to live here and I like it a lot. (R6)
Beautiful, I like where I live. (R2)
I think it's beautiful. (R4)
My house is beautiful, it has a TV, a sofa, it has a soundsystem[...]. (R10)

Regarding a routine centered on schedules, such as in health services (time for bathing, meals), most participants report having autonomy to organize their schedules:

Yes, I wake up when the sun is already up, I sleep half a day and I wake up whenever I want [...]. (R6)
I always shower when I want. (R9)
I decide the time, sleep at 10 pm and wake up at 6:30 am. (R3)
I always sleep in the afternoon and wake up whenever I want. (R4)
I wake up on my own at 6 am and sleep at 9 pm. (R2)
I drink coffee and eat biscuits any time I feel like it. (R5)

However, two participants argue that they need help at times to maintain their routine, or limited hours:

Sometimes yes, they wake me up sometimes. (R1)
Yes, there is a set time to sleep, it is until 10 pm. (R10)

The presence of furniture to store personal belongings was also investigated and three of them reported that there is such furniture, but they do not have keys:

I have it, but there's no key. (R5)
I have a locker of my own, but it doesn't have a key. (R1)
I have a wardrobe just for me, there's no key. (R2)
Yes, I share it with colleagues, there is no key. (R7)

Some also reported autonomy regarding choosing their clothes, or asking for help:

I choose the best one to use for the day. (R7)
I choose the ones I like and wear the most. (R2)
I choose, and sometimes the nurse helps me choose. (R1)

Two residents reported limitations in relation to circulation in the house:

You can't go into the caregivers' room, there are important things there, otherwise they'll disappear. (R6)
You can't go into the kitchen all the time, it's not forbidden, but it's not okay. (R10)

Faced with these issues, only one of the participants did not recognize their possibility of autonomy and the right to have their identity protected when complaining:

Bad house, I like nothing here [...]. (R9)

This same participant continued to report not having a locker or access to elementary materials for cleaning maintenance. It is noteworthy that, throughout the interview, he denied everything that was questioned, have positive things to say only about medications, answering:

This is all that there is here. (R9)

Unlike this participant, the others expressed satisfaction in relation to cleaning (with the help of some residents) and access to basic hygiene products:

[...] *the house is very clean, it even smells like perfume.* (R1)
Very good, they clean it up well. (R6)

Normal, it stays clean. (R2)
Caregivers who clean sometimes sweep or do something. (R10)
Caregiver who cleans the whole house, I help with the dishes and the yard. (R7)

At meals, the offer of five meals was mentioned and that food is appreciated:
Early morning snack, 2 pm snack, evening snack, lunch and dinner, the food is delicious. (R1)
Breakfast, lunch, afternoon snack, dinner, supper, I really like the food here. (R6)
[...] *I like the food, yes.* (R7)

Communication with people outside the home does not exist, reported by most:
I don't talk to anyone over the phone. (R10)
I can't handle it. (R6)
I don't know how to deal with the internet or telephone. (R5)
Nobody calls us here. (R3)
The CAPS people don't know the phone number here and I don't even know their phone number. (R1)
There's no way to communicate, because I think the people I know don't have mobile phones either. (R8)

One participant reported that he had a friend who owns a business and that he helps him in this establishment and another that his external contact is restricted to the use of services:
I help my friend at his bar. (R10)
Not on the phone, just when I'm getting a haircut. (R7)

About visits, two residents reported not receiving them and the others said they do, highlighting the presence of students and interns:
None of my friends visit me here. (R8)
I never see visitors coming. (M4)
They bring students here, people who teach us how to paint, draw. (R7)
The nurse brings the visits. (R5)
Interns visit us here, just let the nurse know. (R10)
There are always people from college who come here to see us. (R3)
The nurse brings the students' visits. (R6)
People come to visit us in lab coats, but it's from time to time. (R1)
Once a month college students come and that's cool. (R9)
The nurse is always close to the interns during visits and from time to time I talk to them. (R2)
Anyone can come, I usually show the house to whoever comes. (R10)

Regarding leisure activities, three residents reported that they did not perform them:
I do not do anything. (R6)
I never go out for a walk. (R8)
I don't do that. (R2)

Other residents consider the possibility of assisting in the care and routine of the homes as interactive activities such as leisure, or when going to the CAPS:
Watch TV, listen to music, but I do the dishes from time to time to help the caregivers too. (R1)
I help my friend Marquim at Zero Grau. (R10)
I watch TV, listen to music. (R7)
Only the times I go to CAPS. (R4)

Considering that none of the participants have family ties, it is not possible to leave the TRS for family events and the participants point out that routine activities performed voluntarily in this service correspond to those socializing activities offered by this service, as can be seen in the following statements:
I can, but I have never gone [...] *all voluntary, I do things to help the caregivers".* (R3)
No, my family has no contact. (R2)
Never go out for that, you can, you can, but I was never invited. (R10)

Seeking to ensure an adequate standard of living and social protection, the TRSs in question offer residents access to basic supplies (property infrastructure, furniture, means of communication, clothing, among others) in the proper amount, as well as proper hygiene. Most respondents expressed satisfaction with access to such resources. It was also noted that, in their perception, there is autonomy in the appropriation of space and organization of the routine, with the exception of residents who need support due to cognitive and/or motor issues.

Regarding social support and establishing bonds, it was found that residents mention satisfactory communication, but the reality of TRSs shows gaps in relation to the access of visits,

since they are restricted to professionals and interns. Leisure activities within the context of TR are restricted to television and radio.

The right to enjoy a higher standard of living and physical and mental health

It is possible to notice the resident's lack of knowledge in recognizing situations of people in need of housing and their difficulty to acquire them. None of the participants report any knowledge on the influence of related issues, such as: gender, religion, culture and/or politics. Also, they do not know about the actions of the team to assist in the search for housing for people who cannot obtain them through the service:

I didn't hear that. (R1)

Only R3 recognized the demand of a user while performing activity at the Psychosocial Care Center:

[...] *but there was a man who sought the CAPS to live here, but I don't know why he didn't come. They find another place, yes.* (R3)

As for memories of leaving the TR, seven residents say they do not remember. One of the participants reinforces that the behavior of going out more often is practiced by one of the residents:

I don't remember, because there is just one person here who leaves. (R3)
One of the residents here, because he fought with the caregiver. (R2)
I stay here when I behave badly, because I can go out every day at 4 pm and come back at 8 pm. (R10)

About the different professionals present in the house, nine residents highlighted the presence of caregivers and nurses, as well as interns. The way they name these professionals varies among the interviewees' discourse, R7 calls them mother, while R3 calls them housemaids. Professionals who assist them at CAPS were also mentioned:

Nurse, psychologist, caregivers and the doctor. (R6)
Our mother, nurse, psychologist and doctor. (R7)
The doctor who prescribes our medicines, the nurse, the housekeeper and the occupational therapist. (R3)
Nursing and medicine intern, nurse, caregiver. (R2)

In general, participants claim that professionals have knowledge of their human rights as residents. Two of them highlight the relationship between the care they receive and the perception of these rights:

They treat us very well. (R10)
You know, they take care of us. (R7)

About mechanisms and opportunities for residents to express opinions and criticisms about interventions and care, the professionals who follow the home's routine (nurse and caregivers) are mentioned:

We talk to the nurse or caregivers, and they solve what you need. (R6)
You can speak, but I never complained about anything. (R7)
We say nothing, we remain silent, but the nurse always asks us how things are going. (R3)

Regarding the residents' possibilities of social rehabilitation, they recognize this possibility and highlight self-care activities:

They teach us how to take a bath properly, but each person does it their own way. (R6)
They teach how us to take care of ourselves. (R8)
They teach us everything, they try to please us. (R3)

In addition to the existence of activities, the presence of autonomy of the residents in relation to the performance of what is proposed is perceived:

They offer it, but each one does it the way they like best. (R1)

When asked about motivation to contact family and friends, they state that there was a loss of family ties, reporting that there is debate about it, but there is no contact with family members:

I don't have a family, I just have the caregivers and José. (R10)
They talk about family, but I have no contact. (R7)
They motivate us, but the nurse hasn't found them on the computer yet. (R8)
They motivate us, but I couldn't because I have to go to Belo Horizonte. (R2)

Regarding the articulation with other services, they point out that nursing professional and the caregivers are responsible for this intermediation:

It makes it easier, the nurse does that. (R1)
Caregivers help with everything. (R10)

About medications, nine participants report that they are accessible and correctly administered:

There's for everyone, no one is ever in need of it. (R1)
There is never shortage of it. (R7)
We have it here every day. (R5)
There are all kinds of remedies. (R6)
It is always availablefr. (R4)
Everyone takes them here and there's no shortage of them. (R10)
No medicine is lacking. (R3)
They give us all the medicine we need. (R2)
We are never without the medicines that the doctor orders us to take. (R8)

One of them highlights the mobilization of nursing professional for purchasing medication when there is not any:

There's enough for everyone. When there isn't, the nurse gets it. (R6)

Regarding the investigation of side effects, three residents claim that there is no such investigation, diverging from other residents who emphasize the existence of this process:

They take us to the doctor when something different happens. (R8)
They try to find out, but it never happened to me. (R5)

When asked about exams before arrival at the residence, most respondents deny taking any:

They took a lot of blood from me, I think that's why I'm kind of disoriented. (R1)
I don't remember any exams. (R5)
There's every kind of exam you need since I got here, but to come here I don't remember taking anything. (R6)
I did a lot of X-rays already, but not for coming and living here. (R4)
They just put us in the van and brought us. They didn't take any. (R10)
My mate took a lot of exams, but he didn't want to live here. (R3)

In health problems, they claim to receive assistance, emphasizing medical and dental treatment:

The nurse takes us to the doctor, to the dentist. (R1)
They take us to the doctor and to the dentist, I go to the doctor to change my glasses' prescription every year that they get too weak. (R6)

The therapeutic residences in question protect the residents' autonomy rights in relation to free movement, since most interviewees do not report restrictions regarding the possibility of leaving the house.

Access to health professionals is ensured, mainly by the Psychosocial Care Center and the different health services in the network. The recognition of human rights by professionals is noticed by the residents through the care relationship, access to necessary medication and investigation of side effects and medical support for follow-up.

In access to housing, they show ignorance of the influence of social issues, such as religion, gender and culture, nor familiarity with the mobilization by the team to help in this process.

DISCUSSION

In mental health legislation, there is an agreement to ensure the rights of people with mental conditions. Faced with the right to an adequate standard of living and social protection, the questions raised show its guarantee to residents. Ordinance No. 3.090/2011 recommends the re-appropriation of the space seen as housing in the Therapeutic Residential Service, so that the construction of skills for daily life related to self-care, food, clothing, hygiene, establishment of affective bonds and forms of communication[4].

In the domestic environment, it is necessary to consider possible adjustments in the physical space that meet the needs of residents[4]. Regarding physical and functional characteristics, it is emphasized that TRs need to be furnished with the equipment necessary for daily activities, in addition to maintaining the structure of the house. Considering the

current legislation, the TRSs in question meet the needs in relation to the site's infrastructure and access to elementary supplies[13].

The autonomy of residents is closely related to the right to citizenship, considering the subject's possibilities of having an active participation in society in view of their decision-making possibilities[14]. Autonomy is manifested from everyday choices, contradicting submissions present in institutional orders. It is noticed that, in the researched Therapeutic Residences, residents participate in routine activities and exercise the right of choice in relation to food, clothing, activities in which they will participate, and even in not performing any function, if they do not wish ot or are unavailable.

In addition, they have the right to organize their schedules according to their own pace and needs. In this sense, it is possible to verify satisfaction of the residents inhabiting the Therapeutic Residential Service, which is also clear in another investigation[14] carried out in the state of São Paulo, in which participants considered the service as a welcoming space and propellant of autonomy, through simple everyday activities. However, this reality does not occur in all TRSs, as a study carried out in the state of Piauí found a routine permeated by pre-established rules and time, which directly interferes with the autonomy and therapeutic character of this service[15].

From this perspective, it is reinforced that the therapeutic character of these residences is expressed through the articulation of clinical and psychosocial knowledge, aiming to constitute therapeutic projects that respect the abilities and skills of each one[5], and this requires that this house be welcoming and propelling the exercise of rights of equality and freedom[6].

In addition to accessing these rights, it is important to identify and strengthen the residents' capacity for action by providing co-responsibility in the daily life of this housing space, which is expressed in the TRS's in which this research took place, through the incentive to participate in the housing maintenance activities. Residents, when inserting themselves in everyday practices, tend to reframe their role and develop a sense of belonging in this space, and this allows them to establish new life plans, which correspond to the presuppositions of deinstitutionalization and psychosocial rehabilitation[16].

Regarding the right to enjoy a higher standard of living and physical and mental health, it is noted that, in general, this is also guaranteed to residents. Article 1 of Law No. 10,216 advocates the need to ensure the rights of people with mental conditions without any type of discrimination, reinforcing the need to protect them from any form of abuse and/or exploitation[10]. In this research, participants did not report situations motivated by prejudices of gender, religion, culture and or politics.

In organizing the routine of a Therapeutic Residential Service, it is also necessary to establish a contractual relationship between team and residents that allows for a space for exchanges[2]. TR professionals are directly in contact with the possibility of helping residents to rediscover their daily lives. It is noticed that the knowledge of professionals in relation to the rights of residents directly influences these subjects' access to their rights. In the interviews, residents emphasize that professionals know the human rights of people with mental conditions and help them to exercise them based on the care relationship.

From this perspective, there is the possibility of overcoming exclusion barriers, bringing into play the potential of rehabilitation with the realization of their rights through affective, relational, housing and productive relationships that promote reintegration to oneself and to a subjective network[17]. However, this reality may not be frequent. In this sense, a study in different places in the American continent showed that, in countries such as Chile and Colombia still do not prioritize the rights of people with mental disorders in public policies[18].

There was an articulation between TRS and other Mental Health services present in the network[19], such as the *Centros de Atenção Psicossocial* - CAPS (Psychosocial Care Centers), as

recommended in Ordinance No. 175/2001, which recommends the link between residences and outpatient services specialized in mental health[20].

Residents report that they are monitored by a multidisciplinary team, including doctors, psychologists and nurses. In addition, residents participate in activities aimed at leisure at the institution, as well as participants in an investigation[14] carried out in a city in São Paulo. In this sense, Decree No. 3.298/99 provides for the National Policy for the Integration of Persons with Disabilities and in its Article 2 expresses the need for Public Power entities to ensure the exercise of basic rights, including, among them, the right to leisure[21].

CONCLUSION

The exercise of rights that ensure standard of living, social protection and physical and mental health among residents are mostly ensured in the TRSs studied, with regard to: physical structure, quality material and human resources, professional support, activities and services health network, protected from social discrimination perceived by them.

The exercise of the rights to autonomy, inclusion and social rehabilitation are possible in the daily activities of the residents, with their free movement, including in practices outside the residence, aiming at proximity to the community. Despite this, a gap was noticed in relation to access to visits and leisure activities, as well as residents who have more cognitive and/or motor difficulties, professionals, at times, have difficulties in stimulating them as active subjects, keeping them more dependent care.

It is understood as limitations of the study the fact that it took place in only two Therapeutic Residential Services, with the participation of ten residents, since the others did not meet the inclusion criteria and there is still a shortage of scientific investigations on the subject to add more to the discussion of the findings.

However, the findings of this investigation contribute to the professionals working in therapeutic residences to encourage the participation and development of the autonomy of the residents, especially those who have more exacerbated cognitive or motor difficulties.

It is also proposed to enhance spaces for exchange between professionals involved in TRSs, so that they recognize the rights of residents, turning to the construction of strategies that realize the exercise of fundamental rights such as social protection and physical health and mental. For this, the performance of all network services is necessary, based on social, political and assistance investments in Mental Health.

Considering the gaps observed in the TRSs surveyed, the need to implement practices that encourage greater proximity between residents and the community is highlighted, which will favor gradual social inclusion. This process must occur concurrently with discussions on the interventions needed to ensure a better standard of living with social protection and access to physical and mental health, especially through the participation of people with mental disorders and professionals working in therapeutic residential services.

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Carla Aparecida Arena Ventura and **Darlisson Bueno Paranhos** collaborated on the conception, writing and reviewing. **Diego Augusto Flôres** and **Jenifer Graneli Soares** contributed to data collection and analysis and writing. **Marciana Fernandes Moll** participated in the design, collection and analysis of data, writing and reviewing. **Mariana Bonomi Goulart** worked in data collection and analysis.

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