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Deinstitutionalization as a disputed concept: understanding of professionals of a mental health service

Desinstitucionalização como conceito em disputa: compreensão dos profissionais de um Centro de Atenção Psicossocial

Desinstitucionalización como concepto en disputa: comprensión de los profesionales en una Unidad de Atención Psicosocial

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ABSTRACT
Objective: to identify and analyze the understanding of workers at a Psychosocial Care Center about deinstitutionalization. **Method:** exploratory study with a qualitative approach, carried out in a Psychosocial Care Center in the city of Rio de Janeiro. Data collection was carried out in 2019, through a semi-structured interview with ten service workers. Thematic content analysis was used for data analysis. The research protocol was approved by the Research Ethics Committee. **Results:** service professionals understand deinstitutionalization aligned with the deconstruction of paradigms, enabling changes in workers' practices. However, there are professionals who understand deinstitutionalization as synonymous with dehospitalization of people who have been hospitalized for long periods in a psychiatric hospital, which can contribute to the persistence of asylum practices in the daily routine of the service. **Final considerations:** deinstitutionalization was presented as a concept-tool that puts into action modes of care that produce life in freedom.
Descriptors: Mental Health; Mental Health Services; Deinstitutionalization.

RESUMO
Objetivo: identificar e analisar a compreensão dos trabalhadores de um Centro de Atenção Psicossocial acerca da desinstitucionalização. **Método:** estudo exploratório de abordagem qualitativa, realizado em um Centro de Atenção Psicossocial do município do Rio de Janeiro. A coleta de dados foi realizada em 2019, por meio de entrevista semiestruturada com dez trabalhadores do serviço. Utilizou-se análise temática de conteúdo para análise dos dados. O protocolo de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** os profissionais do serviço compreendem a desinstitucionalização alinhada à desconstrução de paradigmas, possibilitando mudanças nas práticas dos trabalhadores. No entanto, há profissionais que compreendem a desinstitucionalização como sinônimo de desospitalização de pessoas que passaram por longas internações em hospital psiquiátrico, o que pode contribuir para a persistência de práticas manicomiais no cotidiano do serviço. **Considerações finais:** a desinstitucionalização apresentou-se como um conceito-ferramenta que coloca em ação modos de cuidado produtores de vida em liberdade.
Descritores: Saúde Mental; Serviços de Saúde Mental; Desinstitucionalização.

RESUMEN
Objetivo: identificar y analizar la comprensión de los trabajadores de una Unidad de Atención Psicosocial sobre la desinstitucionalización. **Método:** estudio exploratorio con enfoque cualitativo, realizado en una Unidad de Atención Psicosocial de la ciudad de Río de Janeiro. La recolección de datos se realizó en 2019, mediante una entrevista semiestructurada con diez trabajadores de ese servicio. Para el análisis de los datos se utilizó el análisis de contenido temático. El Comité de Ética en Investigación aprobó el protocolo de investigación. **Resultados:** los profesionales del servicio comprenden la desinstitucionalización acorde con la deconstrucción de paradigmas, posibilitando cambios en las prácticas de los trabajadores. Sin embargo, hay profesionales que entienden la desinstitucionalización como sinónimo de deshospitalización de personas internadas durante largos períodos en un hospital psiquiátrico, lo que puede contribuir a la persistencia de prácticas típicas de manicomios en el cotidiano del servicio. **Consideraciones finales:** la desinstitucionalización se presentó como un concepto-herramienta que pone en acción modos de cuidado que producen vida en libertad.
Descriptores: Salud Mental; Servicios de Salud Mental; Desinstitucionalización.

INTRODUCTION

The Brazilian Psychiatric Reform (BPR) started in the late 1970s, and proposed a reconfiguration of the mental healthcare model, highlighting Psychosocial Care as a way of producing care, operating the deinstitutionalization and construction of the subject's autonomy[1].

However, even considering its advances, the intense field of disputes of interests, models and public resources is affirmed when the epistemological, social, political agencies and in the care production model are

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identified. On the one hand, popular representations, workers' groups, the Anti-Asylum Fight movement and academics aligned with the Reform; on the other, representatives of traditional psychiatry who defend the perpetuation of the asylum apparatus[2,3].

Consequently, partial adoption of the assumptions of the Reform as guides for professional training, public policies and work processes in institutions is evident. At this juncture, especially after 2015, one can see the establishment of an anti-reformist agenda in the National Mental Health Policy, which renews the imperative need for a debate about care in freedom and deinstitutionalization[2,3].

The concept of deinstitutionalization emerged in the United States through withdrawal of people from psychiatric institutions, directing them to services in the community. However, this understanding did not challenge psychiatric knowledge or integrate community life as a clinic[4]. It was with Italian Democratic Psychiatry that deinstitutionalization began to be related to the deconstruction of the asylum apparatus beyond its physical structures, serving as an inspiration for the Brazilian Psychiatric Reform process in its anti-asylum bias[5].

Deinstitutionalization is a process of transforming the power relations between the institution and the subjects, shifting the gaze from the disease to existence-suffering. It moves away from healing to focus on the invention of health, on the production of life, on the use of collective spaces for coexistence in the territory. It is about enhancing possible social roles and prioritizing the production of autonomy and new ways of being in the world[6].

When defining the Psychosocial Care Network's (*Rede de Atenção Psicossocial – RAPS*) care points, Decree no. 3088/2011 determined that the Deinstitutionalization axis is composed of Therapeutic Residential Services (TRSs) and the Return Home Program (*Programa de Volta para Casa - PVC*)[7]. However, what is described by the ordinance differs from the understanding of deinstitutionalization that inspired the Brazilian Psychiatric Reform, since it is not only up to the two services to implement it, but to all professionals, who must be committed to a daily practice within all devices of the Network.

The contradiction between what is established in the *RAPS* regulatory framework and what is defined in the theoretical-practical field is presented as a question for the daily life of mental health devices: after all, which deinstitutionalization concept should be implemented? Is deinstitutionalization a topic that only concerns TRSs and PVC, or should it underpin all work in psychosocial care?

Based on these questions, the present study aims to identify and analyze the understanding of workers at a Psychosocial Care Center about deinstitutionalization.

METHOD

This is an exploratory study with a qualitative approach. The setting was a Psychosocial Care Center (*Centro de Atenção Psicosocial - CAPS II*) in the city of Rio de Janeiro. In order to obtain a broad overview of the concept understanding and due to the multidisciplinary nature of the device[7], the investigation was conducted with all of the institution's workers (10 professionals), including nurses, social workers, caregivers, psychologists, social workers and administrators.

Thus, semi-structured interviews[8] were performed for data collection, which included questions about the professionals' understanding of the deinstitutionalization concept; how the practices contributed to deinstitutionalization; and how users' wishes were validated.

Participants were personally invited to the survey and the interviews were conducted at the service from January to March 2019. The interviews had an average duration of 60 minutes, were digitally recorded and transcribed in full. The Consolidated Criteria for Reporting Qualitative Research (COREQ)[9] was used to support the methodological path. Data were analyzed using Bardin's thematic content analysis and analytical categories were established that will be presented in the results[10].

The research began after approval of its protocol by the Research Ethics Committee of the institution involved. The study included the ethical principles determined in Resolution No. 466, of December 12, 2012, of the National Health Council[11]. The participants were identified by letters and professional categories for the preservation of anonymity.

RESULTS AND DISCUSSION

The data presented below are related to the workers' understanding of the deinstitutionalization concept. Thus, two analytical categories emerged from the thematic content analysis: 1. Deinstitutionalization aligned with the concept of dehospitalization; and 2. Deinstitutionalization aligned with the deconstruction of paradigms.

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Deinstitutionalization aligned with the concept of dehospitalization

This category deals with workers' understanding about deinstitutionalization in a logic linked to the North American concept that approaches deinstitutionalization. This alignment is perceived in the workers' speech when asked about what deinstitutionalization is and how it is carried out in the unit:

> *The team is always in contact with users who are still in asylums to carry out this deinstitutionalization. (P4 - Social Worker)*
>
> *The idea of dehospitalization is the main one, thinking about cases that have a long-term hospitalization, because it is usually understood that long-term hospitalizations, regardless of the cases (...) are more likely to make the subjects institutionalized. (P7 - Caregiver)*

The interviewees' speeches show that those who were hospitalized in psychiatric hospitals are deinstitutionalized when they leave the asylums. However, this understanding disregards the complexity of the process and deinstitutionalization[12], since the closure of hospital psychiatric institutions does not guarantee adoption of non-asylum practices, which can be perpetuated in the care production in the most diverse devices[13].

The asylum apparatus endures, regardless of its architectural structure, calling for constant questioning of professional practices in order to direct them to criticize the place of madness in society. The institutions and their practices must be up to the new object of care: the lives of the subjects[6].

With this, it is necessary to go beyond the idea of dehospitalization, since this is related to the permanence of the asylum logic due to the continuity of the excluding and segregating practices used in Psychiatric Hospitals, and reproduced in other mental health services in the community. In this sense, the characteristic of the institution of violence remains, in which professionals with psychiatric knowledge hold power in the relationship with the subjects.

Deinstitutionalization aligned with the deconstruction of paradigms

This analytical category addresses the workers' understanding of deinstitutionalization as a deconstruction process of psychiatric knowledge and practices through practical-theoretical invention of new ways of dealing with the subject with psychic suffering, in accordance with what is advocated by Italian Democratic Psychiatry and by the Anti-Asylum Brazilian Psychiatric Reform. To this end, mental illness is placed in parentheses, questioning the cure, isolation, medicalization, guardianship and disqualification of the subject. The focus is the invention of life and social production, enhancing desires and producing new ways of being in the world[4].

It is observed that *CAPS* workers adopt this concept, explained in the following statements:

> *Each one is different, [the] diagnosis, it is not secondary for me, it is tertiary. In the end, it's the person. I arrive, I don't want to know what their CID is. I go and then I get the chart, see what it is, read the story. What matters is the person who is there. (P2 - Nurse)*
>
> *We even studied a text here at the CAPS (...) think of deinstitutionalization as a line of care (...) not as dehospitalization, but as a deinstitutionalization of practices, teams and professionals, so she will actually think about it as a work direction. (P5 - Psychologist)*

This understanding of deinstitutionalization proposes a break with the traditional psychiatric model, reaffirming another way of producing care for people in psychological distress, aligned with the production of life and autonomy. The latter is reinforced by the workers for effectuating deinstitutionalization, when they state that deinstitutionalizing:

> *It is allowing them to have more autonomy every day. If at that moment we need to be together, accompany, great; tomorrow, if we need to monitor less, even better; the day after tomorrow if they can go alone and we are aware of also monitoring this. (P3 - Administrator)*

Autonomy is linked to the ability of subjects to produce norms and orders for their lives. In this sense, it is not related to independence or self-sufficiency, but to dependence on interpersonal relationships and all the elements that make it possible to rescue contractuality as a fundamental element of mediating social relationships[14].

The *CAPS* can enhance autonomy production, providing subjects with the (re)construction of social, family and community ties, so that they are protagonists of their lives. For this, professionals need to be open and available so that this process can be carried out in each subject's time, based on their own life trajectory and their social life. Deinstitutionalization aligned with the construction of new ways of being in the world also appears in the following statements:

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> *If desire is a way of placing oneself in the world to which one's passions point, I think that deinstitutionalization is important in the sense that we can build new ways for this person to be in the world, therefore, new ways for them to be able to wish and desire in the world (...) But it also involves being able to enroll in society in an accompanied way and thinking in a way that makes sense for them, in short, that they can build a life. (P6 - Psychologist)*
>
> *It's a continuous exercise of non-chronification and inventiveness, of being always available and flexible to be able to invent new ways of being in the world and thinking about your insertion in the world (...) deinstitutionalization, nowadays, that's it. (...) When we try to think of CAPS as always promoting life, this is a way for us to have deinstitutionalization as our guide. (P5 - Psychologist)*

Subjects increase their powers in fabricating their life[15] by producing new forms of sociability and existential connections. To do so, mutual availability for the meeting between workers and users is necessary in order to expand bonds and experimentation of different existence modes. The bond is fundamental for understanding users as valid interlocutors and recognizing their self-government, which is fundamental for deinstitutionalization.

Ways of being in the world are aligned with the deinstitutionalizing understanding of health, as it is linked to the stock of resources, we have to lead life in the best possible way. Thus, in order for there to be health production, it is necessary to have good encounters, life projects and the possibility of living (and subjectively sustaining) gains and losses[15].

In this sense, to deinstitutionalize is to deny the disciplined, passive and normative body. Refusing these limiters widens the availability and openness of encounters that enable the construction of new ways of affecting and being affected. Thus, it is necessary to be open to difference, promote sociability, expand existential territories and activate the force-invention of life, building improvisations and inventiveness in the face of the forms of life and daily life of the society of control[16].

In turn, to think about deinstitutionalization in the logic of a society of control, which deconstructs the walls that defined the institutions of a disciplinary society, is to reflect on how power is exercised through an introjection of filters which sequester desires and restrict multiplicities (skin color, gender, class and those from the socially accepted place for madness). They are not crystallized rules of conduct, but rather a variable web of flows which pass through each body, establishing what is acceptable from each subjectivity to then frame them in models[17].

In this sense, one cannot disregard the current political situation of the advance of ultra-conservatism, which has intensified the retreat of mental health policies towards re-asylum, putting at risk the epistemological and practical advances of deinstitutionalization as production models of mental healthcare[18-20]. This process materialized with the approval of Ordinance No. 3588, of December 21, 2017, which amended the National Mental Health Policy, inserting Psychiatric Hospitals in *RAPS*[21]. The document corroborates the exclusive link between deinstitutionalization and TRS without problematizing the concept, relating the term to dehospitalization.

The asylum logic contributes to the social exclusion of people with psychological suffering. This element is important for the presented analysis, as it goes against the grain of the mental health care model that advocates deinstitutionalization. Therefore, it is affirmed by the need to expand the debate about the concept of deinstitutionalization in its anti-asylum dimension.

Study limitations

As limitations of the study, we point out that it was was carried out in a single *CAPS* in the city of Rio de Janeiro. Therefore, there is a need to develop new studies in other *CAPS* in order to broaden the panorama about the conceptions of deinstitutionalization.

FINAL CONSIDERATIONS

The study showed the coexistence between two understandings about deinstitutionalization in the same device, pointing to the dispute in the work process. If on the one hand, there is the concept defended by the Anti-Asylum Brazilian Psychiatric Reform, on the other hand, the understanding based on the simple removal of people from the Psychiatric Hospital is still present.

Therefore, it is important to strengthen the debate that understands deinstitutionalization as a concept-tool that puts into practice care in tune with life production by building different existences in everyday micropolitics which enhance the lives of subjects, expanding networks of existential connections.

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It is hoped that this study will contribute to reflections on the work process in services that replace asylums from the perspective of deinstitutionalization. It would therefore be committed to producing mental healthcare which enables expanding the power of life, autonomy and other forms and possibilities of being in the world.

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