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RETHINKING THE ROLE OF SUPPORTED HOUSING SERVICES IN COMMUNITY MENTAL HEALTH: A FOCUS ON EMPOWERMENT AND PARTICIPATION

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Abstract

Supported housing services are key elements of the healthcare network that serves people with a diagnosis of severe mental illness, within the community mental health model. This model has as a central purpose to stimulate both autonomy and social participation of users. The restrictiveness present in these centers and factors associated with their prediction was assessed. A total of 21 residential services were assessed by means of the scale of restrictive practices applied to one caregiver per place. It was observed that these services have a level of restrictiveness that limits the ability to make decisions of the residents regarding their lives. This situation hinders both empowerment and participation of people in their communities.

Keywords: community mental health; restrictiveness; supported housing services; severe

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People with a diagnosis of Severe Mental Disorder (SMD) have suffered a long history of marginalization. Until a few decades ago, the main model of care for the mental health and psychosocial needs and problems of this population was organized around admission to psychiatric institutions for long periods of time or even for life. However, for some years now, the World Health Organization

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has recommended a community care model for this population (World Health Organization, 2006; Pan American Health Organization, 1991). Community mental health (SMC) is a model that transcends mere clinical care, centered on the user as an individual seat of suffering, to project itself into the community; It is there where the subject's discomfort arises, and therefore, where its recovery can occur (Marcos & Topa, 2012). It implies the recognition of the community not only as a user, but also as a generator of resources that must ally with specifically technical people to address their health problems. This model, like community psychology, encourages the participation and empowerment of people (Cantera, 2004; Perron, Rudge, & Holmes, 2010; Storm & Edwards, 2013). The recovery of the subjects will only be possible if they once again form part of the social fabric, from which they have been excluded, through the exercise of citizenship (Saraceno, 2003). Especially considering the strong stigma that weighs on people who have a severe psychiatric diagnosis, various investigations indicate that social stereotypes present them as dangerous, irrational and incapable of taking care of themselves; beliefs that health teams also have (Liggins & Hatcher, 2005; Rose, Thornicroft, Pinfold, & Kassam, 2007). These attitudes affect the intervention that is carried out, since an authoritarian and infantilizing treatment that perpetuates exclusion and stigma is justified as necessary (Corrigan, 2002).

From a practical point of view, the SMC involves a way of organizing psychiatric care that is characterized by including programs focused on the promotion of mental health, prevention and treatment of mental disorders, and rehabilitation and inclusion in the community (Ministry of Health, 2008).

The Ministry of Health of Chile, through the "National Plan for Mental Health and Psychiatry", adheres to this model and from it has developed a network of

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community care devices intended for these purposes (Ministry of Health, 2001). A challenge for this model, in the area of rehabilitation and social inclusion, is the design of residential structures that avoid the replication of mass and reproductive models of institutionalization. In this context, protected homes and residences emerge, also understood as "social support devices", which try to counteract the difficulties and problems derived from mental suffering and to eliminate some of the barriers that block the full functioning of citizens of people with a disability. diagnosis of TMS (López & Laviana, 2007). Protected homes and residences aim to promote social inclusion through the integration of these people in their neighborhoods (Kloos & Shah, 2009). To achieve this, we work by promoting personal autonomy, under the assumption that through the exercise of recovering their social role, people can empower themselves and assert themselves as subjects of rights. In this sense, these devices should encourage the participation of users in their organization, through decision-making on all those aspects that affect them (Ministry of Health, 2000). However it is not always so; There are housing organization models that facilitate recovery and integration and others that are maintained from a more asylum perspective (Wright & Kloos, 2007). In this line, Some research indicates that the level of restrictiveness of the device is negatively associated with the autonomy that users develop, in addition to influencing the relationship established between caregivers and residents (Kyle & Dunn, 2008; López, Fernández, García-Cubillana , Moreno, Jimeno, & Laviana, 2005). Sprioli and Silva (2011) found that, in an unstructured environment, staff interacted with users more normally, while in a highly structured environment they behaved in a more professional manner and responded based on the perception that the user had. operation user. 2008; López, Fernández, García-

Cubillana, Moreno, Jimeno, & Laviana, 2005). Sprioli and Silva (2011) found that, in an unstructured environment, staff interacted with users more normally, while in a highly structured environment they behaved in a more professional manner and responded based on the perception that the user had. operation user. 2008; López, Fernández, García-Cubillana, Moreno, Jimeno, & Laviana, 2005). Sprioli and Silva (2011) found that, in an unstructured environment, staff interacted with users more normally, while in a highly structured environment they behaved in a more professional manner and responded based on the perception that the user had. operation user.

In this sense, it has been found that restrictiveness is associated with the domestic and community skills of residents of residential services; Specifically, less restrictiveness of the center is related to greater skills for daily living in users (Tapia, 2014).

In relation to the above and considering the limited research that exists on the practical implementation of the SMC model both in Chile and in other Latin American countries, this research aimed to understand how the SMC model is operationalized in residential services. Specifically, the objective of the study was to evaluate the level of restrictiveness of residential devices and identify variables, dependent on the healthcare area and the device, that are involved in its prediction. The hypothesis of the study is that characteristics of the health area and the device will contribute to the prediction of the levels of restrictiveness of residential services.

Method

The research carried out is descriptive-correlational. The measurements were obtained in only a single time slice (cross-sectional design).

Participants

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The study was carried out in 15 homes and 6 protected residences located in the Maule and Biobío regions of Chile. The devices belonged to the health areas of Maule, Nuble, Biobío, Talcahuano, Concepción and Arauco. Only homes with an operating time of more than one year and residences that operated for more than eight months were included. Information on the general characteristics of the center and its restrictive practices was obtained from one caregiver per place, with the exception of the question about the homogeneity in the operation of the residential devices in the health area, which was asked to the person in charge of mental health. of the entire respective health area.

The caregiver was selected by convenience among those workers in the homes and residences who had worked there for more than a year. Therefore, 21 caregivers were interviewed, of which 93.3% were women.

Instruments

Restrictive Practices Scale (Jordá & Espinosa, 1990)

Evaluates the functioning of residential devices in the following areas: personal activities, personal possessions, food, hygiene and health, resident rooms and services. The original instrument consists of 55 dichotomous questions (Yes/No) related to the listed areas. The reliability study of the instrument was carried out in 58 accommodations located in the province of Valencia, where people with TMS had been transferred (Jordá & Espinosa, 1990). Test-retest reliability between interviewers was confirmed, obtaining a rho coefficient (Spearman) = 0.98, significant $p < 0.05$. The biserial correlation between each item and the total scale score ranged between 0.2 and 0.97. For use in this study, 12 items that were not applicable to the reality of the country were eliminated. All questions worded in the opposite direction in the original were changed to positive and a Likert-type response format was used with four

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alternatives: always, usually, rarely and never. The final instrument was made up of 43 items. A Cronbach's alpha reliability coefficient of 0.82 was obtained for the scale.

In addition, a form was prepared to collect information from the caregiver and the device. Regarding the home or residence, we consulted about: (a) the frequency of technical advice, (b) the assignment of tasks and schedules in a personalized way to each resident, (c) the homogeneity of operation of the devices within the respective healthcare area. , (d) the type of professional who provides technical advice (e) the type of device (home, residence) and (f) the operating time.

Procedure

A pilot test was applied in a protected residence that was not incorporated into the definitive study. Subsequently, the instrument was revised to readjust it to the local context. Contact was made with mental health managers from all health areas included. They were asked about the number of residential devices in their area, the homogeneity in their operation and their availability to collaborate with the research. Once authorization was obtained from the ethics committees of the different locations, visits to the respective devices began.

An interview was conducted with the caregiver who, meeting the inclusion criteria, was present at the time of the visit. The objective of the study was explained to them and their collaboration was requested. Those who agreed to participate and signed the informed consent had the instruments applied individually, in rooms of the same establishment.

Data analysis

The data were entered into the SPSS version 15 statistical system and the responses were analyzed using the R statistical software version 3.1.2. The

internal consistency of the restrictive practices scale was established using Cronbach's alpha.

First, descriptive statistics for the overall restrictiveness of the devices were estimated. To evaluate the restrictiveness of specific practices, the restrictive practices of the device in general and those that deal with restrictions towards users were separated. The Friedman test was used to determine if there were differences in the restrictiveness of practices, regardless of location. Finally, a multiple regression using ordinary least squares was carried out to identify the variables of the healthcare area and the device, which allow predicting the level of global restrictiveness.

Results

The average global restrictiveness of the centers is 2.63 (SD = 0.34), which indicates that it is above the theoretical midpoint of 2.5. The distribution is almost symmetrical (skewness = -0.03) and with a slight negative kurtosis (kurtosis = -0.79), which allows us to affirm that the distribution of the data is practically normal, which is confirmed by using the Shapiro-Wilk test. : W = 0.977, p = 0.877.

When analyzing the specific practices present in the restrictiveness scale, 23 of the 43 items measure general restrictions, while 20 represent direct restrictions towards the resident.

Using the Friedman test, statistically significant differences were observed in the level of general restrictiveness, X^2 ($_{22}$) = 175.49, p < 0.001. As can be seen in Table 1, the biggest restrictions of the devices are in the schedules, both arriving at the place and going to bed during weekdays. In relation to this last point, residents are monitored to ensure they are in their beds at night. Staff can also enter the rooms at any time, manage users' medications and in 80% of

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devices between, always and generally, residents' money is managed by caregivers. In terms of the activities where there are fewer restrictions, there is allowing visits to residents, the absence of visits by a psychiatrist to the facility, the lack of weight control of residents and the freedom to decorate the rooms.

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Tabla 1
Distribución de prácticas restrictivas generales

Ítem	Descripción	Nunca		Rara vez		Generalmente		Siempre		Mediana	Media
		n	%	n	%	N	%	n	%		
13	Durante la semana, los residentes deben regresar antes de las 23:00 h.	0	0	0	0	0	0	21	100	4	4
18	Durante la noche el personal revisa que los residentes estén en la cama.	0	0	0	0	1	4.8	20	95.2	4	4
11	La puerta principal permanece cerrada a partir de las 22:00 h.	1	4.8	0	0	0	0	20	95.2	4	3.9
29	Los fármacos de los usuarios son manejados por el personal.	1	4.8	0	0	0	0	20	95.2	4	3.9
4	El personal de la residencia/hogar puede entrar en las habitaciones a cualquier hora.	2	9.5	0	0	0	0	19	90.5	4	3.7
9	Los residentes deben preguntar al personal cuando quieren asistir a médico general.	2	9.5	0	0	2	9.5	17	81.0	4	3.6
14	Durante la semana se recomienda que los residentes estén acostados antes de las 23:00 h.	3	14.3	0	0	1	4.8	17	81.0	4	3.5
25	El personal es responsable del dinero de los residentes.	1	4.8	3	14.3	5	23.8	12	57.1	4	3.3
1	Los residentes deben levantarse diariamente a una hora determinada.	1	4.8	1	4.8	9	42.9	10	47.6	3	3.3
10	Hay reuniones periódicas entre el personal y los residentes.	5	23.8	1	4.8	4	19	11	52.4	4	3
40	El baño está supervisado por el personal.	6	28.6	2	9.5	0	0	13	61.9	4	3
16	Los fines de semana se recomienda acostarse a las 23:00 h.	4	19	2	9.5	6	28.6	9	42.9	3	3
17	Los residentes deben estar acostados a una hora determinada.	5	23.8	2	9.5	4	19	10	47.6	3	2.9
35	Periódicamente se revisan las pertenencias personales de los residentes para buscar cosas prohibidas.	5	23.8	6	28.6	0	0	10	47.6	2	2.7
2	Durante los fines de semana los residentes deben levantarse a una hora determinada.	5	23.8	4	19	6	28.6	6	28.6	3	2.6
3	Las puertas de la residencia/hogar deben permanecer cerradas para evitar que los residentes salgan.	8	38.1	3	14.3	3	14.3	7	33.3	2	2.4
43	Las pertenencias personales de los residentes están catalogadas.	10	47.6	1	4.8	3	14.3	7	33.3	2	2.3
31	Hay un control periódico de peso de los residentes.	12	57.1	1	4.8	1	4.8	7	33.3	1	2.1
20	Un peluquero visita regularmente la residencia/hogar.	14	66.7	1	4.8	1	4.8	5	23.8	1	1.9
30	En el momento de la llegada de los usuarios a la residencia/hogar, estos deben ser pesados.	14	66.7	1	4.8	1	4.8	5	23.8	1	1.9
8	Hay un psiquiatra que visita regularmente la residencia/hogar.	14	66.7	2	9.5	1	4.8	4	19.0	1	1.8
6	El horario de visitas a los residentes está restringido.	14	66.7	3	14.3	2	9.5	2	9.5	1	1.6
34	Hay restricciones a la libre decoración de espacios personales (habitaciones).	15	71.4	3	14.3	0	0	3	14.3	1	1.6

Nota. Valor más alto de la media y mediana indica mayor nivel de restricción.

Fuente: elaboración propia

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When analyzing direct restrictiveness towards residents, there are statistically significant differences between the different practices, regardless of the device, $X^2_{(19)} = 229.35$, $p < 0.001$. In Table 2It can be seen that the three behaviors that are not allowed in any home are: smoking in the rooms, drinking alcoholic beverages and going out at night without informing the staff. In 81% of places you cannot lock the bathroom door, and in 76.2% you are not allowed to prepare food after hours or have a key to the main door. On the other hand, residents have greater freedom in those activities that have to do with the administration of their personal belongings and with the possibility of choosing clothes, resting in their room and preparing a hot drink.

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TABLA 2
Distribución de la restrictividad directa hacia los residentes

Ítem	Descripción	Siempre		Generalmente		Rara vez		Nunca		Mediana	Media
		n	%	n	%	n	%	n	%		
15	Los residentes pueden salir solos por la noche sin informar al personal.	0	0	0	0	0	0	21	100	4	4
24	Está permitido el consumo de bebidas alcohólicas.	0	0	0	0	0	0	21	100	4	4
42	Los residentes pueden fumar en las habitaciones.	0	0	0	0	0	0	21	100	4	4
23	Los residentes pueden prepararse comida fuera de los horarios establecidos.	2	9.5	0	0	3	14.3	16	76.2	4	3.6
12	Los residentes tienen llave de la puerta principal.	2	9.5	2	9.5	1	4.8	16	76.2	4	3.5
39	Los residentes pueden cerrarse con llave en el WC.	4	19	0	0	0	0	17	81	4	3.4
5	Los residentes pueden ver TV después de las 23:00 h.	4	19	0	0	6	28.6	11	52.4	4	3.1
7	En la residencia/hogar está permitido que las personas de sexo contrario (excluido el personal) entren en las habitaciones.	4	19	1	4.8	4	19	12	57.1	4	3.1
21	Los residentes participan en la planificación de la alimentación.	2	9.5	6	28.6	5	23.8	8	38.1	3	2.9
27	Está permitido que los residentes tengan máquinas de afeitar, cuchillos o tijeras.	6	28.6	0	0	7	33.3	8	38.1	3	2.8
37	Los residentes se lavan sus propias ropas.	7	33.3	2	9.5	7	33.3	5	23.8	3	2.5
26	Está permitido que los residentes tengan fósforos o encendedores.	8	38.1	6	28.6	1	4.8	6	28.6	2	2.2
28	Los residentes tienen la opción de guardar bajo llave sus pertenencias.	13	61.9	0	0	1	4.8	7	33.3	1	2.1
41	Los residentes pueden elegir la hora del baño o la ducha.	10	47.6	5	23.8	1	4.8	5	23.8	2	2
22	Los residentes pueden prepararse un té o café.	14	66.7	3	14.3	1	4.8	3	14.3	1	1.7
19	Los residentes hacen su propia cama.	17	81	3	14.3	0	0	1	4.8	1	1.3
36	Los residentes pueden descansar en su cama durante el día.	17	81	2	9.5	2	9.5	0	0	1	1.3
32	Los residentes pueden elegir la ropa que quieren vestir.	18	85.7	3	14.3	0	0	0	0	1	1.1
33	Los residentes tienen ropa suficiente.	18	85.7	3	14.3	0	0	0	0	1	1.1
38	Los residentes tienen responsabilidad total sobre el uso de sus pertenencias.	19	90.5	2	9.5	0	0	0	0	1	1.1

Nota: Valor más alto de la media y mediana indica mayor restrictividad.

Fuente: elaboración propia

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Evaluation of the restrictiveness of residential devices for people with a psychiatric diagnosis in the Community Mental Health model in Chile

To analyze the predictive factors of the overall restrictiveness of the centers, a multiple regression analysis was carried out using as predictors (a) the frequency of technical advice,

(b) the assignment of tasks and schedules in a personalized way to each resident, (c) the homogeneity of operation within the respective healthcare area, (d) the type of professional who provides technical advice (e) the type of device (home , residence) and (f) the time of operation.

When analyzing the regression model, Table 3 shows that it is statistically significant, with 83% of the variance explained. The conditions that allow predicting the overall restrictiveness of the centers are (a) the operating time, with lower restrictiveness in centers with an operating time between one and two years, (b) the frequency of technical assistance: there is presence of greater restrictiveness in centers that have less regularity in technical assistance and (c) the homogeneity of the place's operation: there is greater restrictiveness in centers whose health areas are homogeneous in their policies.

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TABLA 3
Predictores del nivel de restrictividad de los centros

Variable	B	EE	t	Valor-p	
Constante	-1.17	1.01	-1.16	0.27	
Tiempo=entre un año un mes y dos años	-1.59	0.58	-2.73	0.02	*
Tiempo=entre dos años un mes y 4 años	-0.66	0.97	-0.68	0.51	
Tiempo=mayor a 4 años	0.07	0.82	0.08	0.93	
Regularidad asistencia=una a dos veces por semana	0.76	0.65	1.17	0.27	
Regularidad asistencia=cada 15 días	0.1	0.87	0.12	0.91	
Regularidad asistencia=cada 3 a 4 meses	2.98	0.97	3.08	0.01	*
Homogenedad=Sí	1.84	0.51	3.64	0	*
Tareas personalizadas=Sí	-0.76	0.82	-0.92	0.38	
Asistencia=Equipo Servicio de Salud	-0.8	0.71	-1.12	0.29	
Tipo dispositivo=residencia	0.76	0.65	1.17	0.27	
R^2	0.83				
F	4.879			0.01	

Nota. Intercepto corresponde al valor estandarizado de la escala de restrictividad para un tiempo de funcionamiento del centro inferior a un año, asistencia técnica diaria por parte del equipo clínico de la red, la ausencia de homogeneidad en las políticas del servicio de salud y de tareas y horarios personalizados, y un dispositivo de tipo hogar.

Fuente: elaboración propia

Discussion

The descriptive results indicate that homes and residences have a higher level of global restrictiveness than the theoretical midpoint. When analyzing the level of restrictiveness of specific, general device and user practices, significant differences appear, indicating that there are practices that are more restrictive than others. It can be seen that the residential service imposes rigid rules on arrival times, alcohol and tobacco consumption, and free movement at night. They also have limitations when it comes to preparing food and having a key to the place. Along these same lines, staff supervise that residents are in their beds during the night and have the freedom to enter the rooms. Besides, The restrictiveness of the place limits the decision-making of users in actions such as the management of drugs and money. Although support for residents is an important aspect of these devices, it must be aimed at helping people learn skills and increase their autonomy, as this favors their inclusion in

the community (Wong & Solomon, 2002). This level of restrictiveness is surprising, since in these places it is possible to imagine a "home environment." Different results have been found in other countries. In Andalusia (Spain), 16 homes and 67 supervised dwellings were evaluated; only a minority of these devices had restrictive norms and were associated with more institutionalized environments (López, García-Cubillana, Fernández, Laviana, Maestro, & Moreno, 2005). Although support for residents is an important aspect of these devices, it must be aimed at helping people learn skills and increase their autonomy, as this favors their inclusion in the community (Wong & Solomon, 2002). This level of restrictiveness is surprising, since in these places it is possible to imagine a "home environment." Different results have been found in other countries. In Andalusia (Spain), 16 homes and 67 supervised dwellings were evaluated; only a minority of these devices had restrictive norms and were associated with more institutionalized environments (López, García-Cubillana, Fernández, Laviana, Maestro, & Moreno, 2005). Although support for residents is an important aspect of these devices, it must be aimed at helping people learn skills and increase their autonomy, as this favors their inclusion in the community (Wong & Solomon, 2002). This level of restrictiveness is surprising, since in these places it is possible to imagine a "home environment." Different results have been found in other countries. In Andalusia (Spain), 16 homes and 67 supervised dwellings were evaluated; only a minority of these devices had restrictive norms and were associated with more institutionalized environments (López, García-Cubillana, Fernández, Laviana, Maestro, & Moreno, 2005). This should be aimed at people learning skills and increasing their autonomy, as this favors their inclusion in the community (Wong & Solomon, 2002). This level of restrictiveness is surprising, since in

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Regarding the freedom of the residents, they have the possibility of deciding on their personal belongings and in general on aspects that do not put into play the control that the device has over the structure and rules of the place such as decorating the rooms, choosing the clothes They are going to use or prepare tea or coffee.

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According to these results, the autonomy and decision-making capacity of residents is subject to the device; Although these services are within the community mental health network, they continue to reproduce asylum practices that institutionalize the subjects. The institutionalization of residents is inversely related to their initiative and capacity to participate (López, Lara, Laviana, Fernández, García-Cubillana, & López, 2004). From this perspective, the SMC model to which mental health policy in Chile adheres (Ministry of Health, 2001), has difficulties in promoting participation and empowerment in its concrete practices. Within the principles of SMC, empowerment is central so that subjects can go from "patients" to social actors (Corrigan, 2002).

Some authors add that work must also be done on awareness-raising processes in this marginalized group, to enhance the acquisition of social and political power, which allows them to organize and have influence over aspects of their interest (Kelly, 2006). To work on this empowerment process, residential devices would have to encourage the participation of users in decision-making about life at home, through real co-direction of these services with healthcare teams. This implies, beyond adopting official regulations, opening spaces for negotiation between the different social actors (Saraceno, 2003). However, although mental health policy in Chile has included a community approach,

This view of people could be related to the stigma that weighs on this social group. Social stereotypes show people with a psychiatric diagnosis as dangerous, irrational and generally incapable of self-management (Rose et al., 2007). These prejudices are updated in the treatment and consideration that the health device has for the user; someone dangerous who cannot use private spaces without supervision and who requires the attention of a child. From this perspective, homes have not managed to establish themselves as real

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empowering contexts that in turn foster empowerment processes (Silva & Martínez, 2004). Following Montero (2009), the unequal exercise of power between social groups hinders empowerment, as it naturalizes certain forms of social exclusion, that come to be seen as something normal and even necessary. In this case, it is often argued that people with a psychiatric diagnosis require this type of environmental restrictions in order to improve; However, as this research and others show, the different profiles of the residents do not explain the levels of structuring of the devices (López, Fernández et al., 2005).

The present study highlights the great explanatory capacity of the predictive model used ($R^2 = 0.83$), in which characteristics related to the device and the healthcare area are those that mostly contribute to determining the level of restrictiveness. These results reaffirm that variables related to residents are not central to determining the structure of residential devices. Rather, this would be fundamentally given by the conception that residents have of residents as subjects who require permanent care.

From this perspective, and according to what was found in other studies, the promotion of citizenship in residential spaces has received little attention (Sylvestre, Nelson, Sabloff, & Peddle, 2007). It could be said that a "protected" citizenship is promoted, where residents can make minor elections, but not those that return them to the political-social role from which they are excluded and which is a central element within the SMC model (Perron et al. ., 2010; Storm & Edwards, 2013). Current health policies, following the orientation of social policies in Chile, during the last decades, discursively incorporate the valuation of autonomy, rights and participation (Alfaro, 2004), however, These aspects are reduced to specific strategies such as the promotion of groups of family members and mental health users at the national level (Funk, Minoletti,

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Drew, Taylor, & Saraceno, 2005), but they fail to penetrate the daily work of residential devices. . Along these lines, participation only reaches the first levels of Hickey and Kipping's (1998) continuum, informing and consulting, but fails to reach co-management and control in decisions. This result reflects the dissynchrony between the discourses and practice of mental health participation (Bang, 2014). Therefore, what was stated by Méndez and Vanegas (2010) is reinforced, who point out that health policy has instrumentalized social participation as a way to improve the health of the population through the efficient use of resources.

Regarding the prediction of restrictiveness, only three variables were significant: operating time (between one and two years), frequency of technical advice (every 3 or 4 months) and homogeneous operation of the devices within the healthcare area. If a home/residence has been in operation for less time, it has a lower level of restrictiveness.

This seems to indicate that not only are the residents institutionalized within a residential space, but also the devices are institutionalized, it can be suggested that those who have less operating time are unaware of or have not acquired the "cultural regulations" that they are expected to possess. . In this same sense, when services behave as total institutions and do not adapt to the needs of people, but rather function in a homogeneous manner, the level of restrictiveness is greater. This form of social construction permeates people's subjectivity and in this way reproduces a system where sufferers are transformed into passive and alienated individuals (Galende, 2008).

Regarding the technical advice variable, it stands out that the less regular it is, the greater the level of restrictiveness of the device. This activity consists of supervision by professionals who depend on the mental health program of the

respective health areas. Its objective is aimed at complying with ministerial regulations (Ministry of Health, 2000); Therefore, this result could indicate that in some way the personnel who perform this task would be promoting an environment of greater autonomy in the place. Consequently, although mental health policy in Chile has managed to install a service network model with a series of regulations based on community principles,

Along these lines, the evaluation of restrictive practices can be considered as a measure of the quality of care provided in residential facilities; This perspective could contribute to monitoring the implementation processes and adaptation of interventions to the community mental health model. This would facilitate the implementation of the model in the daily practice of health care.

The main limitation of this research is the small sample of homes and protected residences and the fact that only one caregiver per device was interviewed. It would be necessary to expand these results with a larger sample.

On the other hand, it would be interesting to be able to contrast these results with the vision that the residents themselves have of the home/residence; To do this, we could work under a research model based on community participation that promotes during the process the principles of the SMC model that we want to promote (Stacciarini, Shattell, Coady, & Wiens, 2011).

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