

Right to mental health in prison system: reflections on the process of deinstitutionalization of the HCTP

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Abstract *This study aimed to discuss the close relationship between mental health, the criminal justice system and the prison system, whose specific interfaces are the HCTP (Hospital de Custódia e Tratamento Psiquiátrico, or Judicial Psychiatric Hospital) conflict and the person with mental disorder in conflict with the law. There will be presented extensive discussions on the Penal Execution Law and the Brazilian Psychiatric Reform Law, as well as cross-sector actions taken by the judiciary and the federal government (Brazilian National Health System - SUS and National Social Assistance System - SUAS) to bring the criminal justice system and the prison system to the anti-asylum combat. Two successful experiences in the states of Minas Gerais and Goiás will also be presented for they reflect the emergence of a new strategy on public health policy: The Evaluation Service and Monitoring Therapeutic Measures for the Person with Mental Disorder in Conflict with the Law, device connector between systems, willing to operate in the process of deinstitutionalization of people with mental disorders of HCPT.*

Key words *Mental disorder, Psychiatric reform, Prison system, Criminal justice*

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Introduction

This article aims to discuss the research in the field of mental health, public policies and the infra-constitutional standards that deal with law-breaking mentally ill people, as well as the possible cross-sector strategies for the deinstitutionalization of the HCTP (Hospital de Custódia e Tratamento Psiquiátrico, or Judicial Psychiatric Hospital). For this purpose, an exploratory, indirect, documentary and bibliographical survey has been conducted. It was based on writings of legal, mental health and sociology scholars and on the regulations of Brazilian legal system.

So, historically, to CFP¹ - Conselho Federal de Psicologia or Federal Board of Psychology -, the only remedy offered to the so-called “mentally-ill” was the psychiatric hospital, which was a place of violence, death, silencing, humiliation, segregation, disrespect for human rights and social exclusion, directly associated to a model that conceives mental suffering as pure subjective and civil negativity.

Corroborating with that thought, the Program for Comprehensive Care to the Legal Patient - PAI-PJ (2002), launched in the Brazilian States of Minas Gerais and Goiás, claims that negligence, callousness and the convenient attitude of not promoting justice are no longer possible. To make matters worse these attitudes mentioned before are “justified” on behalf of the law enforcement. This program emphasizes that for more than a century, the mental suffering offender has been jailed in exile of silence, on intolerance of segregation; away from their families, with no rights, highlighting the fact that these individuals do not receive even the basic treatment established by the Mental Health National Policy on account of its close relationship with the justice system, which signals double punishment: for being “a messenger of chaos” and for being “different”².

According to Foucault³, it was back in the early 19th century that the methods of “analytical sharing” of power in nursing homes, prisons, schools and insane asylums started by promoting a set of techniques and institutions that measure, control and correct the “freaks”. Criminal and psychiatric discourses blend in order to establish causal links between the individual’s biography and a sentence, understood by Foucault as “punishment-correction”.

The hospitalization of people with mental disorders in Brazil also begins in the 19th century. Since then, as in most Western countries,

attention to people with mental disorders meant hospitalization in specialized psychiatric hospitals, providing community isolation. The almost exclusive expedient to the prolonged confinement in psychiatric hospitals resulted in stigmatization and accentuation of the isolation of this clientele³.

Since the 1970s, experiences of transformation of mental health assistance have been adopted. They are based, in the beginning, on the reorientation of psychiatric institutions, with the aim of humanizing the asylum environment, and later, on the proposition of a model centered in the community, replacing thus the “hospital-centric” model.

Tundis and Costa⁴ explain that a large number of mental health workers, motivated by the democratization of the country in the second half of the 80, reported situations of abuse and violence of psychiatric hospitals patients. Such a move has intensified efforts to demonstrate, in practice, the need for replacement of the “hospital-centric” model for various political, socio-cultural, scientific, legal and administrative initiatives, in order to change the society’s relationship with mentally ill persons, allowing the guarantee of their right to citizenship.

In 1987, the motto of the movement “for a society without mental asylums” was created and May 18 was set as the National Anti-asylum Day, which has been commemorated all over the country since then⁴. With the proclamation of the Constitution in 1988, Brazilian Public Health System (SUS) was created and institutional conditions for the implementation of new health policies are established⁵.

In the 1990s, the Ministry of health, in accordance with several experiences of psychiatric reform in the Western world, but especially with the law 180/1978, of Italy⁶, and the recommendations of the Pan American Health Organization (PAHO) in the letter of Caracas (1990)⁷, defined a new mental health policy, which had been started with PAD (Programa de Apoio e Desospitalização, or Program of Support and Deinstitutionalization). Following the political advances, in 2001, the World Health Organization (WHO) declared that year as the international year of Mental Health. In Brazil, the psychiatric reform law 10.216/2001 came into force⁸.

Currently, the Brazilian Government has as main goals for mental health policies: a) progressively reduce the psychiatric beds; b) qualify, expand and strengthen the Network of Psychosocial Care (RAPS – Network of Psychosocial Care

(RAPS – Rede de Atenção Psicossocial)⁹; c) include actions of mental health in Primary Health Care; d) implement integral attention policies for users of crack, alcohol and other drugs; and) strengthen the program “De Volta pra Casa” (“Back Home”); f) keep a permanent program of human resource training for psychiatric reform; g) promote rights to users and their families, encouraging participation in their care; h) ensure decent treatment and quality to the mentally ill offender (surpassing the assistance model centered on the insane asylum); and i) continuously evaluate all psychiatric hospitals. Such actions are justified by the data of the Ministry of health of 2003: 3% of the general population suffers from severe and persistent mental disorders; 6% of the population report severe psychiatric disorders arising from the use of alcohol and other drugs; 12% of the population requires some care in mental health, no matter if continuous or not⁹.

These data are reflected also in the Brazilian prison system. According to the Prison Information System - INFOPEN (2014), 813 men and 33 women with intellectual disabilities and 2,497 people are under security measure in psychiatric hospitalization. Approximately 85% of these people are in Psychiatric Wards or HCTP (Judicial Psychiatric Hospital) and 15% in regular prison units¹⁰.

As we may learn from the study on *Desafios da Loucura Judicializada* - Challenges of Judicial Mental illness - (2013), it is necessary to deconstruct the double stigma of the mentally ill offender and invest in existing experiences that take into account the possibilities of incorporation of anti-asylum movement and the implementation of social policies, as the ones ruled by SUS¹¹.

As Basaglia¹² states, by analyzing the situation of the patient hospitalized in a mental institution, we can say that he is, first and foremost, an individual with no rights, subjected to the power of the institution, at the mercy of delegates of the society that took them away and excluded them. In the case of the deinstitutionalization of the mentally ill in the judicial system, there is the aggravation of the crime, of the sentence and the imperious need for a coordinated work of public policies, from the experience of the service of monitoring and evaluation of therapeutic measures.

The Brazilian prison system and its interface with the health system and criminal justice

The Brazilian Prison System is a large and complex universe: according to the Prison Information System (2014), the prisons in the country keep over 607,731 people in custody, 41% of them still without a final conviction. In this system, 67,176 professionals work daily. Approximately 85% of them are security officers and the others are part of health, education, work, social work teams, administrative support and management¹⁰. According to the National Council of Justice (2013), these professionals work in approximately 2,720 prison units, such as prisons, jails, police stations, open prison, work prison, relocation and provisional detention center, custody hospitals and Judicial Psychiatric Hospital. Such facilities are located in more than 1,880 municipalities, especially in County headquarters and in regions called “correctional”, which concentrate penitentiaries¹³.

This structure requires a legal complexity that involves ethical, strategic and operational issues, which contributed to favorable conditions for studies and debates that could provide the agreement of strategies and budgetary agendas and, of course, to the necessary interventions in the Brazilian prison system. As an example, from the publication of Order 3088 of 23/12/2011 which established that the Psychosocial Care Network for people in suffering or with mental disorder and in need of care as the result of crack, alcohol and other drugs use would be part of SUS scope⁹, there is a definition of the structure and integration of health services actions aimed at psychosocial care: organized, at first, by reference centers for comprehensive care articulated to the logic of primary care and family health. They have one direction and, depending on the complexity of the demand, more complex levels on their devices are reached.

By that regulation, the criminal justice bodies, at national level, can find ways in the current legal system to become more congruent with the premises of social security, even when it constitutes a normative confrontational situation, modifying clearly, the purpose of the security measure: a transposition, “treatment”, “crimi-

nal presumption” for “care”, “prevention”; and “social inclusion”. In our view, it constitutes the recognition of “ownership rights” of people with mental disorders in conflict with law.

SUS intervention runs against the normative context in art. 1, Law 7.210/1984¹⁴, Law of Penal Execution (LEP), in which criminal enforcement is determined with the purpose of carrying out the sentence provisions or criminal decision and provide conditions for the harmonious social integration of the convict and admitted patient. As well as in art. 99 of that law, where it comes to establish that HCTP is intended for those ones who cannot be imputable or “semi-imputable” also referred to in Article 26 and its sole paragraph of the Criminal Code¹⁵.

It also highlights the vision of outpatient treatment in art. 101, LEP, provided in Article 97, Part II of the Criminal Code, that regulates it will be held in Judiciary Psychiatric Hospitals or any other appropriate medical location. Since HCPT should be gradually replaced by therapeutic measures of community-based, it is possible envision, through the efforts of health workers and activists of anti-asylum struggle movements in the country, a replacement model, especially since the publication of Law 10.216, of April 6 2001⁸.

Moreover, the care of persons with mental disorders in conflict with the law, in the context of criminal justice, has been enshrined in important legal landmarks which set guidelines for judicial attention to patients, namely: CNPCP Resolution 5 of 04/05/2004, which regulates the Guidelines for compliance of the security measures; CNPCP Resolution 4 of 30/07/2010, which provides for the National Guidelines for Care of Judiciary Patients and Enforcement of Security Measure, adjusting them to the provision of Law 10.216/2001¹⁶; CNJ Resolution 113 of 20/04/2010 stipulates the procedure for the enforcement of custodial sentences and security measures; CNJ and Recommendation 35, of 12/07/2011, on the guidelines to be adopted in regard to judicial patients and the implementation of security measures¹⁷.

As we examine this dichotomy of positions between SUS and the rules of criminal enforcement, given the reality of people with mental disorders in custody for criminal justice, it is possible to see that: treatment model is determined by criminal law and not by public health policies; suspension of internment is conditional on the cessation of dangerousness, it is important to emphasize this is a rare step in the justice system; perpetual hospital internment happens

without clinical indication for it and regardless of the severity of the offense; treatment is carried out in the sphere of Justice; there is limited participation of public health/social care, with unaccountability of health services and social care in attention to this clientele; there is chronicity, stigma strengthening and institutionalization of patients; irreversible loss of family ties and impossibility to come back to social-familial interaction; there is consumption of public resources that should be used to finance open, inclusive and community-based services.

Thus, decisions to be taken by the justice system, in congruence with the health care and social assistance, may consider the following options: work on the reorientation of the care mode at the state level, which had been predominantly custodial and hospital-centered before: the care place becomes the community itself; promote the admission of the judiciary patient as treatment of last resort and for the shortest time possible; prohibit admissions to asylums; create alternative services to hospitals and ensure greater investment in primary health care network; create specific policies for deinstitutionalization and social reintegration of long inpatients; improve cross-sector policies for wholeness care.

Another aggravating factor is also observed: the publication of Law 11.343 of 23/08/2006 establishes the National System of Public Policies on Drugs (SISNAD)¹⁸ and defines measures to prevent the use of drugs, attention to drug users and drug addicts, repression of production and trafficking. However, contrary to what was expected, indictment and imprisonment of many who are users have grown, as they are typified as traffickers. As an example, in art. 28 of this law, the judge must determine to the Government to make available free, health facilities, preferably ambulatory, for specialized treatment to the offender. Added to that, because of what is enshrined in the Criminal Code, art. 28¹⁹, and Law 10216/2001, in its art. 6, in which the Courts have given compulsory admissions in HCTPs, psychiatric wards and prisons⁸.

In this sense, it is essential to produce evidence (studies, surveys) and interventions, enabling the necessary understanding of individuals “subjected” to these contexts, the adequacy of the care offer, of practices and a number of important institutional and legal dimensions with the construction of strategic and operational arrangements, as well as the production of interfaces to improve the regulatory interaction (overcoming, then, ambiguity and normative confron-

tations). Similarly, it is considered imperative to offer support to the federal units to redirect their models of care to judicial patients and to the treatment of issues which are relevant to users of psychotropic drugs, adopting SUS paradigm as central reference.

Security measure and judiciary psychiatry hospitals: the only life sentence in Brazil

For Foucault³, psychiatry is a range of institutions, discourses and standards subject to human imperfection and made of its own technical development the permanent course correction and domination of bodies tool.

Delgado²⁰ affirms it is necessary, however, to distinguish from the fundamental structure of the current rule, the economics of its distortions and errors. The rule says that the insane is not punishable or capable, that is, not imputable. This is a premise, which stem from the standards, ethics and system procedure. Distortions, abuse and errors, defined as such, do not deny the universal validity of the rule. One must understand the economics of distortions and describe them, know their accidental and systematic mechanisms, its regularities.

When the Judiciary Mental Hospital of Rio de Janeiro was founded in 1921, the prestige of the medical “mentalist” as an indispensable forensic expert had already been consolidating. In that period, according to Delgado²⁰, the discussion about the reach of the concept of “alienated” began, as well as its comprehensiveness within the broader notion of psychopatha, reflecting the hardships of the expert knowledge of psychiatrists, when they had to assert criminal liability of the offender.

The expert conclusion “cessation of dangerousness” is quite exceptional in the slow routine of Brazilian Judiciary Mental hospitals. Either the tests do not take place, or they are monotonously labeled “dangerousness”. Delgado²⁰ states that psychiatrists called to testify if they would keep dangerous offenders imputable, when criminal law required so, had the mental illness as a privileged index: “the only condition considered pathognomonic of dangerousness is the presence of mental disease activity.

Delmanto¹⁵ states that with the change of the criminal law (LEP) in 1984, Brazilian psychiatrist experts returned to the interior of the Judiciary mental hospitals, not having to face the danger of the regular offender. In this context, people who commit a crime and that perhaps are in acute or

chronic condition with symptoms of mental disorders, necessarily undergo a forensic psychiatric evaluation by the instrument “Mental Insanity Incident”. If the relationship between crime and mental disorder is confirmed by the incident, the judge, depending on the severity of the offense committed, will absolve the offender of a sentence and impose a penalty of “preventive” and “treatment” security measure. If the offender is not imputable, the Security Measure may be applied in the admission form in HCTP (or a similar one, in case there is not one in the surrounds) and if semi-imputable, the criminal sanction in the outpatient treatment form may be applied.

Going back in history, in the late nineteenth century, there was the need to replace the penalty for a new type of sanction in several sentences: The Security Measure, in order to treat the person, the author of a criminal offense. That new sanction was disconnected from the idea of punishment and its main objective would be to withdraw from society every individual who, by their previous behavior or mainly for their bio-psychological constitution, reveal real danger to the community³.

According to Leal²¹, Criminal Law would be transformed into a medical-psychiatric discipline and would disappear as a subject of purely ethical-political nature. The proposed change, however, clashed with one of the basic premises of liberal Criminal Law that crime is an act of free and conscious will against certain values and interests of the social group and that its judgment necessarily requires an ethical-legal nature reasoning, which could not be the result of a simple biomedical diagnosis.

Types of security measures are outlined in Art. 96 of the Criminal Code (CP – Código Penal) where the intention was to serve as a measure of treatment in which the person subjected to this penalty, if not imputable, would be exempt from the common penalty converted to security measure¹⁹.

In Mirabete’s view²², institutionalization happens in a psychiatric hospital (CP, Article 96, I.) and has custodian character. The custodial security measure imposed on a not imputable person because of mental illness would be an example. (CP, Art. 26). In other cases, if the penalty prescribed for the offense is not jail, the author considered semi-imputable may undergo outpatient treatment (CP, Art. 96, II), whose character is restrictive. The author states that the security measure are of two types: custodial and restrictive. The custodian type means admission to HCPT

and is, strictly speaking, the merging of security measures provided for in the former legislation: admission to judicial mental hospital and hospitalization in a custody and treatment home.

For the security measures to be imposed, the following assumptions should be present: the practice of the fact provided as crime and the dangerousness of the agent. It is important to note that before the reform of the Brazilian Penal Code, 1984, all “excluded” persons were considered dangerous to society. After this date, only people with mental disorders were considered dangerous¹⁵.

Brazil only implemented this right from the 1981 LEP Preliminary Draft, which guaranteed people submitted to psychiatric hospitalization all rights inherent to their human and legal status, subject to the restrictions arising from the sentence and the law. It was also guaranteed outpatient treatment as a restrictive measure, since the sentenced attended the hospital in days as may be determined by the doctor who will monitor them, aiming evaluation and recommendation for proper treatment.

In this sense, the dangerousness of people with mental disorders is defined as the probability that they have to commit violent and criminal acts. The penal law on the issue of criminal insanity uses this concept explicitly to justify the type of penalty that should be applied to the mentally ill¹⁵.

Delmanto¹⁵ writes that the security measures are also, as discussed earlier, penal sanctions, like sentences. They differ, however, of these, especially in the nature and foundation. While sentences have retributive and preventive character and are based on guilt, security measures have only preventive and are based on the dangerousness of the subject.

Foucault³ has already seen the strong relationship between psychiatry and criminal justice by stating that the “irrationality” of the delinquent act, that is, the impossibility to identify a rational motive for the crime called into question the classic doctrine of criminal law (which was based on free will) and subverted the punitive logic in question at the time, which turned to an attempt to recover the delinquent and no longer functioned as a revenge against crime.

For Castel²³, the argument used by psychiatrists demonstrated the need to build a specific place for the insane emphasizing their dangerous nature, besides the present difficulties in the identification and diagnosis of mental illness at that time.

Successful experiences of replacing the judiciary mental hospital for an extra-hospital model

In Brazil there are two major successful experiences with about 10 years of activities in monitoring the security measures by replacing the mental hospital model for an extra-hospital model based on the premises of the Brazilian Psychiatric Reform (Law 10.216/2001). The Comprehensive Care Program for the Mentally Ill Offender (PAI-LI), in Goiás and the Comprehensive Care Program for the Judicial Patient (PAI-PJ), in Minas Gerais. What distinguishes one from the other is that PAI-LI is under the management of the Department of Health and PAI-PJ is under the management of the judiciary²⁴.

These two programs do not work with the interpretation of the LEP for people under Security measure, but with the Law of Brazilian Psychiatric Reform associated with the National and State Mental Health Policies. There are multidisciplinary teams engaged in the connection between the actions of the criminal justice system and the Network of SUS and SUAS.

The Ministry of Health, inspired by these two successful programs and responding to the provisions of §3 of Art. 8 of the Interministerial Ordinance 1777/2003²⁵, decided to establish, collude and publish a national strategy in 2014, which does not observe the security measures only, but that could reach all persons with mental disorders in conflict with the law. The paragraph of the article states that: The Judicial Psychiatric Hospital will benefit from the actions provided on this Ordinance, and, because of their specificity, will be object of proper regulation.

This national strategy called “evaluation service and monitoring of therapeutic measures for the person with mental disorder in conflict with the law” established by Ordinance 94 of January 14, 2014, created a deinstitutionalization device to the so-called “judicial patients” connecting the criminal justice systems, SUS and SUAS²⁶.

Evaluation service and monitoring of therapeutic measures for the person with mental disorder in conflict with the law

The great legal landmark for the evaluation and monitoring of therapeutic measures applied to the person with mental disorder in conflict with the law was based on the publication of Ordinance 94 of 14 January, 2014, as a result of discussions by various institutions, through a

technical group that dealt with the relevant issues concerned to the security measures at national level, such as the Ministry of Health, the Ministry of Justice, the National Council of Justice (CNJ), the Federal Prosecutor's Office for Citizens' rights (PFDC), among other institutions²⁶.

The present regulation emerged as an alternative to set up a "connecting" mechanism between the health system, through the policies of the deprived from freedom and mental health person, the care and social protection system, among other sectoral policies and the criminal justice system²⁶.

That health service offered by SUS has five (5) professionals with Higher Education: one (1) nurse; One (1) Psychiatrist or physician with experience in mental health; One (1) psychologist; One (1) Social Worker; and one (1) professional with training in human, social or health sciences. The duties of this team are based on demands presented by different social actors: coordination and health services of PNAISP, Court, Public Prosecution, the judicial patient or their representative and the reference services network²⁶.

These individuals must perform the following functions: multi-purpose and integral studies on the social and health conditions of people with mental disorders in conflict with the law and their set of relationships (family and social), indicating therapeutic measures, as opposed to hospitalization and institutionalization measures; mapping of existing networks (health and welfare) and agency of production of guided measures in premises of "extended clinic"; contributing to the realization of the unique therapeutic project and the deinstitutionalization process of those who are still in the custody of the prison administration; coordination with the judiciary, influencing them towards the adoption of security measure conversions for outpatient treatment or the termination of the measure; contribution so that the health system, together the criminal justice system, may ensure the individualization of the measures under Law 10216/2001, following and evaluating them; and finally, acting as technical reference and as support poles and training of those working in the set of institutions that provide such measures for awareness and receiving of deinstitutionalized in the Health Care and Social Assistance Networks²⁶.

Thus, such a device is intended to support the adoption of alternative models to treatment within the criminal justice, this applied historically with strong dangerousness bias, with asylum characteristics and little understanding of

the subject, of the security measure and their network of relationships.

So, what is proposed is that people with mental disorders in conflict with the law are placed, preferably, on health networks, recognizing the importance of assistance and social protection, welfare benefits and inclusion in social networks.

Potential beneficiaries of this Evaluation Service are the people who, presumably or demonstrably present mental disorder and are in conflict with the law, under the following conditions: with the police investigation in progress, custody of criminal justice or freedom; or with criminal proceedings, and in compliance with custodial sentence or provisional arrest or responding in freedom, and that has brought mental insanity incident; or in compliance with security measures; or under conditional release of the security measure; or with extinct security measure and need expressed by the criminal justice or by SUS singular therapeutic project sustainability assurance²⁶.

As of the composition of PNAISP Group Conductor, established by Ministerial Decree 01/2014, the establishment of a specific working committee is stipulated to propose and support the Evaluation Service, structured at the state level, staffed with representatives from the Court of Justice, the State Prosecutor's Office, the State Public Defender's Office, the State Department of Social Welfare or the like, instances of social control at the state level, and preferably of the Health Councils, Social Welfare, Drug Policies or the like and Human rights or the like²⁶.

It is expected that anywhere the Evaluation Service discussed here is instituted, good matrix models with extensive interactive capabilities arise, together with the judiciary and state and local governments. In this case, competence levels or local insufficiencies - social policies derangements, political injunctions, etc. - may directly affect the implementation of the Evaluation Service in question, compromising their effects on the lives of persons with mental disorders in conflict with the law.

Final comments

This is one of the most complex issues debated in the areas of the Criminal Justice System, SUS and SUAS, since it requires paradigm shifts: for the Criminal Justice it requires to extinguish the interpretation and application of the Law of Penal Execution and start interpreting the Law of Psy-

chiatric Reform; for SUS and SUAS, it demands to include or implement and monitor the services of deinstitutionalization and social inclusion.

Thus, the evaluation service and monitoring of therapeutic measures for the person with mental disorder in conflict with the law is a model that finds foundations in three complex systems: Justice, SUS and SUAS. It is based on decentralization of management and on the operationalization based on local competences, adopting the perspective of mutual responsibility between levels of governments, intersectionality, accessibility, development of local capacity for interpretative skills about judicial patients, redirection of their attention and the provision of basic social and health services, recognizing such criminalized individuals as rights holders.

This conceptual complexity added to the lack of a dissemination plan of that policy strategy can be seen as the main factors for the low number of demand for the Evaluation Service. Since its implementation in 2014, only four Brazilian states have shown interest in the service, mainly because of the sensitivity of the judiciary and the state executive. Moreover, only five multidisciplinary teams of the Evaluation Service were deployed in two of these four states, indicating a clear need to create a dissemination strategy of service to members of the judiciary in their regions, managers of the executive in the Health, Social Assistance, Penitentiary Administration Departments and civil society in general.

Historically, the Criminal Justice and Prison System treat the judiciary patient as very dangerous, even though their reoccurrence indicator is negligible compared to the common offender, disregard the knowledge of the Mental Health professionals who claim that those patients are not dangerous, but their lack of assistance, and that the crimes committed, for the most part,

happen at times when they are not being watched.

Despite of being called “Hospital”, The HCTP institution is an exclusive responsibility structure of the prison system, replacing the therapeutic rationale for a psychiatric, segregating and prison operation, causing the judiciary patient a double stigma: “mentally ill” and “criminal”.

For this mental institutions and prisons, one can glimpse the terrible conditions of service offered to the judiciary patient, reason enough for the urgent development of a deinstitutionalization project, contemplating methodologies already structured by the Mental Health Policy and an agreed timetable, focusing on the definitive closure of HCTP.

In this scenario, a controversial and polemic issue will be introduced (especially for the militancy of psychiatric reform), but a last resort needs to be adopted: the “transinstitutionalization”.

As far as there is no other solution or deinstitutionalization services in the territory, we believe in the methodology called “provisional transinstitutionalization” of patients from HCPT to conventional psychiatric hospitals, since this method is closely aligned between the judiciary and the executive powers, with the primary aim of creating conditions and judicial measures for the extinction of the Security Measure.

Transinstitutionalization will be transitional in order to give visibility to these patients in SUS and, at the same time, start the progressive desinstitutionalization process and development of the Unique Therapeutic Project together with RAS, through RAPS and the Social Assistance Network of SUAS.

This cross-sector alignment between the judiciary and the executive for “provisional transinstitutionalization” should generate local regulatory agreements of transfer of responsi-

bility of judicial patients for SUS, as well as the permanent banning of HCPT, the extinction of the Security Measures and the implementation of public services such as the Evaluation Service (discussed in this article) and/or the deinstitutionalization team of Mental Health Policy, contemplating unique a therapeutic project to be developed with SUS and SUAS Networks. Ordinance 2.840, of 29 December 2014, which establishes the Deinstitutionalization Program as part of Deinstitutionalization Estrategies of the Psicossocial Attention Network (RAPS), within SUS, and institutes the respective financial incentive of monthly funding.

Collaborations

MM Soares Filho worked in documental research, design and initial writing and PMMG Bueno in the methodology and the final writing.

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