DOI: 10.1590/1413-812320222712.12622022EN

Deinstitutionalization and mental health of the deprived of liberty with mental disorders: the Rio de Janeiro, Brazil experience

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Abstract *This paper presents an experience report on the supervision of deinstitutionalization of the prison system through the articulation of the Psychosocial Care Network (RAPS) conducted from 2014 to 2021 within the Superintendence of Mental Health/Municipal Health Secretariat of Rio de Janeiro. This work of deinstitutionalizing people deprived of liberty with mental health problems consists of actions at the exit and entrance doors of the prison system and actions for the care of unimputable and imputable people with mental disorders. In the light of the Brazilian Psychiatric Reform, formalized by Law No. 10,216/2001, we aim to present an approach to this process counting on the possibilities of building care policies for insane offenders that are not punitive or segregating. The practical results of this work include more significant participation of the network in the construction of care for insane offenders, elaborating policies that avoid the prison career or reduce the asylum time in the penal system, and understanding that security measures must always have an outpatient nature.*
Key words *Deinstitutionalization, Prisoners, Mental health*

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Introduction

This paper presents a discussion on the experience of articulation between the Psychosocial Care Network (RAPS) and the Prison System, whose guideline includes insane offenders in the care logic recommended by the Brazilian Psychiatric Reform and formalized by Law nº 10.216/2001[1]. Based on the assurance of rights and the assumptions of freedom and territorial and community care that guide psychosocial care, the experience discussed here takes deinstitutionalization as a necessary paradigm for changing practices and discourses[2] related to people with psychiatric disorders in the prison system. Deinstitutionalization is understood as a social process of transforming power relationships between users and institutions and the invention of health through the multiple possibilities of producing life, meaning, and social roles[3]. This work supervised the deinstitutionalization work by the Superintendence of Mental Health of the Municipal Health Secretariat (SSM/SMS) of Rio de Janeiro from 2014 to 2021. It is a long title – supervision of deinstitutionalization – a name as complicated as deinstitutionalization itself.

The deinstitutionalization supervising role was initially created to ensure the follow-up of patients hospitalized on a long-term basis in psychiatric clinics affiliated with the Unified Health System. It consists of elaborating and following up on the Singular Therapeutic Project with the hospitalization teams and asylum's substitutive services, articulating care in the extra-hospital network. Several psychiatric clinics were deactivated from this perspective of strengthening services and substitutive programs, reversing the asylum and privatist logic that Amarante[4] named "industry of madness", with public money being transferred to private clinics that hospitalized at low cost and without restrictions.

Deinstitutionalization has been an undertaking of the Brazilian Psychiatric Reform, whose motto is "for an asylum-free society", for about four decades. However, the anti-asylum logic was challenging to consider institutionalized psychiatric patients in prison units, leaving the inclusion of insane offenders – who seem to embody the darkest social ghosts – forgotten for many years. Ten years after the enactment of the Psychiatric Reform law, the process of replacing asylums with territorial community services, such as Psychosocial Care Centers (*Centros de Atenção Psicossocial* - CAPS) and Therapeutic Residential Services (*Serviços Residenciais Terapêuticos* - SRT), was advancing, with the public policy mandate to promote discharge and citizen inclusion of patients coming from long hospitalization periods. This ten-year time frame after the formalization of the deinstitutionalization policy by Law No. 10,216 of 2001 is a landmark in contextualizing the reality of the Custody and Psychiatric Treatment Institutions in the country. This is because, in 2011, the first and only national census that finally counted numerically and on these institutions that had almost one hundred years of existence and received offenders incapable of being criminally held accountable for their acts was conducted. The critical survey by Diniz[5] gives visibility to this population of 3,989 inmates from 23 Custody and Psychiatric Treatment Hospitals and three Psychiatric Treatment Wards in the country active at the time.

Judicial asylums – today more delicately called Custody and Psychiatric Treatment Hospitals (CPTHs) – are justified by the alleged relationship between madness and dangerousness to exclude in the name of "defense of society"[6]. Carrara[7] pointed out the profound ambivalence between the punitive/legal and therapeutic/health models of judicial asylums, whose violence is also found in any institution where madness serves as a justification for behaviors that do not conform to social rules and values, as Arbex denounced[8].

Currently, public mental health policies in Rio de Janeiro and other Brazilian regions are approaching to give visibility and dignity to these patients who spent so many years on the sidelines of the Psychiatric Reform. The Minas Gerais and Goiás experiences are successful and precursors (The Comprehensive Care Program for Judicial Patients with Mental Suffering - PAI/PJ[9], and the Comprehensive Care Program for Insane Offenders - PAILI[10]). However, deinstitutionalization is still a considerable challenge, significantly when the stigma of "dangerousness" weighs on these stories. This process presupposes patient de-hospitalization and public policies to make it feasible, but also changes in discourses, practices, and culture, with a significant challenge of a dual stigma of madness and crime.

Methods

This experience report is the unpublished result of the author's doctoral thesis[6], whose investigation was approved by the human research ethics committee (CAAE: 64151617.2.0000.5263). This intervention research adopts the narrative meth-

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odological tool about the professional experience of deinstitutionalizing people with mental disorders in conflict with the law.

Experience report

The psychosocial care fronts at the entrance and exit doors of the prison system will be presented, specifying the work performed towards deinstitutionalizing patients who served security measures referred to the Municipality of Rio de Janeiro, and the still incipient actions to take care of those prisoners in ordinary jails who have psychiatric issues.

Unimputable

The clientele most immediately benefited from actions aimed at mental health in the prison system are the unimputable people deprived of their liberty; in other words, those who, due to mental illness or incomplete or retarded mental development, were considered incapable of understanding the illicit nature of the offense or be determined per that understanding. Thus, in general, these are people whose mental disorder is formally identified in the legal process, which supposedly guarantees mental health care. However, although the unimputable are acquitted and receive treatment instead of the sentence, they remain under the tutelage of the Judiciary System. They are almost always deprived of liberty in prison institutions called hospitals, which function and are structured as a jail. Unlike internment in any other hospital, discharge is determined by the Judiciary and not by Health.

Thus, the first challenge of the mental health promotion and deinstitutionalization work for those deprived of liberty was to include the RAPS in the follow-up of asylum patients in CPTHs. If at first this approximation of the health network and the prison system was not evident, the CAPS now increasingly exercise the mandate of accompanying patients under the tutelage of judicial asylums. Besides patients in judicial asylums, RAPS is mandated to monitor the safety measures of patients who comply with them on an outpatient basis, that is, in freedom. This model is the only one meeting the rationale that the security measure, as a treatment proposal, must be referred to levels of care, such as the health network, and not to total institutions with a punitive, moral and segregating nature.

Understanding that freedom is one pillar for mental health care, and that the notions of citizenship, territory, and support network are important, the following work fronts with unimputable people to avoid their institutionalization in the prison system will be presented, dividing them into two types of action: entrance and exit doors.

Exit door

Ensuring the exit door's opening was the first task of the deinstitutionalization supervision through the regular discussion of the asylum cases in the CPTHs and the accountability of the care network of each patient, intermediating between inside and outside, offering perspectives of estrangement and deconstruction of asylum practices from the inside and seeking to give visibility to these people who were invisible to the outside world.

The initial work was to revive histories, relationships, territories, and bonds, activating substitutive mental health services and social assistance devices, education, work, income, and culture initiatives to transform institutional bonds into citizenship ties and ensure rights.

Exclusion, violence, and abandonment require much care and listening, which is what the Psychosocial Care Network (RAPS) does with its legitimate but commonly unapplicable mandate to take on these cases when building a Singular Therapeutic Project (STP) for each patient. A therapeutic project is a follow-up design that includes community, citizenship, treatment, housing, and income. In these cases, it is the perspective of building a life project that is affectively, ethically, and politically capable of resignifying the place of these people, in general, so impoverished by social ties.

Thus, the exit door work consisted of giving visibility to institutionalized cases in CPTHs, seeking partnerships, including the network, until it was possible to transfer the responsibility from Justice to health and social assistance.

Besides the regular discussions of the cases to articulate the care network, the inclusion of all patients from the custody hospitals in the FORMDESINS was formalized, and a database created by the SSM/RJ that gathered information about each individual within the Municipality of Rio de Janeiro, formerly in long-term institutionalizations or hospitalized for more than a year in psychiatric hospitals, or still living in Therapeutic Residential Services. Linked to the Ministry of Health's FORMSUS platform, the data went offline in February 2021 by the decision of the

Department of Informatics of the Unified Health System (SUS) to discontinue the tool. To facilitate and monitor the deinstitutionalization process of these patients, FORMDESINS consisted of a platform on which information on everything known about these subjects was entered: origin, family relationships, ties, territorial references, life history, work, documents, treatment locations, hospitalizations, therapeutic projects, and health data. Besides indicating territories, services, and strategies for deinstitutionalization projects, FORMDESINS allowed surveying the profile of long-stay clientele, pointing to the need for investment in the substitutive network.

This inclusion quantified and qualified the CPTHs' population as a target of the deinstitutionalization policy and symbolically interrupted a cycle of exclusion, in which psychiatric patients in institutions of the Penitentiary Administration Department (SEAP) were not so visible because they were formally outside the health network serving security measures. FORMDESINS facilitated the numerical count of people and also counted about them. Pragmatically, it was a tool that enabled recording, integrating, and exchanging information about patients and helped to organize the demand for the network. Symbolically, it was a way of giving visibility to previously invisible people.

Also, intending to give visibility to insane offenders, investments targeted the inclusion of security measures as a practical setting for mental health residents, which favors the awareness of future professionals in the network regarding patients deprived of liberty.

Moreover, finally, a meaningful change that accelerated the deinstitutionalization of people serving security measures in judicial asylums was replacing, since June 2017, the Dangerousness Cessation Verification Exam (EVCP) with the Multidisciplinary and Expert Examination of Psychosocial Assessment (EMPAP)[11]. The Special Judicial Procedure VEP No. 2018/0017795-6 was the legal instrument that formalized the new inter-institutional flow[12], according to which disinternment was no longer grounded on assessing the possibility that the subject may represent a danger to society, a psychiatrist expert's assessment allegedly scientific and neutral in a specific period in time and space. Now, the evaluation started to include the technical team responsible for following-up the patient at the CPTH, whose core was the therapeutic project and the possibility for the subject submitted to examination to live in freedom. The expert doctor discusses with the assistant team the prospect of continuing treatment in an open regime and starts to work *in loco*, going to the judicial asylum, thus better evaluating the subject submitted to examination, who no longer has to travel to the Forensic Institute, which could be very disorganizing. A new assessment is carried out within 90 days if the discharge is not indicated. Once the discharge hearing is scheduled, the CAPS responsible for the care network for the subject who is leaving the CPTH is summoned, guaranteeing the formalization of the network's presence to avoid vulnerability and the inclusion of the service in this freedom agreement, whose central issue is treatment.

Replacing the EVCP with EMPAP shifted the asylum perspective, whose solution to the supposed social danger that a person represents is isolation, to the network perspective, in which what matters is a therapeutic project that avoids the vulnerability of that subject. Thus, a concept of dangerousness as an individual problem shifted to a concept of vulnerability as a community right-based responsibility (in this case, the right to health and, as this is a universal right, it also applies to subjects who committed a crime).

With this change, the process of leaving the judicial asylums, which previously took from six months to a year, counting from the appointment of the technical team until the arrival of the release order, gained speed[13]. This process reduces the length of stay and makes the Therapeutic Project's vitality feasible, which was often hampered by the postponement of hospital admission, "cooling down" the bonds, the therapeutic exits, the management in the sense of deinstitutionalization, which used to be accompanied by a deteriorated patient's psychological condition due to the deprivation of liberty.

Gateway

While it might seem more natural to address the gateway before the exit door, in the case of deinstitutionalization work, the focus is often on exit processes. It is not by chance that the actions related to the articulation for territorial care that promotes freedom are more evident in this field and perhaps even more numerous and structured. Although it seems primary, closing the gateway is complex. It involves greater engagement of other fields of knowledge at this moment when the excluded subject gains visibility because he becomes the target of the social issue control, which here turns to insane offenders.

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Thus, in parallel with CPTHs' follow-up work to guarantee the deinstitutionalization projects and curb the number of asylum patients in these institutions, there was some expectation of closing the judicial asylums, with the understanding that the security measures must always be carried out on an outpatient basis in the CAPS or other network devices.

For now, however, work is still required to resist the entry of new patients into CPTHs, avoiding institutionalization before it happens and breaking with a culture of hospitalization/exclusion of insane offenders. To this end, an approach was sought with the team of custody hearings, the first level of the relationship of the subject who committed a crime with the judiciary. This focus expectation is that by sensitizing the actors responsible for the custody hearings to the issue of psychological distress and the possibility of care in the health network, there is a tendency to avoid incarceration as a response and include the scope of health before the subject starts a judicial and exclusionary path. This initiative became a reality through the partnership with the technical team responsible for servicing the subjects who attended the custody hearings to refer prisoners who presented a demand for evaluation and follow-up thereof to the Mental Health Network and sensitize judges so that subjects who were in apparent psychological disorganization could be heard in their suffering and not just their crime. Moreover, if psychological distress was identified and contact with the mental health service was made even before the hearing, this could be an element in favor of the subject's freedom.

Moreover, in this sense of valuing the importance of psychosocial care at the gateway to the prison system, public defenders responsible for defending the accused in custody hearings were approached. By opening up a dialogue with them, the possibility of finding out whether a subject arrested in the act who was in psychic disorganization was already a patient of the Mental Health Network was facilitated, requesting a report or the participation of the responsible service in the custody hearing, or even already arrange an initial reception in network service to ensure that this subject who found the justice system at a time of mental illness could be cared for. With this approximation between the Defender's Office and the SSM, RAPS stakeholders could also contact the defenders responsible for the custody hearing when they learn of the arrest of a patient in the act.

Another vital front for closing the gateway to the CPTHs was including the SEAP multidisciplinary team in the mental insanity assessment. Comprised of an occupational therapist, a social worker, and a psychologist, this team assumed this role besides the forensic psychiatry experts. As this team was experienced in deinstitutionalization and worked directly with patients in a custodial hospital for years, a much more sophisticated evaluation perspective than the specific expertise performed by a forensic psychiatrist was inaugurated. This assessment by the multidisciplinary team of the Heitor Carrilho Institute focused on the history of the subjects indicated for examination, along with the examined subject, their family, and network (social, treatment, and support). The work included interviews, home and institutional visits, and medical records research to prepare with the patient's reference teams a Singular Therapeutic Project sent to the judge and the psychiatrist's expert report. In general, the team indicated that the security measure could be carried out on an outpatient basis (in CAPS) instead of the judicial asylum, and the judges commonly accepted this[14]. Besides the welcome consequence of avoiding these subjects' institutionalization, this work was a precursor to the change in the expertise's neutrality and distance culture and paved the way for a perspective of building a therapeutic project in the network before the offender enters the institutionalization circuit.

We should also mention the inclusion of the field of expertise as a practice setting for Mental Health residencies and internships, training the new generations of professionals in the network with attention to the issue of security measures and the perspective of an evaluation work that includes the subject in its completeness.

Imputable

Initially, people serving security measures were the most evident focus of the work on this deinstitutionalization front in the penal system since they are mental health patients, many of whom are long hospitalized, in a vulnerable situation, and therefore with a clear indication of follow-up in the RAPS. As mentioned, much progress has been made in recent years regarding the accountability of the network for cases in custody hospitals and participation in the formulation and support of a deinstitutionalization project for these patients.

However, the number of prisoners in ordinary jails who suffer from psychiatric illnesses and do not receive adequate treatment is enor-

mous. According to Job Neto[15], 2% of people deprived of liberty have schizophrenia, and mental illness is the second cause of morbidity in the prison system.

The data collected by Oliveira and Boiteux[13] reveal the size of the problem: while, in the state of Rio de Janeiro, we had 184 inmates in CPTHs in February 2018, the prison population in ordinary prisons was 50,040. In other words, the percentage of people in judicial asylums against those in ordinary prisons is 0.36%. The mental health of this 0.36% is being taken care of, but little is known about the mental health of the 99.64% of prisoners who are not in psychiatric prisons. Oliveira[16] presented data about them referring to October 2017 and still restricted to four prisons in the State of Rio de Janeiro on the use of psychiatric drugs. In two women's units where it was possible to access these data, the mean number of women receiving monthly antipsychotics, antidepressants, or anxiolytics was 34.74%. In another prison unit, this one for trans men and women, the mean number of medicalized patients was 4%. In a semi-open male unit, the share of men receiving controlled medication was 1.25%.

Another observation brought by Oliveira and Boiteux[13] was that the increase in the population of provisional prisoners who end up being admitted to CPTHs before the enactment of security measures points to the psychic illness that the prison system produces. The researchers noticed that while the population serving security measures decreased by 85.95% from 2011 to 2018, the temporary population (emergencies, court orders, and other situations other than security measures) in CPTHs increased by 9.65%. In other words, mental health care for the unimputable has produced effects, avoiding institutionalization, but did not reach imputable prisoners. These, on the contrary, are subject to the pathologization and medicalization produced by the prison system, which induces sickness but does not have prevention programs and mental health care.

Given the lack of adequate mental health care in the prison system and the need to assist these people, a protocol for RAPS teams to access prison units was built. Thus, entering professionals into ordinary prisons was facilitated, which was previously seldom possible. Even when prisoners were already followed-up by CAPS, team technicians were very commonly prevented from visiting them, except for having a visitor's card as a "friend". The resolution that allows healthcare professionals access to prisons was finally made possible after an episode of violation of rights reached the media: an inmate gave birth in a solitary cell, where she stayed due to a significant psychic disorganization condition. This inmate was a patient at a CAPS of the Municipal Health Network of Rio de Janeiro. This service attempted to facilitate visits to the patient in several contacts with SEAP and informed her of her pregnancy, and it was impossible to visit or confirm the gestation. Only when, by the tragic fact, she came out of invisibility and was transferred to a mental health facility, the psychiatric penal hospital, did the reference team become welcome.

Thus, after some meetings between the management of SEAP, SSM, the Public Defender's Office, and the Public Prosecutor's Office, a resolution was published to allow those deprived of liberty whom the Mental Health Network already accompanied to continue this treatment through visits by their reference technicians. The resolution also guides prison directors to seek reference CAPS if they identify a detainee with significant psychological distress.

The proposal to involve the RAPS in the mental health monitoring of people under the tutelage of SEAP generated many discussions, given that the Mental Health Network cannot cover the absence of health teams in the prison system at all levels – from primary care to specialized mental health care. On the other hand, a CAPS mandate is the psychosocial follow-up of severe and complex psychiatric cases, such as people who end up being captured by the penal system. This discussion also stumbles against the hardships of sustaining regular care for patients in prison units, almost always outside the CAPS' territory, due to lack of transport or the impossibility of professionals leaving the units amid so many urgencies for commonly reduced teams. Another issue is responsibility again: the Mental Health Network, taking care of inmates in psychological distress, strips the prison system's duty to ensure access to health and the primary rights of this population. Thus, if, on the one hand, CAPS monitoring of people deprived of liberty with significant psychological distress advocates the logic of bonding with the territorial service and deinstitutionalization. On the other hand, it may represent an arrangement that conceals the absence of the National Comprehensive Health Care Policy for People Deprived of Liberty in the Prison System (PNAISP), which was only partially implemented in Rio de Janeiro.

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Discussion

Many challenges are involved in letting go of the containment of institutional walls. Although deinstitutionalization is tirelessly defended, we should never forget that a subject outside the hospice becomes more vulnerable and requires more psychosocial care than an institutionalized subject.

It is worth reaffirming that deinstitutionalization is not dehospitalization. Opening the asylum door is fundamental, but it is only one step in social inclusion. There is arduous work to sustain the sealing of social bonds outside the hospice, a path in which resistance, prejudice, and years of an exclusion culture and practice are faced all the time.

A citizenship project is a challenging construction requiring quality clinical work for people with an institutionalization history who have lived through years of segregation. When it comes to insane offenders, the challenge is even more significant due to the stigma of dangerousness and the mark of the passage to the act.

Although it is an "undefined and indefinable concept, of an almost oracular nature, which produces standardized responses to standardized behaviors of crisis, violence, crime, and seclusion"[17], dangerousness is used as a defining tool of lives and bodies, dictating on desire, freedom, and capacity. The notion of dangerousness is enshrined in the Criminal Code but disregards social issues, which are the primary cause of the deprivation of liberty. Now, a social problem must be answered with attention or care that considers social issues. In this sense, assessing unimputable subjects serving security measures due to a crime must be psychosocial and not "cessation of dangerousness". It is necessary to consider the subjects' network, the possibility of them no longer being vulnerable, and their connection with the treatment and other reference devices.

The perspective of a care network points to the possibility of avoiding a recurrence with much more property than expertise that assesses dangerousness, disregarding the complexity of the deinstitutionalization processes. Data that reveals the fragility of the idea of dangerousness is comparing the rates of about 70% of recidivism of ordinary convicts[18] with the recidivism of about 7% of those released from judicial asylums[19]. In the case of homicide, Diniz[4] showed that the specific recurrence for this type of crime is 1% among people in Custody and Psychiatric Treatment Establishments.

This network construction emerges as the only relevant resource for the care of the insane offenders, taking the clues presented by each subject and their history as pieces for constructing their unique therapeutic project and pointing out the path that will serve as the social bond fabric. This bond will allow their exit. The work of deinstitutionalization of those deprived of liberty is performed through inclusion, which is radically opposed to the proposed security measures as internment. It is about affirming freedom and citizenship in a movement contrary to segregation in institutions, such as asylums and jails, which induce sickness and reproduce and establish violence. Violence, hallmark of the prison population in general, this reinforces marginalization and lack of access to rights and guarantees and does not match the function of care or resocialization.

It is a complex task to move away from the marginalization culture that is so pressing in a prison institution and perform this job of building identity and belonging, helping those incarcerated to find meanings for themselves, the criminal act, and future life. Besides the internal work, external constructions point to community responsibility, the guarantee of rights, equality, and fairer justice.

Final considerations

The experience of Rio de Janeiro reported here is just one, among other care initiatives in a network of those deprived of liberty with mental disorders that aims to reverse the punitive and segregating culture of the Prison System. Among the many daily difficulties of this work are the limitations of fragile RAPS teams, which often do not have transportation or time to visit patients in prison units, besides the barriers of a Justice System that is not open to the construction of expanded care policies.

Despite the obstacles to a deinstitutionalizing perspective for the mental health care of people deprived of their liberty, we can affirm that the experience of Rio de Janeiro proposes the model of the security measure in an outpatient regime as the ideal legal modality in the case of crimes committed by psychiatrically ill people.

Investing in the deinstitutionalization work in the prison system supports an ethic that reverses the logic of exclusion, which is especially perverse to insane offenders. It is a clinical and political endeavor, seeking to bring subjects who

were excluded to the fore, valuing the social bond, recognition, and special knowledge in contrast to segregation and pathologization. Reconstructing stories and narratives, setting a network of reference and care, and formalizing a care policy for insane offenders from a perspective of the creative and powerful invention of a fragile SUS, are ethical and political strategies.

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Article submitted 28/11/2021
Approved 08/08/2022
Final version submitted 10/08/2022

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva