



## PEOPLE IN A SAFETY MEASURE IN THE PSYCHOSOCIAL CARE NETWORK: PROFESSIONALS' PERSPECTIVE

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### ABSTRACT

**Objective:** to know the perceptions of professionals working at the Psychiatric Custody and Treatment Hospital about the embracement of people in a safety measure in the Psychosocial Care Network. **Method:** exploratory, descriptive and qualitative study. Fifteen professionals working in a hospital in the southern region of Brazil participated. Semi-structured interviews were conducted between May and June 2019. The data were analyzed by the use of content analysis. **Results:** two categories were identified: Possibilities and limits for welcoming people in a safety measure; Perceptions of professionals about the Psychosocial Care Network. **Final considerations:** teamwork between the health and safety sector contributes to welcoming. The safety measure should be understood by professionals who work in the Psychosocial Care Network as a penalty that has an end, having the need to separate the disease from the offense to achieve embracement with an individual and integral look at this population.

**Keywords:** User Embracement. Safety measure. Mental health care. Health care. Nursing.

### INTRODUCTION

The Against madhouse movement, which led to the deinstitutionalization of madness and the creation of new possibilities for the care and inclusion of people with mental disorders, converged with the creation of the National Mental Health Policy, implemented by Law 10.216/01<sup>(1)</sup>.

This scenario boosted the debate about human rights violations, experienced in madhouses linked to the criticism of the care and tutelary model that such places represent and the need for a territorial and humanized assistance network – (Psychosocial Care Network) PCN<sup>(2)</sup>.

PCN aims, through comprehensive and humanized care, to serve people with suffering or mental disorder and the needs resulting from the use of crack, alcohol and other drugs. It seeks to ensure the free movement of mentally ill people through services, community and city. It consists

of 07 components or points of care, among which: primary health care, specialized psychosocial care, urgent/emergency care, transitory residential care, hospital care, deinstitutionalization strategies and Psychosocial Rehabilitation<sup>(3)</sup>. Thus, deinstitutionalization is proposed, which is perceived as a still unfinished process, which is seen in society by the biased concept of the "crazy", when referring to the person with a mental disorder in conflict with the law, previously called the "crazy offender"<sup>(4)</sup>.

However, there are psychiatric hospitals with madhouse characteristics in Brazil so far, and the Psychiatric Custody and Treatment Hospital (PCTH) is one of them. Custody hospitals can be characterized as places of segregation, where usually, by the safety measure,<sup>(\*)</sup> physical or chemical containment of the individual occurs, contradicting the treatment proposed by studies and consolidated practices in the area of mental

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health<sup>(5)</sup>.

The safety measure comes into force when there is state intervention in the freedom of the unaccountable individual, diagnosed with a mental illness, who has committed a typical and unlawful fact, giving him treatment to preserve society from the danger that this person may represent. Art. 97 of the Penal Code highlights two types of safety measure: hospitalization and outpatient treatment. Hospitalization should generally be applied by the judge, while outpatient treatment should be the exception. Therefore, the judge can only determine outpatient treatment if the crime is punishable by detention<sup>(6,7)</sup>.

In this context, the implementation of the National Humanization Policy is perceived as a powerful strategy to improve resoluteness in the expansion of embracement. This guarantees comprehensive care, essential to have inclusive practices that provide opportunities for the participation of the actors involved. Welcoming makes it possible to receive the demand of the mental health situations of the general population, including those deprived of freedom, in which the individual goes through dehumanizing situations. And it is because of this need for humanization that the hospital-centered model must be overcome in order to achieve human dignity, equity, and the extinction of the madhouse, including the Psychiatric Custody and Treatment Hospital<sup>(8,9)</sup>.

The process to end the madhouse can be understood, etymologically, by the word "madhouse": mania (mania, madness) + *koméō* (to care).). However, PCTH is still designated as a place to care for the mentally ill, termed "crazy." It is believed that the deconstruction of the madhouse model is a challenge that can still be achieved by multiprofessional teams, but which has been hampered by political measures. Therefore, the new processes of care and embracement of people in a safety measure can reduce the stereotype of crazy, transforming the imagination of multiprofessional teams and society in general<sup>(5,10)</sup>.

In a safety measure, people usually receive a punitive and segregatory system with great difficulties in resocialization and return to community life<sup>(11,12)</sup>. In addition, teams of PCNs professionals, sometimes without specific training to assist people with mental illness or suffering, opt for the medicalization of care, keeping the individual "controlled" in an attempt to protect

themselves from the "criminal madman". From then on, it is determined whether the person should be received at the PCNs or at the Basic Health Unit (BHU), which can leave them out of the network and the Family Health Strategy (FHS) teams themselves<sup>(13)</sup>.

When analyzing the relationships between the field of Primary Health Care (PHC) and mental health in the territories, it is revealed that medicalization is the condition used to act in the suffering and life of people in a measure of safety. The prescription and renewal of medications are usually carried out without proper evaluation of the conduct of health professionals or the proposal of a therapeutic project, continuing the compulsive behaviors of imprisoning outside the walls, configuring segregation, which is a violent practice<sup>(14)</sup>. In this regard, it is essential to reflect on the mental health of people deprived of liberty, since it lacks public policies that provide a true social insertion of these people who live, for the most part, in the scenarios called "judicial madhouses".

In view of the above, the following research question emerged: what are the perceptions of professionals working in a PCTH about welcoming people in a safety measure at RAPS? It is urgent that the safety measure be reviewed based on the psychiatric reform, posing itself as a counterpoint to the practice of hospitalization. In this sense, it is relevant to know the perceptions of professionals working in the PCTH, in order to contribute to policy improvements in the sector and give light to this theme, which still needs to expand studies and greater visibility of its results in the area of Nursing and Health, in search of qualification in care, with recognition of the rights of people in safety measures. Therefore, the objective was to know the perceptions of professionals working in a PCTH about the embracement of these people at PCN.

## METHOD

This is an exploratory, descriptive research with a qualitative approach<sup>(15)</sup>, having as theoretical reference the health promotion policies included in the Mental Health Law and PCN. The writing of this article was developed according to the consolidated criteria for qualitative research reports (COREQ).

The research site was a PCTH in the southern

region of Brazil, in the state of Santa Catarina, which integrates the following servers: 15 nursing professionals, including nurses, technicians and assistants; a psychiatrist; three psychologists; an occupational therapist; and a social worker. These professionals work together with the teams of criminal police, who are in charge of the trips to the institutions of the public health network. Criminal police duty teams are divided into seven professionals for every five shifts, totaling 35 in this sector.

Fifteen professionals were invited and accepted to participate in the study, composing an intentional/purposeful sample. The inclusion criteria were professionals working in the PCTH, including health professionals and criminal policies, over 18 years of age. The exclusion criteria were: professionals who did not have a direct relationship with people in a safety measure and with less than one year of experience on the site.

Data collection was carried out through semi-structured interviews, containing questions that addressed the embracement of people in a safety measure at PCTH and PCN. The interviews took place individually in a reserved location of the PCTH itself, between May and June 2019, lasting approximately 30 minutes, and were kept until data saturation, achieved when the answers became replicated. The interviews were conducted by a master's student nurse, recorded and later transcribed.

The organization and interpretation of the data were based on the thematic analysis of Minayo<sup>(16)</sup>, which unfolded in three moments: 1) pre-analysis: reading of the transcribed data, in order to seek approximation with the initial objective, constructing hypotheses of the data found in the collection; 2) exploration of the material: moment in which the data were codified; 3) treatment of the results obtained: categorization and subcategorization, with classification and interpretation of the material<sup>(16)</sup>. Thus, two categories emerged, which will be presented and discussed below.

The operationalization of the research began only after the approval of the Research Ethics Committee of a public University of Santa Catarina, with opinion number 3.254.630, on April 19, 2019, in accordance with Resolution 466/2012 and 510/2016 of the National Health Council.

Before starting data collection, participants signed the Informed Consent Form. To preserve the confidentiality and anonymity of the interviewees, we chose to name them by the letter I, followed by a numeral, which was determined according to the chronological order of the interviews (I1, I2, I3, and so on).

## RESULTS

The profile of the participants was characterized on sociodemographic data. The study participants were aged between 30 and 60 years, seven female and eight male. As for the profession: eight were criminal police officers, four nurses, two technicians and one nursing assistant. The minimum working time at PCTH was one year and the maximum was eleven years. Most had complete university professional training and different levels of post-graduation, with the exception of nursing technicians and assistants only. The data analyzed resulted in two categories, namely: 1) Possibilities and limits for welcoming people as a safety measure; 2) Perceptions of professionals about PCN.

Possibilities and limits for the embracement of people in a safety measure

In this category, the professionals highlighted, as a possibility to better welcome people in a safety measure, the fact that the hospital receives private donations, which are coordinated by the social worker. PCTH receives donations of food, clothing and footwear, within a predetermined schedule:

[...] We have an institution that reaches out to us at parties. Our social worker has contact with several partnerships such as supermarkets, which all week (?) leaves our vehicle for the supermarket and collects fruits and other food (I1).

[...] we received clothes. Then, people choose the clothes they want, the shoes, two pants, a pair of shorts, two T-shirts and go home. So they are very well assisted here [...]. (I3)

The situation of family abandonment of the person in a safety measure is an immutable circumstance, triggered by hospitalization. In this scenario, they highlighted that they seek to fill this shortage by supporting this population with food supplies:

[...] when I saw that he needed it and no one could do it for him, I started doing it [...] sometimes, I take

my car and come here in the lobby and leave a bag with cookies, with soda [...]. (I2)

The participants revealed that prevention and health promotion actions in the PCTH can welcome people in safety measures, as well as covering hospitalized individuals, they also involve professionals. The habit of smoking, for example, was decimated from the place, contributing to improve the quality of life of these people:

We extinguished the cigarette in here. The cops, the vast majority, also got to stop. The work that was done with the patients at the time was taken advantage of, and they adhered to the treatment as well [...]. (I4)

They portrayed that the qualification of the hospital spaces provided opportunities for their use for educational, sports and leisure activities:

[...] we have several therapeutic activities. We have physical education, pilates, basketball, football, volleyball, tennis, capoeira, film workshop, narrative workshop, assembly with patients, [...] hygiene group with nurses and nursing technicians, we have an occupational therapist who develops various activities. (I7)

[...] here we celebrate with families; there is a Christmas party, a June party and an Easter party, interacting with the patient and the family [...]. (I6)

The health status of people in a measure of safety, already fragile because of the disease, requires continuous work by professionals to prevent risks. In this perspective, the professionals mentioned that acting in a preventive way and encouraging this population to participate in the proposed activities is a fruitful strategy for care:

[...] try to have this perception of acting preventively, already knowing when the patients are altered, seeing, sometimes, by their attitudes, we can see if they will commit any physical aggression, sometimes with another patients, or with someone who is disturbing them. So, intercede whenever possible, preventively" [...] and their health is to collaborate, encouraging them to do physical activities, to participate in workshops and try, on a daily basis, to have a dialogue with them. (I5)

The professionals also revealed, in this first category, some limiting factors for the care of people in a measure of safety, such as the need to transfer to other places, as a result of the various diseases that involve these individuals:

[...] When we need to take someone to another hospital, we take the patient and go with him. Then go talk to the nurse, to the boss. We have been and spent more than hours waiting for service [...]. (I9)

They pointed out that the limited permanent education, together with the professionals who work at PCTH, is a limiting factor added to constant substitutions. There is a need for greater training to attend the PCTH and longer service time of these professionals, avoiding leaving after two years of work:

Another very great difficulty for nurses is that every two years they leave. When you start bonding, you leave, so it's hard. The criminal police also, because he leaves, goes to another place, and comes from another; they come from a prison. So, there should be a competition for a criminal police officer specific to this hospital and training to work here [...] and as much as we want the police officer to stay, the exchange for a police officer who was previously working in the penitentiary ends up prevailing. (I8)

Another difficulty is related to the conditions of vulnerability of people in a safety measure, which varies according to their origin and social environment. The lack of support from the family at the time of hospitalization generates several complications, since, in most cases, the crime happened against a family member. Such a situation requires the work of the entire team to promote greater interaction between the family and the person in a safety measure:

First the family does not accept the disease, does not accept that he is sick. From the moment the family accepts that he is sick, there is a whole work of psychology, social work, nursing, seeking this family to start visiting this person. (I4)

Another issue evidenced is associated with the care of the egress, requiring the constant displacement of the professional, which makes it difficult to coordinate actions and control risks, as well as the investment of time:

The vast majority of therapeutic residences, of the communities that absorb our patients are from the countryside cities. Professionals need to leave here and go to other institutions, to another state and it is difficult to coordinate this. (I12)

In the second category, which addressed the perceptions of professionals about PCN, it was evident that the monitoring of the public health network is not yet linked to the needs of the person

in a safety measure. The assistance provided is usually insufficient and lacking in solutions that can meet his needs:

The hospital has partnerships with public companies, with private companies, of course there is the SUS network, which we use in basic units, medium and high complexity hospitals. However, the network is still very flawed; for example, the mental health network is almost non-existent here [...]. (I11)

To welcome people as a safety measure, the municipality should adhere to recent prison health policies. In this way, the demands would be met by the prison health teams:

The network outside is meeting the demand at that time, but also in the prison system, the municipality could have already joined the prison health policy and have health teams within the hospital. Then, it would solve the problem at the root. And here, there could be trained professionals, who would not be working on a contracted basis for two years. (I1)

Another worrying situation reported is about the fragile support network offered by families, as well as the scarce monitoring of psychiatric treatment prescribed for people in the community, and the lack of protection also favors the individual to commit crimes:

[...] there is lack of care in the health network that makes the patient arrive here [...] they do not find support from the family, or from anyone. (I12)

[...] this patient does not take medication, is not supported by our mental health network and ends up committing a crime. (I14)

Also noteworthy are the difficulties that patients have when they are referred to PCN. This place is considered a place of reference and treatment for people who suffer from severe and persistent mental disorders and often do not receive intensive, personalized care according to their demand.

[...] Many of them could be in the PCN, but there is no preparation to be in the PCN, because the professionals there cannot even attend to patients from abroad. (I11)

## DISCUSSION

There are two pillars that support mental health care based on psychosocial care: the elaboration of shared strategies aimed at coping and the

empowerment of people deprived of liberty in their families, considering the rescue of daily life, their particularities, self-esteem, as well as devices offered in different social contexts<sup>(17, 18)</sup>.

The safety measure defines the person as "criminal and sick" through a judicial sentence. Nevertheless, this measure can only be issued for a certain time, and is called cessation of dangerousness, which allows the continuity of treatment in community services of the mental health network<sup>(19,20)</sup>. This design proposes hospital-centered disruption, in order to favor network care, with the establishment of new care models, in which the person from a safety measure can be considered in an integral and individual way. Thus, the condition of being mentally ill or incommunicable is removed, inside or outside the PCTH<sup>(21)</sup>.

The legitimate purpose of PCTH gives rise to several controversies in the field of health, due to the dual function it performs: treating and custody. Given this legal and hospital situation, PCN, together with the health teams, have standards of care based on the disease of the "crazy" offender, which is opposed to the current health policy<sup>(21)</sup>.

The challenges for the consolidation of PCN are endorsed by realizing the limited coverage of community mental health care services. *Law No. 10.216/2001* proposes redirection, but there is no legal document providing goals for the implementation of these services. In addition, recent regulations authorize psychiatric hospitals to offer community services and even integrate the network with the offer of the traditional hospital bed service that was initially sought to replace<sup>(22)</sup>.

For the proper functioning of PCN, human, financial and physical resources are required. They must provide appropriate devices in the territory of coverage, developing actions of promotion, prevention, diagnosis, treatment and rehabilitation. Technological resources are also needed, such as the information system articulated to the components of the network with intersectoral action for the continuity of comprehensive care<sup>(23)</sup>.

Another factor to highlight is that the PCTH emerge as the only entity capable of assisting the person in a safety measure, who is prevented from developing in his social and family environment, which violates the right granted by the Law. Thus, it is worth reflecting that this population lives institutionalized and also coexists with a disease that stigmatizes and judges it<sup>(19)</sup>, which reveals,

once again, the urgency of greater training of professionals who welcome this public in PCTH.

Care practices that are based on disease, dangerousness, and safety measure reduce the opportunity for deinstitutionalization. People in a measure of safety and their families, when devalued in the hospital public health network and in the PCN, bring as a consequence the loss of the individuality of the being, keeping them in a condition of vulnerability<sup>(20,24)</sup>. These care practices focused on the hospital-centered model emphasize that the "crazy offender" must be kept "under control", avoiding harm to society. On the contrary, health promotion as a care practice responds to actions that deal with people's conditions of vulnerability when they consult the health network<sup>(25)</sup>.

Currently, PCN teams discuss therapeutic strategies to meet the current regulations of the process of deinstitutionalization and reintegration of the person into society<sup>(26,27)</sup>. However, the difficulties expressed by the lack of partnerships with PCN lead to the chronicity of the disease, which intensifies the family relationships previously weakened by the disease and the crime<sup>(28)</sup>.

In the state of Goiás, people in a safety measure are assisted with the Program for Integral Attention to the Crazy Offender (PAILI). This is a current strategy in the search for compliance with policies, being an experience that is opposed to the difficulties exposed in other realities of Brazilian states<sup>(11)</sup>. PAILI questions the setback of health promotion policies and highlights the efforts to replace the previous madhouse logic, which results from the competence of teamwork, with the scope of transforming outdated hospital-centered practices<sup>(4,11,29)</sup>.

The reality of people in a safety measure still needs several investments, one of the ways being the reconciliation with health promotion strategies. The mental health reform, since 2001, emphasizes the search for autonomy and well-being of people in mental suffering and PAILI is an experience that is positioned as a paradigm that can be replicated in the fight against the segregation of this population<sup>(30)</sup>.

The changes in the National Mental Health Policy and in the Guidelines of the National Policy

on Drugs contribute to the dismantling of the health reform, generating a setback with the establishment of guidelines for the care of people in mental suffering, by offering Electroconvulsive Therapy (ECT) as a treatment based on scientific evidence. This situation becomes a return in the fight against madhouse, in an attempt to keep the hospital-centered culture above human rights and awareness<sup>(7)</sup>.

The National Human Rights Council has an important role in the performance of care policies in the logic of psychosocial care for the human rights of people who are sometimes vulnerable in PCTH. However, there are still limits to the transformation of this reality in several states of the country, seeking to guarantee the embracement of people in a safety measure and legal assistance as a right<sup>(14)</sup>.

The limitation of this study is the difficulty in reconciling the time to carry out the interviews with the professionals who work in the PCTH, and the only possible moment on the agenda was precisely the lunch time of these servers, given the intense work they had. In the field of Health and Nursing, this study instigated reflections on the need for greater training of professionals to work in the area of mental health in a humanized and integrated manner, especially for the population in terms of safety. It also revealed the relevance of intersectoral actions for the health care of this population, involving the health and safety sector.

## FINAL CONSIDERATIONS

PCTH are still considered as prisons, unaware of their legitimacy of belonging to PCN. However, there are efforts by professionals to better welcome and preserve the integrity of people in a measure of safety, contributing as a source of support in the face of family instability. The binomial "nursing-safety" is located in front of its antagonist, the "criminal patient", as a singular paradigm of care.

The security measure must be understood by professionals who work in PCC (Psychosocial Care Center) and throughout PCN (Psychosocial Care Network) as a penalty that has an end, and it is essential to separate the disease from the offense to achieve embracement with an individual and integral look at this population.

## RESUMO

**Objetivo:** conhecer as percepções dos profissionais que atuam no Hospital de Custódia e Tratamento Psiquiátrico sobre o acolhimento às pessoas em medida de segurança na Rede de Atenção Psicossocial. **Método:** estudo exploratório, descritivo e qualitativo. Participaram 15 profissionais atuantes em um hospital, na região Sul do Brasil. Realizaram-se entrevistas semiestruturadas entre maio e junho de 2019. Os dados foram analisados através da análise de conteúdo. **Resultados:** identificaram-se duas categorias: Possibilidades e limites para o acolhimento das pessoas em medida de segurança; Percepções dos profissionais sobre a Rede de Atenção Psicossocial. **Considerações finais:** o trabalho em equipe entre o setor da saúde e da segurança contribui para o acolhimento. A medida de segurança deve ser compreendida pelos profissionais que atuam na Rede de Atenção Psicossocial como uma penalidade que tem um fim, tendo a necessidade de separar a doença do delito para alcançar o acolhimento com olhar individual e integral a esta população.

**Palavras-chave:** Acolhimento. Medida de segurança. Assistência à saúde mental. Atenção à saúde. Enfermagem.

## PERSONAS EN MEDIDA DE SEGURIDAD EN LA RED DE ATENCIÓN PSICOSOCIAL: PERSPECTIVA DE LOS PROFESIONALES

### RESUMEN

**Objetivo:** conocer las percepciones de los profesionales que actúan en el Hospital de Custodia y Tratamiento Psiquiátrico sobre la acogida a las personas en medida de seguridad en la Red de Atención Psicosocial. **Método:** estudio exploratorio, descriptivo y cualitativo. Participaron 15 profesionales actuantes en un hospital, en la región Sur de Brasil. Se realizaron entrevistas semiestructuradas entre mayo y junio de 2019. Los datos fueron analizados a través del análisis de contenido. **Resultados:** se identificaron dos categorías: Posibilidades y límites para la acogida a las personas en medida de seguridad; Percepciones de los profesionales sobre la Red de Atención Psicosocial. **Consideraciones finales:** el trabajo en equipo entre el sector de la salud y la seguridad contribuye a la acogida. La medida de seguridad debe ser comprendida por los profesionales que actúan en la Red de Atención Psicosocial como una penalidad que tiene un fin, teniendo la necesidad de separar la enfermedad del delito para alcanzar la acogida con un enfoque individual e integral a esta población.

**Palabras clave:** Acogida. Medida de seguridad. Atención a la salud mental. Atención a la salud. Enfermería.

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