

The performance of health professionals in a custody and psychiatric treatment hospital: the perspective of the psychosocial rehabilitation¹

Eline Vieira da Silva^a, Mara Cristina Ribeiro^b, Marilya Cleonice Santos de Souza^b

^aHospital das Clínicas, Universidade Federal de Pernambuco – UFPE, Recife, PE, Brasil.

^bUniversidade Estadual de Ciências da Saúde de Alagoas – UNCISAL, Maceió, AL, Brasil.

Abstract: Introduction: The Brazilian Psychiatric Reform proportionated the appearance of mental health attention services and substitutive services in psychiatric hospitals that provided the inclusion based on the Psychosocial Rehabilitation strategy. Although the Custody and Psychiatric Treatment Hospitals (CPTH) are one of the services that must be included on the set of those transformations, actions against the Psychiatric Reform are still happening, which indicates the necessity of important changes. Objective: This paper has the objective to recognize how a CPTH team articulates with the new propositions recommended by the National Policy of Mental Health Attention and analyze if the interdisciplinary actions are being developed on the institution. Method: Research developed in a CPTH, as a qualitative analysis through interviews with 11 higher educated professionals for the data collection, examined by thematic analysis. Results: The lack of communication and understanding of the need for teamwork leads to individualized actions and disarticulation in the care, evidencing actions committed to the institutional needs and not to the needs of the patients; the speeches highlight the lack of activities aimed at the reintegration and social participation of inmates in the family and community. Although professionals claim to know the concept of Psychosocial Rehabilitation, many attribute a misleading sense, indicating it as an approach to the asylum model that aims to occupy the inmates to reduce institutional idleness. Conclusion: The articulation between the professionals of the place is fragile, which prevents the actions to be carried out in an interdisciplinary and intersectoral manner, maintaining ducts in the asylum model. Occupational Therapy can act as a protagonist of changes, contributing to the achievement of objectives consistent with the Psychiatric Reform, facilitating care processes based on Psychosocial Rehabilitation.

Keywords: *Mental Health, Occupational Therapy, Deinstitutionalization, Mental Health Services, Health Care Reform.*

O cuidado e os processos de trabalho em um hospital de custódia e tratamento psiquiátrico sob a perspectiva de seus trabalhadores

Resumo: Introdução: A Reforma Psiquiátrica oportunizou o surgimento de serviços de atenção substitutivos aos hospitais psiquiátricos que proporcionassem a inclusão com base na estratégia da Reabilitação Psicossocial. Os Hospitais de Custódia e Tratamento Psiquiátrico ainda preservam ações contrárias à Reforma, indicando a necessidade de mudanças. Objetivo: Identificar os processos de trabalho desenvolvidos pela equipe de um desses hospitais e construir uma reflexão crítica acerca das possíveis contribuições da terapia ocupacional na instituição. Método: Estudo de abordagem qualitativa desenvolvido por meio de entrevistas com 11 profissionais de nível superior analisadas com a técnica de Análise Temática. Resultados: A falta de comunicação e do entendimento da necessidade do trabalho em equipe provoca ações individualizadas e desarticulação nos cuidados, evidenciando ações comprometidas com as necessidades institucionais e não com as necessidades dos pacientes; as falas destacam

Corresponding author: Mara Cristina Ribeiro, Universidade Estadual de Ciências da Saúde de Alagoas, Rua Dr. Jorge de Lima, 113, Trapiche da Barra, CEP 57010-300, Maceió, AL, Brasil, e-mail: marauncisal@yahoo.com.br

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a falta de atividades voltadas à reinserção e participação social dos internos na família e comunidade; apesar de os profissionais afirmarem conhecer o conceito de Reabilitação Psicossocial, muitos atribuem um sentido equivocado, indicando-o como uma abordagem do modelo asilar que visa ocupar os internos para diminuir o ócio institucional. Conclusão: A articulação entre os profissionais do local é frágil, o que impede que as ações sejam realizadas de forma interdisciplinar e intersetorial, mantendo condutas prioritariamente no modelo asilar. A terapia ocupacional pode atuar como protagonista de mudanças, contribuindo para o alcance de objetivos condizentes com a Reforma Psiquiátrica, facilitando processos de cuidado alicerçados na Reabilitação Psicossocial.

Palavras-chave: *Saúde Mental, Terapia Ocupacional, Desinstitucionalização, Serviços de Saúde Mental, Reforma dos Serviços de Saúde.*

1 Introduction

In Brazil, the first place specifically for the imprisonment of the insane person who committed crime and the criminal who went mad in prison was the Judicial Asylum, inaugurated in the city of Rio de Janeiro in 1921.

The concept of criminal imputability emerged in the Criminal Code of 1940, which is still in force today. In this, security measures were incorporated as an innovation, however, the system adopted at the time was double-binary, in which the same individual could receive deprivation of liberty and security measure. Law nº 7.209, of July 1984, which modified the Criminal Code, entered into force the former system, establishing that an individual can receive penalty or security measure, according to the characteristics of each case, but never the two simultaneously (CRESPO DE SOUZA; MENEZES, 2006).

The security measure may determine hospitalization or outpatient treatment, depending on whether the crime is grieved with incarceration or detention. In the case of hospitalization, it has been considered a solution of a preventive and assistance nature, being reserved to individuals considered by the courts to be unmanageable, that is, those who due to mental disorders or cognitive deficits were at the time of action or omission completely unable to understand their illicit character, or to be determined according to this understanding (COHEN, 2006).

The Hospitals of Custody and Psychiatric Treatment (HCTP) denominated more recently in substitution to the Asylum Judiciary, acting like an ambiguous institution, transiting between justice and health. This ambiguity can be attributed to the characteristic of the institution, which has the legal and penal guidelines in its foundations, since

[...] it is governed not by laws and decrees that govern the health field, but by Law nº 7.210

of 1984, that is Criminal Enforcement Law, which governs the entire Brazilian penitentiary system (SOUZA, 2014, p. 629).

In this way, justice and mental health are articulated in the attempt to seek a common language, an adequacy, an organization to the multidisciplinary proposal.

In the late 1970s, a social movement called the Brazilian Psychiatric Reform was awakened, anchored in the changes in progress in Europe and the United States, which started to question the treatment directed to those who needed care in psychiatric care. One of the objectives of this movement was to end the psychiatric hospitals that segregated a group of people from the social community. In this perspective, the movement facilitated the emergence of substitutive services that provided for inclusion and were based on care through Psychosocial Rehabilitation (RIBEIRO; BEZERRA, 2015).

From Law nº 10.216 of 2001, also known as the Law of Psychiatric Reform, the National Mental Health Policy starts to stimulate the creation and expansion of community-based, open services for the treatment of mental disorders.

Therefore, the hospitalization is considered as the last resort to be offered to treatment and even considering the safety measure, it should only occur under the medical recommendation attesting to its need (SILVA, 2010).

Currently, with the establishment of the Network of Psychosocial Care (RAPS), through ordinance nº 3,088 of 2011 of the Ministry of Health, the creation, expansion and articulation of health care points for people suffering or mental disorder are intensified, which may mean a further advance in the field of protection and guarantee of the rights of people with mental disorder who committed some crime, when we consider that one of their objectives is to overcome the care model centered

in the Judicial Asylum, guaranteeing dignified and quality treatment to the insane offender (SOARES FILHO; BUENO, 2016).

By these norms and the transformation movements of mental health care, HCTP should be progressively replaced by other devices, and care should be provided in Outpatient and Psychosocial Care Centers (LIRA, 2016), from the point of view of Psychosocial Rehabilitation.

According to the World Health Organization (ORGANIZAÇÃO..., 2001), Psychosocial Rehabilitation is configured as a process of offering opportunities to people in mental suffering, with the objective of promoting independent functioning potentials in the community. This process involves the development of individual skills and environmental changes.

With the important task of restructuring the care of individuals suffering from psychic suffering within the perspectives of Psychosocial Reform and Rehabilitation, health professionals should understand the importance of interdisciplinary work.

Despite being considered difficult, the interdisciplinary work allows the work to be performed in a lighter way due to the co-responsibility of the professionals (ZGIET, 2013) in front of the intended results. Therefore, the rehabilitation of these individuals must be carried out by a multidisciplinary team in intersectoral and interdisciplinary actions, so the individual in psychic suffering reaches his highest level of contractual, ensuring (re) insertion in their territories of life.

Therefore, the Psychiatric Reform and the use of the Psychosocial Rehabilitation strategy indicate important changes in the work processes developed within mental health services. Thus, when we deepen our understanding of these transformations, it is not possible to construct critiques of psychiatric hospitals that are not related to HCTP as institutions that are part of this group and that, therefore, are also characterized as being necessary for the reforms advocated in the new models of attention.

Exclusion must be removed from the whole context that involves the new paradigms of mental health, since it operates against everything that involves a real rehabilitation in the psychosocial field, because it is necessary to assume that the process of transition from the asylum model to the community model is time-consuming and fragile, since these models coexist with their political, ideological and social forces (RIBEIRO, 2015).

Based on these reflections and having the Psychiatric Reform and the Psychosocial Rehabilitation strategy

as theoretical references, the proposed research covered the work processes within one of the institutions of care for people in mental suffering that is still maintained in foundations known to be focused on exclusion and the asylum model.

This study aimed to identify the work processes developed by the HCTP team and to verify if these processes, in any way, have been articulated to the new proposals advocated by the National Mental Health Care Policy. It also sought to analyze whether interdisciplinary and intersectoral actions are developed and, based on these results, it sought to construct a critical reflection about the possible contributions that occupational therapy can offer to the institution within the theoretical references in which the study is embodied.

The research was submitted to the Ethics Committee in Research and approved on December 2, 2014, under CAAE number 38396514.1.0000.5011.

2 Method

The methodology used to make the challenge of the study feasible was the qualitative approach, as it allows the research of the mental health area to emerge the social and subjective meanings related to the subject, as Flick (2009), indicates, allowing to study the knowledge and practices of the participants, considering the different perspectives and social contexts related to them.

The research was developed in a Hospital of Custody and Psychiatric Treatment (HCTP) of a capital of the Brazilian Northeast, being the only service responsible for the reception of people with mental disorders who committed crimes and also those who developed mental disorders during the time of detention in prisons.

During the period of the survey between September and December 2015, the HCTP had a total of 82 inmates, divided into two categories: those that complied with a security measure, a total of 38 individuals, and sub judice or provisional population, with 44 individuals. The inmates with the longest incarceration had a history of 26 to 30 years of hospitalization and had no indication of discharge. Regarding the professionals responsible for care, the team consisted of 5 psychologists, 4 social workers, 5 physicians (3 psychiatrists and 2 general practitioners), 2 nurses and 12 nursing technicians.

The individuals of the study were the professionals of the institution who represent the group of workers of higher level of the health area and other

professionals who developed actions directly with the patients and helped to reach the objectives of the investigation, although they did not compose the health team. Thus, the higher level workers who were, directly involved in the care of the patients at the time were included.

The instrument chosen for the production of the data was the interview technique because it allows the possibility of obtaining free and spontaneous considerations of the interviewee. To that end, the professionals who accepted to participate in the study were invited to read the Informed Consent Term (TCLE), and the interview started only after all the clarifications about the research and their signature.

As a way of organizing data production, a guideline was drawn up by the researchers, which allowed the approach to issues considered important for the theme. The interviews were recorded with the permission of the participants.

For the analysis of the material collected, the Content Analysis technique was used, in the thematic modality. In this way, all the operational steps have been fulfilled, as Minayo (2010) guides: Pre-Analysis, Material Exploitation, Treatment of Results Obtained and Interpretation.

Trying not to reveal the identity of the respondents in the presentation of the results, they were organized with letters of the alphabet (A, B, C, D, E, F, G, A, B, C, and D, H, I, J and K) and not differentiate them by the professions.

3 Results

There were eleven workers interviewed, nine from the Health area, one from the Law area and another from the Public Administration area. The categories of Health part of the research were: Nursing (2), Psychology (2), Social Work (2) and Medicine (3).

Regarding the characterization of the interviewed workers, the study showed that the average working time in the institution was 1 year and 7 months, with a minimum of 1 month and a maximum of 9 years. Six of the 11 professionals interviewed were female. The average age was 35 years old, with a minimum of 30 years old and a maximum of 72 years old.

From the analysis of the interviews, the following themes were outlined: 1) Professional actions developed at the institution; 2) Objectives of the institution and its ambivalences; 3) Psychosocial Rehabilitation and its theoretical-practical ignorance in care actions.

3.1 Professional actions developed at the institution

When they were asked about the actions developed specifically by each professional category, it was possible to detect some common activities, especially among non-medical health professionals and others quite specific to each area and category.

We provide care to the patient and the family and raise awareness of their importance to the success of treatment (B).

Individual care for the patient, the family, and some assignments related to the profession, which is the interview and the home and institutional visits [...]. (F).

I analyze the legal situation of patients and re-educators because it has the re-educators who come for treatment and others who already take security measures, which is a more definitive situation (H).

When questioned about actions developed in partnership with other professionals, it was observed the presence of two very different groups. Group one (G1), with professionals of Psychology, Social Service, and Nursing, presenting articulation in front of some actions developed in the service:

The activities that we develop are meetings and consultations with the family and the patient. It is a team service: psychologist, social worker, and Nursing (C).

We work together because my work alone will not have any effect [...]. The activities we carry out together are the fortnightly meetings with the family to show the importance of their presence to inform the new changes (B).

Group two (G2) with the other professionals who participated in the study, seems to work in an individualized way, with the goal of fulfilling specific professional obligations.

I take care of the clinical part and there is only me, so I practically work alone (I).

I have developed here administrative activities, medical management and in the area of medical expertise (D).

Therefore, G2 professionals have the accomplishment of the assignments of individual form as a characteristic, not existing the sharing of knowledge.

This dichotomy is not restricted to professional activities, but it extends to institutional ones at times,

as evidenced by talking about team meetings: while some claimed that it happened every fortnight (G1), others said that attendance was monthly, and still, others were unaware of such activity:

Because they are not predetermined, meetings occur whenever necessary, for example, if I understand that I need to discuss a case with a colleague, then we have access to this discussion, there is no timetable, no set date for it (K).

Meetings happen fortnightly because we need to meet to articulate the next meeting (F).

They happen once a month (D).

In the face of the interviewees' speech, the lack of information relevant to the team of workers regarding the actions that should be developed in the institution is noted.

The topics covered in these meetings deal with the situation of inmates, medications, care for family members and legal issues.

3.2 Objectives of the institution and its ambivalences

When the participants were asked about the objectives that the institution wants to achieve, the answers highlight the ambivalence of the institution. Some point out objectives related only to the assistance offered in the institution:

The purpose of CPJ² is to provide medical and multidisciplinary support to follow up while you are here (I).

The quality of stay of these patients who stay here (H).

Others point to the objectives from a legal perspective:

The basic function here is: prisoners who have committed crimes outside but who have disorders cannot live in normal unity, they should come to CPJ. [...] then, the purpose here is only to separate prisoners who have no disorder from those who have (G).

Here is a Judicial Asylum where people are by court order, they are here to pay their penalty and be assessed if they really have mental sanity. They are here for this, to pay their penalties, and CPJ's purpose is to provide medical and multidisciplinary support to follow up while they are here (I).

It is interesting to point out that there are those who perceive this ambivalence in the nature of the institution and point it out when they think of the objectives to be achieved:

As the mental health and procedural are together, the mental health wants to achieve the improvement of the patient, the stabilization of the pathology so he returns to live in society, the continuation of his treatment in the CAPS, taking his medicines, this is the intention: to return that patient better to society. As it is a Psychiatric Judicial Center, the issue of penalty is seen, but the focus is on mental health, it is the improvement of the patient (A).

In the analysis of the interviews, there were also those who mentioned the objective to return the individual in psychological suffering to the social and family life. However, it is noticed the difficulty of some professionals in developing these actions aimed at Psychosocial Rehabilitation.

I've never worked in mental health, so sometimes I have a hard time because I'm used to working in other units. In the service you see progress, but here at CPJ progress is sometimes too slow. Sometimes I get an improvement in a care and it seems that they delay two, so because of this there is the difficulty in this process due to the disorder, the hospitalization, the abandonment, everything that involves the patient. My work is a bit more complicated [...] (G).

First resocialization, but you need a long job because she is still very shy, the idea goes through many protagonists who are not prepared for the National Policy of Mental Health Care, many of them are in the asylum model. The product of the hospital is the discharge through the medical report, my thoughts are this, it is very difficult because I do not want to be conniving with asylum treatment (J).

This characteristic of ambivalence that the Hospitals of Custody and Psychiatric Treatment (HCTP) exert can be perceived when some workers cannot really determine the purpose of the institution.

I do not know! It is difficult to talk about it because here it is not a hospital, the name itself is, but we see that there is nothing as a hospital here [G].

When asked about the objectives effectively achieved, the possibility of bringing some family members to the treatment was mentioned. However, the prevailing discourse was the activities focused on simple medical care, compliance with legal and assistance issues.

What we achieve is the demand for reports (K).

At least the purpose of medication and feeding is achieved, follow-up with the psychologist and psychiatrist as well because outside the institution they do not have due to the structure and education level of the family, who often do not know how to seek their rights (B).

3.3 Psychosocial rehabilitation and its theoretical-practical ignorance in care actions

When asked if the institution performed actions in the perspective of Psychosocial Rehabilitation, it was noticed the difficulty of understanding some workers about what this approach represents.

It develops, thus [...]. That is what I am telling you, it depends a lot because sometimes they do therapeutic and handicraft work, but often there is no material (E).

There is a room that they are painting, making handicrafts [...]. The activities concerning Psychosocial Rehabilitation, they are seen by psychologists, by the psychiatrist is seen once in the week (I).

Yes, there is a very beautiful work here of yoga and music (J).

In these affirmations, it was possible to verify the association of this strategy with the occupation of institutional idleness, which, according to these respondents, could be solved by hiring the occupational therapy professional.

So, I think I needed an occupational therapist. There is a sector that has a machine to do Physical Therapy activity, but it does not have the professional (E).

Besides associating Psychosocial Rehabilitation with occupation and distraction activities, there were those who attributed this function to other professionals, noting once again that they are unaware of their real objectives.

I do not know if it works, but it develops. There is the psychosocial team that works in this perspective, somehow collaborates with the improvement of these people. There is also the team of craft activities, in short, the goals are always to improve the patient, now, in fact, we do not have a statistic telling whether this cooperated or not (F).

However, others associate with the qualification of therapeutic work.

So the Social Service and Psychology develop the individual care well, but it is missing the group part, the interaction, the part of discussing with them the disorders. This part of the group is missing and the part of the therapy doing something, which is to close this part of the psychosocial (A).

Some of them present a more critical position, admitting the non-existence of actions of Psychosocial Rehabilitation.

The connection with the CAPS in the interior is our only rehabilitation: the referral. A work that develops this part we do not have (B).

No, just medication. That is the truth! (W).

Within the activities developed, there is no strategy of inclusion of the inmates in activities in the community during the treatment, all the activities are carried out within the institution and they are limited to general services such as gardening, weeding and carpentry:

It does not exist! I can assure you it does not exist (J).

There are activities here at CPJ. They work here in the cleaning, gardening, that stuff... general service work [...] (H).

Regarding the activities of inclusion or integration of the inmates with the family during the treatment, although the biweekly meetings with family members are held as the main strategy, are the difficulties they face to reach this goal stand out in the interviewees' speech, as seen that some of them have committed the crime against their own family and, therefore, acceptance becomes more difficult:

There is an attempt [...] if it is already difficult to insert the patient into the family, it doubles when he committed a crime against a relative. There are families and families... there are some that accept and others not (J).

There is a visit, but many relatives do not come, so this family relationship is somewhat impaired in my point of view, because many of them live far, live in the interior and cannot afford a transportation to come and because, also, they have no interest to come, since the patient usually commits the crime against his own family [...] (H).

One highlighted point is that despite efforts to raise awareness of the importance of their presence and support in the treatment and rehabilitation of inmates, some interviewees affirmed that there are no activities in the institution aimed at inclusion

in the family environment in the pre-discharge period. Faced with this, affective relationships are weakened by the lack of actions aimed at reintegrating into the family. However, another factor that contributed significantly to the difficulty exposed by the workers was perceived. According to some interviewees, discharge is a decision that passes between the psychiatrist and the justice, and there is no communication with the rest of the team:

The discharge is made by the psychiatrist along with justice. Sometimes we only know when the patient is hospitalized and we have to get in touch with the family. Sometimes it does not aggregate and we stay a bit out there [...] (F).

It is an initial medical decision and then a legal one, unfortunately, it is not having a discussion [...] (A).

With this, the professionals are not informed about the discharge of the inmates and are unable to carry out interventions aimed at the reintegration into the family. Thus, some respondents stated that failure to carry out activities in the family environment was attributed to the lack of communication between the team:

No, because we do not know when they will be discharged, everything depends on the judge, when CPJ forwards the report to the judge, he is the one who decides if he is going to discharge, if he will apply the security measure, then we do not know either [...] (B).

The patient is here, suddenly arrives the license determined by the judge, to the delivery direction and that's it, he leaves and he does not have any programming (C).

Activities of inclusion of inmates in health services in the period before discharge also do not exist in the institution, according to some interviewees. As discharge is a medical and legal decision, not shared by all staff, articulation with health services becomes a problem, since professionals do not know who will be discharged:

It does not exist, because the discharge comes and we know it on the day, at the time the patient was discharged, that the patient is on leave and has to leave. There is no way to prepare the patient to leave CPJ. It's a lot like that, from the moment (E).

Some interviewees also stated that they did not articulate the institution with the RAPS; however, others stated that there was a communication, but

indirectly, only to warn of the arrival of the inmate in a certain service that belongs to a psychosocial care network. Also, it was possible to observe the dissatisfaction with the obstacles found in the service to carry out these actions:

The contact is by the phone and when the patient leaves he takes the declaration and the referral to the CAPS of the city where he lives (B).

No, what does exist is: if some of the techniques meet someone who works at CAPS, they connect and communicate that a new patient is coming. The network is more like this, more the desire to really want the patient to stay there and not come back. But it does not have this network, because nobody comes here to find out from CPJ, we have the greatest difficulty to have a car to visit a CAPS and prepare a lecture, if in case the patient went there, unfortunately (G).

Some statements indicated that there is no follow-up of the graduates, other than that they are accompanied by the psychiatrist only when the judge determines the term of return to the institution to be evaluated and to pick up medications. It also determines if the patient should attend some extra-hospital service:

When patients leave CPJ, they return to get medication and to be analyzed by the psychiatrist, but they do not pass through us, only by the psychiatrist (G).

Yes! Generally, the judge determines that for one year the patient returns to CPJ monthly to be accompanied by the doctor and also to sign in the judge, but not all. This determines the judge (B).

4 Discussion

The first main issue to be discussed is the disarticulation of the care verified in the interviewees' speech. It was possible to perceive that the professionals seek to carry out effective care actions. However, the lack of communication between the workers and the fragility of the teamwork provoke individualized actions. Also, the organization of the work developed seems to be focused on the institutional needs and not the needs of the inmate.

Boccardo et al. (2011) argue that to overcome the fragmentation of knowledge and professional specificities, it is necessary that teamwork build articulated and integrated care practices, and only in this way the real needs of the people served can be answered.

When analyzing mental health care actions, it is important to note that services should offer interdisciplinary and intersectoral assistance. Nevertheless, detaching from his field of knowledge and seeking new knowledge does not always please professionals, who are accustomed to the asylum model in which each professional is restricted to his field of knowledge.

Zgiet (2013, p. 314) states:

Mental health work is usually a challenge because it is marked by frustrations ranging from the chronification of the patient's illness, which is intended to be treated until the work process cannot be controlled. The way in which the services are organized and the expectations regarding the relationship of the servers with the patients are also factors capable of corroborating the daily difficulties of the professionals.

The study shows that this difficulty of integration of knowledge and actions is even more intense when it comes to services still rooted in a model of psychiatric care in which some professional categories are apart from the decisions and conduct of the treatment. Therefore, even the attempts of a more interdisciplinary work end up ending in frustrating situations.

To change this reality, as suggested by Souza and Ribeiro (2013), professionals must be open to change, adopt a posture of discovery and curiosity, presenting a desire to enrich with new approaches and overcome trajectories already known, winning to like for new combinations of perspectives.

Thus, professionals working in mental health must detach from their field of knowledge and seek strategies to guarantee integral care, observing the social context and centralizing their actions in the needs of the people, fulfilling the assumptions advocated by the National Policy of Mental Health Attention, which has as one of its main strategies of care the Psychosocial Rehabilitation.

According to Ribeiro and Bezerra (2015, p. 305), the work anchored in Psychosocial Rehabilitation causes questions in the work processes and changes in care actions, because:

[...] it removes the professionals from the comfortable place of a restricted clinic - which is understood as the relation of looking at the disease - and places them in the field of an amplified therapeutic action - in which the relation occurs in the skilled listening of the subject and of what he refers to as important

for his treatment, for his relationships and social exchanges, and ultimately for his life.

Therefore, having the statements of our protagonists under analysis, we can affirm that the HCTP professionals studied show the volubility of the activities developed in the institution. The lack of dialogical situations among the entire team ends up collaborating in the segmentation of care, with the disease remaining in the forefront.

This fact can be attributed to its ambiguous sense, which has objectives of psychiatric hospital and at the same time prison unit in its structure and functionality. In this way, there is the presence of health workers and the area of justice, and these two specters are sometimes confused, sometimes divided.

Another issue is related to the disarticulation of actions outside the institution, that is, all "care" is limited to institutional walls, which, once again, shows that the institution has not structured its actions in accordance with the National Policy of Mental health.

When the institution works in an internally and externally articulated way, carrying out interdisciplinary and intersectoral actions, the individual's need becomes the main object of interest of the team, which must seek ways to solve the problems by forming links with the extra-hospital services, guaranteeing the assistance in the different levels of attention. For this, it is necessary an ethical attitude of professionals, who must seek ways to reinsert the subject in psychological suffering in society, prioritizing care in open and community services.

However, when the service does not work in this perspective, the actions are not well consolidated and the objective, which would be the social reintegration of the subject, is not reached, which can often lead to reentry of the inmate in the service.

An important and necessary aspect to be pointed out is that HCTPs are institutions that operate under the exclusive responsibility of the prison system and, although they are called "Hospitals", they keep their work processes under segregation and prison law in the asylum model (SOARES FILHO; BUENO, 2016).

This fact suggests that therapeutic actions are neglected by prison actions, which leads to infer that rehabilitation actions in the institution do not even touch the psychosocial field.

One of the analyses that reinforce this inference is the lack of knowledge of the objectives of the institution by several of the interviewees, showing

that, because health and justice are found, it is unclear the objectives that the institution must fulfill or which ones are the priority actions that must be developed by the professionals inserted there. This reflects in the daily practices, because if the team does not know the objectives of the institution, how will you act in a way that contributes to Psychosocial Rehabilitation?

Hospitals of Custody and Psychiatric Treatment show a heterogeneity and contradiction that reflects, in this way, the practice of their workers, who seek articulation to carry out their duties but run into the ambiguity that characterizes the institution. In this sense, the HCTP is configured as a complex institution, precisely because it functions as a prison and a psychiatric hospital, dealing with the two polarities of discrimination in society: the criminal and the insane. Therefore, the actions that should follow the psychosocial model, to even break with stigmas imposed by society, are not effectively developed in the institution, since the purpose of HCTP is not understood by professionals.

As Souza (2014, p. 630) states:

The collision of worldviews that permeate the Psychosocial Field and the Psychiatric Field and, as a consequence, the conception of the health - mental illness process, which directly determines the health care practices implanted in the attention to the people institutionalized in HCTPs.

There were no studies in the institution under study aimed at the reinsertion and social participation of inmates in the community. Also, as the statements show, there is also no articulation between the team and the RAPS, which makes any rehabilitation process difficult.

The study also points out that team meetings do not happen frequently and, when they do, they do not involve all professionals. The team meetings are fundamentally important for the effective development of patient-centered actions, as they constitute a space for discussion and creation of therapeutic projects that allow the design of a life project that meets the needs of the individual and places him as the main protagonist of the decisions made.

In this sense, Mângia and Barros (2009) affirm that the therapeutic projects materialize and concretize the set of guidelines proposed by the new policy, besides assuring to the individuals a differentiated assistance context promoting quality

of life, surpassing the asylum model and avoiding the institutionalization.

The study also found that there are no activities in the family environment during treatment, only family meetings are held, but these happen within the service.

The inclusion of the family as the protagonist of care would be a very effective strategy for the rehabilitation of the inmate, since it could help in the process of resocialization if it occupied the space of support in the process of rescue of the potentialities of the patient in psychic suffering and promote the (re) creation of more affective bonds in the face of the rupture caused by the crime committed, which is often committed as part of the family, as well as the length of hospitalization that can be prolonged, further eroding affection and coexistence. In this sense, besides informative meetings, actions aimed at the family should be structured in favor of the family-professional-service relationship (COLVERO; IDE; ROLIM, 2004).

According to Cordioli, Borenstein and Ribeiro (2006, p. 672), the HCTPs aim to

[...] treat and recover their inmates, seeking to reintegrate them into the social environment and to guard those individuals who, by judicial determination, have a security measure to comply.

However, despite the fact that reintegration into social life is one of their objectives, they still preserve the character of segregation, so objectives and reality are opposed, mainly because there are no actions based on Psychosocial Rehabilitation.

The study points out that the practices developed in the institution are still mostly as an asylum, and this is visible in the reports about the activities carried out within the institution, which, in addition to not going beyond its walls, they are still very focused on the occupation of idle time and not for the discovery of potentialities and redirection of protagonism and social inclusion.

Saraceno (1996) states that Psychosocial Rehabilitation is not the strategy to enable the "disabled", making strong the weak, but a process that aims to make changes to create possibilities of life and to build full citizenships.

Therefore, the objectives that the institution proposes to carry out escape the objectives that the Psychosocial Rehabilitation proposes, and the technical lack of preparation is also a factor that contributes with unsatisfactory practices.

Psychosocial Rehabilitation is a strategy created within the Psychiatric Reform, with the objective of reformulating the assistance offered in mental health services, constituting as actions aimed at the resocialization, autonomy, independence and the rescue of the contractility of the subject in psychological suffering, so he can live in society and exercise his citizenship. Thus, it should be an approach undertaken by all professionals involved in mental health care.

The research indicated that, although the professionals affirm to know the concept of Psychosocial Rehabilitation, many attribute a misleading sense, understanding it as an approach that aims to “occupy” the inmates to diminish the institutional leisure. Also, some report that psychosocial work must be performed by a single specific professional, who alone is responsible for developing actions in the perspective of Psychosocial Rehabilitation. This position evidences the ignorance of some about the changes brought about by the Psychiatric Reform and the current policy of mental health.

The lack of awareness or distancing of the therapeutic and social insertion objectives are highlighted by some lines that simplify this process, placing it as a process of time occupation and distraction, without a correlative link with the treatment. In this sense, the very mention of inclusion of occupational therapy is displaced from a sense of care, sometimes referred as a Psychosocial Rehabilitation, now placed in a secondary role, as if its presence could alleviate the idle time that institutionalization can cause.

Thus, to fulfill our last but not less important objective, which is to construct a critical reflection on the possible contributions that occupational therapy can offer to the institution within the theoretical references that the study is embodied, the first point is to discuss the ability of the occupational therapy professional to deconstruct this misconception of many team members who understand that Psychosocial Rehabilitation should be an institutional strategy to relieve the inmates of the institutionalization tensions, understanding it as a secondary activity with distracting purposes, which does not involve the work of all professionals responsible for care.

The occupational therapist has been supporting the Psychosocial Rehabilitation strategy for its inclusion in the services and consolidation of its practice, especially since the product of its work - the activities that aim at autonomy and social participation - coincides with Psychosocial Rehabilitation (ALMEIDA; TREVISAN, 2011),

Therefore, their presence in teams still distant from these concepts and practices becomes indispensable for the care of new mental health policies.

We can also mention possible contributions of occupational therapy within the institution, the use of activities in the development of therapeutic workshops, therapeutic groups and individual care, seeking to rescue the autonomy of the patient so he can exercise his free and independent contractual power in the community.

Lopes and Leão (2002) affirm that the occupational therapist seeks to remain open to the process of the other, because of his training, which in relation to other professionals he carries a singular notion regarding the use of activities in his interventions. Occupational therapy has in its historical-scientific formation the knowledge of several disciplines, being a characteristic that differentiates it from other professions and therefore, it makes possible the knowledge of the individual in his totality, that is, considering his context of life and their social relationships.

Thus, the care strategies used by occupational therapy in the field of mental health

[...] are considered in conjunction with other centers of care and possible acts of care, which are produced in meetings with other knowledge and techniques. It is considered, therefore, that there is a network of care and in its totality, directs the processes of psychosocial rehabilitation (ASSAD; PEDRÃO; CIRINEU, 2016, p. 744).

In the context studied, professionals show difficulties to perform psychosocial actions, such as team meetings and activities aimed at reintegrating into the family environment and into the community. In this way, we can also consider that the occupational therapist can contribute to the relationship between the professionals of the team, articulating horizontalized actions that allow the participation of all the actors involved in this process of care, always focusing on the patient in psychic suffering.

The ultimate objective of occupational therapy is social reintegration (BENETTON; MARCOLINO, 2013). In this sense, the occupational therapist who must be included in this service can favor social empowerment and prioritize interdisciplinary and intersectoral actions, breaking with “occupational” and asylum models and focusing care in the psychosocial perspective.

Also, it is known that mental disorder brings several social stigmas, and they can interfere in the rehabilitation process (UEMURA; MARIOTTI; PALM, 2015), especially if consider the long periods of institutionalization that not only intensify these stigmas and can lead to significant losses in occupational performance, making it even more difficult to reintegrate into society.

In the PCTH context, the stigma is more evident, because, besides mental disorder, there is also crime. Sometimes stigmatizing posture is not perceived by the one who has it, often embedded in serious postures and coarse attitudes. In this sense, it is important to work in all contexts where stigma may exist, be it in the community, in the family environment or even in the rehabilitation team, so the suffering individuals can live and live in society without discriminatory labels.

The occupational therapy professional was not included in the rehabilitation team of the service until the end this research. Considering the results analyzed, the work of this professional within the multidisciplinary team is of great relevance, because in the nature of his functions, there is the objective of deconstructing the existing stigmas and promoting the emancipation and social protagonism of the subject, “[...] since he is the professional who seeks the full participation of individuals in the occupations of society and in their social relationships [...]” (UEMURA; MARIOTTI; PALM, 2015, p. 314).

The occupational therapy has been following the changes by the National Mental Health Policy, re-signifying its practices and expanding the spaces where develops its care actions. For this reason, it has abandoned attention models focused on the disease and focused on health promotion, rescuing the citizenship and social participation (ALMEIDA; TREVISAN, 2011).

In this way, if inserted in the services studied, the occupational therapist can act as a protagonist of changes, contribute to the achievement not only of institutional goals, but also Psychiatric Reform and Psychosocial Rehabilitation, and that the processes anchored in the asylum model are effectively replaced by psychosocial work processes.

5 Conclusion

Having the definitions of Psychosocial Rehabilitation as reference in mental health care, the study was able to demonstrate that the actions developed in the service are significantly contrary to this proposition.

The study also indicated that the articulation of the professionals among them and with the other services of the RAPS needs to be strengthened since the distancing of interdisciplinary and intersectoral practices weakens the care and maintains asylum behaviors.

Psychosocial Rehabilitation is the care strategy indicated by the National Mental Health Care Policy for services directed to mental health care, even those with a more closed structure. However, the lack of theoretical and practical knowledge of its assumptions is one of the factors that prevent transformations in the nature and structure of the institution, as well as in the processes of developed works, can happen.

Given this, the study points out that, despite the intentionality of its workers to ensure inclusion and social reintegration of inmates, this goal is still far from being achieved.

If included in the service, Occupational therapy can help strengthen psychosocial care actions, seeking to articulate the work processes developed within the institution and the development of intersectoral actions with out-of-hospital services and community, and it may be coadjuvant in the process of re-signification of the occupational roles of the individual in the family environment and in their territory of life, achieving the objectives proposed by the Psychosocial Rehabilitation strategy.

New studies within the context studied are necessary for transformations to happen, favoring practices in the perspective of Psychosocial Rehabilitation and having as a presupposition the National Policy of to Mental Health Attention and Psychiatric Reform.

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Author's Contributions

Eline Vieira da Silva contributed with the production of the data, analysis and interpretation of the results and elaboration of the article until its final version. Mara Cristina Ribeiro contributed in the conception of the work, orientation, analysis and interpretation of the results and critical review of the article and final approval of the version to be published. Marilya Cleonice Santos de Souza contributed to the analysis and interpretation of the results. All authors approved the final version of the text.

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Notes

- ¹ The material was part of the research approved by the Research Ethics Committee of UNCISAL under CAAE 38396514.1.0000.5011 and complied with all ethical procedures in force.
- ² The acronym CPJ corresponds to the denomination Centro Psiquiátrico Judiciário, used as a local reference for the institution. In this work, we chose to adopt the acronym HCTP as acronym referring to the denomination of the institution because it is adopted nationally.