v. 2, n. 8, 2022

International Journal of Human Sciences Research

THE CUSTODY AND PSYCHIATRIC TREATMENT UNIT: A PSYCHOLOGICAL PROFILE ELABORATED ON THE INTERNS AND THE EXPERIENCES OF PSYCHOLOGY TRAINEES

Eduarda da Silva Coutinho
http://lattes.cnpq.br/0424792869178025

Emerson Rodrigues Lima
http://lattes.cnpq.br/4628310574836270

Erica Rodrigues Amitti
Graduating in Psychology
http://lattes.cnpq.br/8767179835518258

Gerivaldo Souza Santos
Graduating in Psychology
http://lattes.cnpq.br/4456455477949568

Lorrainy Cristina de Oliveira
Graduating in Psychology

William Sergio Souza da Silva
http://lattes.cnpq.br/3102711955132439

Dalton Demoner Figueiredo
Professor at the Department of Psychology-FAESA
http://lattes.cnpq.br/1197612659504819

Abstract: This is an indirect data collection research, which is carried out through the observation and analysis of each patient/inmate's chart - an indirect data collection - during the Supervised Internship with Emphasis on Public Health, lasting two semesters undergraduate Psychology-FAESA; in addition, a bibliographical research is used in order to enunciate a new academic-scientific material about the theme proposed here. We will outline the psychological profiles of the patients/inmates of the Psychiatric Custody and Treatment Unit, through the analysis of the medical records of all inmates/patients, of both sexes, during the year 2019, corresponding to our internship period. A detailed table with the international classification of mental illnesses was created as a way of illustrating the reality between the pathology/clinical diagnosis (ICD-10) and the infraction. We will use excerpts and facts/chronicles of the daily experiences lived there, in order to define future strategies of psychological intervention based on all the material collected.
Keywords: Craziness, Judiciary Asylum, Mental Health, Psychology.

INTRODUCTION

The reason for our graduation in psychology was because we always questioned the reasons that led human beings to behave through their dreams, desires, acts, fetishes, etc.; until one day in the discipline of Supervised Internship we had to choose a field of internship, thus, opting to do an internship at the Hospital de Custodia e Tecidos Psiquiátrico (HCTP), which today is UCTP (changing the term, Hospital, becoming Unit).

Before going to the UCTP, we tried to imagine what the scenario would be like, assuming that the only reference to a prison system we had were those exposed in the media, nothing more; making the unit a fictitious idea. Upon arriving and getting to know UCTP, on a technical visit, guided by the Institution's team, we found that the physical structure was very similar to "our references"; however, the way they conduct the non-hospital-centric model process, made us evoke the proposals seen in the classroom.

The importance of emphasizing a psychological profile based on epidemiological data, collected by a documental survey, via medical records, allows identifying the needs and solutions for the specific problems of that population surveyed. The study of epistemology is seen as one of the main information sciences about health; becoming the basic science for collective health - inclusive. With this possible identification, what is sought is to develop specific actions - whether therapeutic or medication - as a preventive/intervention measure aimed at the need found there, in order not only to take a disciplinary and/or judicial measure, but also to avoid be a repeating cycle. Thus, tracing the epidemiological profile of UCTP patients/inmates gave us scope to think about possible collective or subjective interventions, leading us to an investigation of possible restoration or establishment of biological, psychological and social bonds.

SEARCH SCOPE

Here we will present you with a brief summary of everything we have studied in literature, along with our experiences. They will therefore be divided into five chapters. In chapter one, we will briefly describe the history of madness proposed by Michel Foucault (1978, p.7-30) - stating that the madman and madness were man's constructions, not being a natural object.

The second chapter brings the conception of a judiciary asylum, where the difficulties of dealing with mental illnesses are apparent,

being then necessary to create a humanized treatment planning. After centuries, he announced a historic achievement, with movements based on the protection and promotion of the rights of people who suffer from mental disorders, called Psychiatric Reform.

The third and fourth chapters address the support network programs inserted in the Custody and Psychiatric Treatment Unit, namely: The Therapeutic Residency Services (SRT) and the Psychosocial Support Center (CAPS). These networks are strategies that do not use the hospital-centered model as a measure of psychic promotion/intervention. A new form of citizenship is put into practice, taking the focus away from psychiatric hospital care, and directing its actions to respect for human beings and their differences. We end, then, with the fifth and last chapter, which report a little of our possibilities and impossibilities as trainees.

LITERATURE REVIEW

MADNESS HISTORY

In ''*História da Loucura*", Michel Foucaultbrings the idea of an exclusion structure to the phenomenon of madness, seeking to understand how technologies and internal logics about exclusion operate. According to Foucault (1978, p. 8), "the focus of exclusion was on leper patients. It is from an ideal of rationality, where the rational would be the human being, that the madman will no longer be treated only as an error, but also a threat to reason". During the 18th century, the phenomenon of exclusion became more evident with hospitalizations. The hospices were then transformed into "therapeutic purposes" and penitentiaries. There was a place called a leprosarium, which kept people isolated and imprisoned from the whole society, because they had a "diagnosis" of a disease, understood as leprosy.

At the end of the Middle Ages, leprosariums no longer received patients with leprosy, thus raising the big question: Who would occupy this place that is now empty? Initially leprosy was replaced by venereal diseases. In the Modern Age, madness would be treated as an exclusion: the mad would be placed on ships, *StultiferaNavis* ((The ship of the mad) and thrown into the sea.

After the 18th century, madness ceased to be just a *mistake* or *illusion* to become a threat. Madness becomes synonymous with incapacity. The madman is no longer a madman, he is a being incapable of adjusting to this society. The mold around the concept of mental illness was only possible through the *act of exclusion*, allowing a distinction between the concept of illness and madness.

"Madness only exists in a society, it does not exist outside the norms of sensibility that isolate, exclude or capture them" (FOUCAULT 1978, p.29). Analyzing this situation, we see that a society in its complexity excludes and deports not only the "crazy", but any individual who threatens its "supposed tranquility", through isolation, *punishment* and the *use of power*.

JUDICIAL ASSISTANCY

For centuries, the psychiatric hospital was seen as a single space for the treatment of people with mental disorders, where isolation and hospitalizations reinforce the exclusion from social life. According to Foucault (1978, p.27) "from all sides, the fascination of man is madness, being it that makes fantastic images appear, not being appearances that they hid, where they soon disappear from the surface of things, but those that made its fascination", that is, what is born of a delusion ("madness") was already a phenomenon hidden in the subject, a kind of secret, inaccessible to the truth.

Until 1950, the treatment used for the

insane consisted of hot and cold baths, the use of medication on a large scale and physical methods such as electroshock. The punishment gradually ceased to be a popular exhibitionism, setting as a negative imprint everything that refers to this "spectacle". This exposure of the punished body is then shared in another way, where the conviction will mark the criminal with a negative sign.

It is possible to think that the enclosure had no idea or medical leadership, but assistance, a "semi-legal" structure. A space that allowed a mixture of inmates, where, the same place that was occupied by the sick, was also occupied by prostitutes, libertines and the insane. It was at the end of the 18th century that there was a "separation" between criminals and the insane in the prison system.

Throughout the 18th century, the dialogue between the doctor and the patient appears, the former becoming an element of the world of mental insanity. However, this approach did not bring about a release from madness, even with medical attention, and ended up uniting her even more with hospitalization. In the 18th century, this form of treatment began to be questioned (FOUCAULT, 1977).

According to Amarante (1996), a hospital-centered model, based on psychiatric medical knowledge that overvalued medicalization, reduced patients to biological determinants, and did not deal with psychological and social issues, it was then that on April 6, 2001, the Law Nº 10,216/2001 was approved, providing for the protection and rights of people with mental disorders, redirecting the mental health care model.

Although torture has been abolished, it still continues in parallel with the constitutional order, being present in the obligation to have high walls around the prison; present in the frightened silence of victims and witnesses and present in the convenience of the authorities, among others. Physical sufferings will no longer be the constitutive elements of the penalty, where punishment has changed from an art of unbearable sensations to an economy of suspended rights. If justice still needs to touch this body, it must be at a distance, through the rigid rules bias - patterns of behavior, where the day-to-day of each inmate is directed, having to obey each order, obey the "schedule" coming of the constituent. According to article 26 of the Penal Code - Decree Law 2848/40:

> "An agent who, due to mental illness or incomplete or retarded mental development, was, at the time of the act or omission, entirely incapable of understanding the illicit nature of the fact or of determining himself in accordance with that understanding, is exempt from the penalty.

Therefore, the Brazilian punitive system works with the concepts of imputability and non-imputability[1], to assign criminal responsibility to people with mental disorders. Understanding that the subject fits the concept of non-imputability (exempt from the penalty), he will need to be subjected to a security measure, a kind of compulsory treatment, whose consequence is perpetual segregation or for a long period through hospitalizations. The constituent adopts biopsychosocial criteria, concerned with building a pluralist society that respects the human person and their freedom.

The difficulty in dealing with mental illness still persists and, therefore, it was necessary to create a humanized treatment plan, including in this context the emergence of the Psychiatric Reform in Brazil. The Psychiatric Reform in Brazil is, therefore, a:

> "complex political and social process, composed of actors, institutions and forces from different origins, and which affects

1. Liability refers to the ability to be culpable, being then able to understand the illicit nature of the fact. Non-imputability, on the other hand, is the inability to determine the illegality of the fact, becoming exempt from the penalty due to the absence of culpability.

> different territories, in federal, state and municipal governments, in universities, in the health services market, in professional councils, in people's associations with mental disorders and their families, in social movements, and in the territories of the social imaginary and public opinion (BRASIL, 2005, p.6).

To the Brazilian panorama, a new form of citizenship of the person with mental disorder was displaced, considering respect for human beings and their differences, removing the hospital-centered focus, and valuing services in the territory, through the Psychiatric Reform.

According to Martins, "that when conceiving the dignity of a human being as the foundation of the Republic, would admit that the Brazilian State was built from the human person" (2003, p.72), recognizing that the minimum material conditions of a human dignity. A new form of citizenship is put into practice, taking the focus away from institutional attention and directing its actions to respect for human beings and their differences. Within this perspective, that of a new model for mental health, some programs were created, such as: "Back home"; the SRT (Therapeutic Residential Service) and the CAPS (Psychosocial Care Center).

THERAPEUTIC RESIDENCES

The Therapeutic Residency Services (SRT) or Therapeutic Residencies have strategies for the treatment and monitoring of people with mental illnesses, where they do not have adequate family and social support. Therapeutic residency services appear as houses intended for the housing needs of these individuals with mental disorders, discharged from psychiatric hospitals, discharged from judicial "asylums".

Law 10,216/2001 guarantees the process of progressive replacement of beds in psychiatric hospitals by a psychosocial community care network. It must be noted that Therapeutic Residences are not precisely a health service, which takes place in Basic Units, but a space where these former inmates need to live and live, being this field the return for a long rehabilitation process. Each house must therefore be treated as unique, being organized according to the needs of each one, respecting the tastes, habits and dynamics of the residents.

This way, for the subject to be inserted in Therapeutic Residencies, it is necessary to go through the process of non-institutionalization, which points to a need for deconstruction of knowledge, leaving the model anchored in the hospital-centric perspective and turning to new possibilities of assistance of the "existence of -suffering" of the individual. The non-hospital-centric model refers to the psychosocial rehabilitation proposed by the Psychiatric Reform, thus being able to rescue ethics, citizenship and the complexity of mental health.

CAPS AND ITS MODALITIES

According to ARTICLE 1, of Ordinance No. 3088, of December 2011: "The Psychosocial Care Network (CAPS) is hereby established, whose purpose is the creation, expansion and articulation of health care points for people with suffering or mental disorder and with needs arising from the use of crack, alcohol and other drugs within the scope of the Unified Health System (SUS)". Complementing, therefore, that one of the specific objectives of CAPS is to promote health care especially for vulnerable subjects; prevent consumption and dependence on crack, alcohol and other drugs; Reduce damage caused by the use of crack, alcohol and other drugs; Promote the rehabilitation and integration of people with mental disorders.

The Psychosocial Care Centers are organized in the following modalities:

I - CAPS I: assists people with severe and persistent mental disorders and also with needs arising from the use of crack, alcohol and other drugs of all age groups; indicated for Municipalities with a population of over twenty thousand inhabitants;

II - CAPS II: assists people with severe and persistent mental disorders, and can also assist people with needs arising from the use of crack, alcohol and other drugs, according to the organization of the local health network, indicated for Municipalities with a population of over seventy thousand inhabitants;

III - CAPS III: assists people with severe and persistent mental disorders. They provide continuous care services, operating 24 hours a day, including holidays and weekends, offering clinical support and night care to other mental health services, including CAPS Ad, indicated for municipalities or regions with a population of over two hundred thousand inhabitants;

IV - CAPS AD: serves adults or children and adolescents, considering the regulations of the Child and Adolescent Statute, with needs arising from the use of crack, alcohol and other drugs. Open mental health service of a community nature, indicated for municipalities or regions with a population of over seventy thousand inhabitants;

V - CAPS AD III: serves adults or children and adolescents, considering the regulations of the Child and Adolescent Statute, with continuous clinical care needs. Service with a maximum of twelve beds for observation and monitoring, open 24 hours a day, including holidays and weekends; indicated for Municipalities or regions with a population of over two hundred thousand inhabitants; and

VI - CAPS I: assists children and adolescents with severe and persistent mental disorders and those who use crack, alcohol and other drugs. Open and community-based service indicated for municipalities or regions with a population of over one hundred and fifty thousand inhabitants.

THE POSSIBILITIES AND IMPOSSIBILITIES OF THE PSYCHOLOGY STUDENT IN THE CUSTODY UNIT FOR PSYCHIATRIC TREATMENT

The Psychiatric Custody and Treatment Unit is a state-operated social defense and psychiatric clinic. It is located at Avenida São João Batista, Cariacica, Cariacica Headquarters – ES. Its care is aimed at people with mental disorders, having thus committed a crime/crime and being in custody.

To Nicácio:

> "The main actors in the deinstitutionalization process are, above all, the technicians who work within the institutions, who transformed the organization, the relationships and the rules of the game, currently exercising their therapeutic profile of psychiatrists, nurses, psychologists, etc. On this basis, patients also become actors and the therapeutic relationship becomes a source of power that is also used to call other institutional actors to responsibility and power. Nearby or not, local administrators responsible for metal health, technicians from local health structures, politicians, etc." (2001, p.31).

This signifier (deinstitutionalization) gives all professionals involved in UCTP a responsibility to mediate over the relationship networks that structure the institutional action system with social demands. The transformation process at UCTP began with the restraints and no longer the handcuffs on the patients/inmates, and also through the reestablishment of the relationship with their own bodies and the production of a social bond, consisting of walks, visits, etc., carried out by the Unit.

According to Brito's ideas (1999, p.74) the psychologist's performance in the judiciary, despite being conditioned to aspects that meet the judge's determinations, does not have such issues as a determining factor in its analysis, before taking into account to the subjectivity of the subject, and how it is psychically structured. Therefore, with some deliberation, you will conduct your diagnosis indicated therein in your process.

In the CTP Unit, the movements for a transformation in the constitutional process are always well addressed by health professionals, but some gaps are persistent, such as: the fact that we Psychology interns do not have exclusive access to patients/ inmates; our proposals for extracurricular activities are always complicated to carry out, as it is necessary to bring together all the multidisciplinary teams on the day of the activities, for the purpose of support in case an accident may happen to the intern. Access to the unit is also one of the variables that imposes difficulty, because to enter the unit there is a bureaucracy, which is understandable, but our assistance started from 2019/1 until mid-November 2019/2, not to mention the arduous path we have gone through. until arrival at the unit's entrance.

We had some impossibilities during this period, that's a fact, but we can't fail to mention the range of possibilities we saw while intern there. One of the possible factors is the form of contracting for the provision of service, as we were informed that in addition to a public tender, there is contracting through a selective process, which would facilitate our graduates to the unit. The accesses we had to patients/ inpatients were only possible through the help of professionals (from the area of psychology, psychiatry and social work), giving us all the necessary support. Anyway, we know that the whole career is permeated by difficulties and possibilities, our trajectory would not be different, and all this journey will make our academic and professional life more meaningful every time we remember what we lived or didn't live in this stage.

MATERIAL AND METHOD

The work is the result of an indirect data collection research, which is carried out through the observation and analysis of each patient/inmate medical record, during the Supervised Internship with Emphasis on Public Health I and II, lasting two semesters of graduation. of Psychology-FAESA; in addition, a documental research is used in order to enunciate a new academic-scientific material about the theme proposed here. Finally, we will resort to excerpts and facts/ chronicles of the daily experiences lived there by us, since, to quote excerpts and speeches from patients, we would have to send the research to the Research Ethics Committee – which at the moment we avoid. Data were collected from all patients/files/medical records in force in the year 2019 at UCTP, corresponding to the year in which we were interns.

Then, a table will be built with the psychological profile articulated to the infraction. See the table 1 below.

RESULTS AND DISCUSSION

Based on the information presented in the table above, we found what would be the three highest incidences of mental disorders based on the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Along with the highest incidence of crime/crime found, namely: ARTICLE 121- Simple Homicide. See the chart 1 below.

According to the ICD-10 (1993, p.85), schizophrenia is among the most common disorders, validating the table elaborated, with the highest incidence as a response: SCHIZOPHRENIA. The general feature

Gender	Age		Education	CID	Article – CBP
M	**18-30 Years**	26	Incomplete Elementary School	F.19/F.71	ARTICLE 121(HOMICIDE) CBP
M		22	Complete Elementary School	F.20.0	ARTICLE 121, §, 2º ITEM, IV AND VI COMBINED WITH ARTICLE 14, II DOCBP
M		29	Complete Elementary School	F.31.7	ARTICLE 121, ITEM VI, COMBINED WITH ARTICLE 14, ITEM II OF THE CBP
M		28	Incomplete Elementary School	F.18/F.70	ARTICLE 157, §2º, I, ARTICLE 150, ARTICLE129, §9º, ALL OF THE CBP
M		26	X	F.20	ARTICLE 129, CAPUT, COMBINED WITH ARTICLE 155 ARTICLE14, II, ARTICLE 61 IN THE FORM OF ART69 OF THE CBP
M		24	X	F.40.8/F.60.1/F.70/ F.19/ F.90.0	
M		21	Incomplete Elementary School	F.71/F.84.3	24 OF LAW 11340/06,146 OF THE CBP
M		29	Incomplete Elementary School	F.31.7	329 OF THE CBP
M		29	X	F.70	
M		24	Incomplete high school	X	
M		28	Incomplete Elementary School	F.70	217-A OF THE CBP
M		29	Incomplete high school	X	ARTICLE 129, §9º-163 CBP
M		26	X	F.78.0	
M	**30-40 Years**	39	Incomplete Elementary School	F.71	ARTICLE 121, CAPUT, combined with article14, PARAGRAPH II CBP 121,§2º, PARAGRAPH I and IV
M		37	Incomplete Elementary School	F.20.0	
M		39	X	F.20	
M		32	Incomplete high school	F.20.0/F.72	ARTICLE 121, CAPUT, COMBINED WITH ARTICLE 14, II (2X) CBP
M		37	Incomplete Elementary School	F.19/F.79.1	ARTICLE 97
M		37	Incomplete Elementary School	F.20	ARTICLE, 147 AND 129,§9, IN THE MANNER OF THE ARTICLE 14, OF LAW 11340/06
M		35	Incomplete high school	F.19	ARTICLE 121, COMBINED WITH ARTICLE.157, §2º, IV CBP
M		34	Incomplete Elementary School	F.20/F.70	ARTICLE 147, CBP IN THE FORM OF LAW 11340/06 129, § 9º CBP
M		31	Incomplete Higher Education	F.20	ARTICLE 121, §2º CBP

M		38	Incomplete Elementary School	F.10	ARTICLE 148, 2º, 129, 9º AND ARTICLE 147, ALL OF THE CBP, IN FORM OF LAW 11.340/06
M		32	Complete high school	F.19/F.31	ARTICLE 121, § 2º ITEM II, IV and VI, COMBINED WITH 14.61, II of the CBP
M		38	Incomplete Elementary School	F.20.0	121§2 ITEM AND ARTICLE IV OF THE CBP
M		29	Incomplete Elementary School	F.20.1	ARTICLE 121, §2º ITEM II
M		30	Incomplete Elementary School	F.71/F.20.1	ARTIICLE 127
M		39	Incomplete high school	F.20	ARTICLE 157, CBP
M		39	Complete high school	F.20.0/F.31	ARTICLE 121, § 2º, CBP
M		32	Illiterate	X	ARTICLE 121 COMBINED WITH 14.61
M		35	Incomplete Elementary School	F.20.0	ARTICLE 121 COMBINED WITH ARTICLE 14, II CBP
M		30	X	X	ARTICLE 415, IV OF THE CBP ARTICLE 26 CAPUT
M		35	Incomplete Elementary School	X	121, § 2º ITEM II IV
M		35	X	F.31/F.60.3/F.19	
M	**40-50 Years**	41	Complete primary education	F.20.0	ARTICLE121
M		42	Incomplete Elementary School	F.20.0	147 of the CBP, 331 of the CBP
M		43	Incomplete high school	F.20.0/F31.0	ARTICLE 24-A OF LAW 11.340/06
M		46	Incomplete Elementary School	X	ARTICLE 129 - MARIA DA PENHA
M		42	Incomplete Elementary School	F.20	ARTICLE 23, ARTICLE 329, ARTICLE 331
F		48	Incomplete Elementary School	F.20	ARTICLE 121, CBP
M		49	Incomplete Elementary School	F.20	
M		42	Illiterate	F.20	ARTICLE 155, §4º, II (3X) IN THE FORM OF ARTICLE 71, BOTH ART 69 OF THE CBP
M		40	Incomplete high school	F.31.7	
M		46	Incomplete Elementary School	F.20	ARTICLE 121, CAPUT, COMBINED WITH ARTICLE 14, ITEM II CBP
M		47	Complete high school	F.32	ARTICLE 121, § 2º ITEM IV OF THE CBP
M		47	X	F.20/F.70	ARTICLE 121, § 2º ITEM IV, COMBINED WITH ARTICLE 14 OF THE CBP
M		43	Incomplete Elementary School	F.20	ARTICLE 129

F		40	X	F.31.7	
F		42	X	F.31.7	121§ 2º ITEM I, III, IV
M		43	Incomplete Elementary School	F.31.7	121§ 2º, II,IV,VI AND §2º-A,I AND §7º, III, ALL OF THE CBP
M		47	Incomplete Elementary School	X	ARTICLE 121 COMBINED WITH ARTICLE 14
M		41	X	F.20	
M		43	Illiterate	F.10.2	ARTICLE 213 OF THE CBP
M	**50-60 Years**	54	Incomplete high school	X	
M		54	Incomplete Elementary School	F10	ARTICLE 121§2º ITEM II AND IV OF THE CBP
M	**60 Years**	76	X	F.00.0	217-A OF THE CBP
M		65	Incomplete Elementary School	F20. 5	ARTICLE 121
M		62	X	F.20	

Table 1.

SUBTITLE:

Higher incidence of mental disorder is the ICD-10: F.20.0

Higher incidence of crime/crime is ARTICLE 121

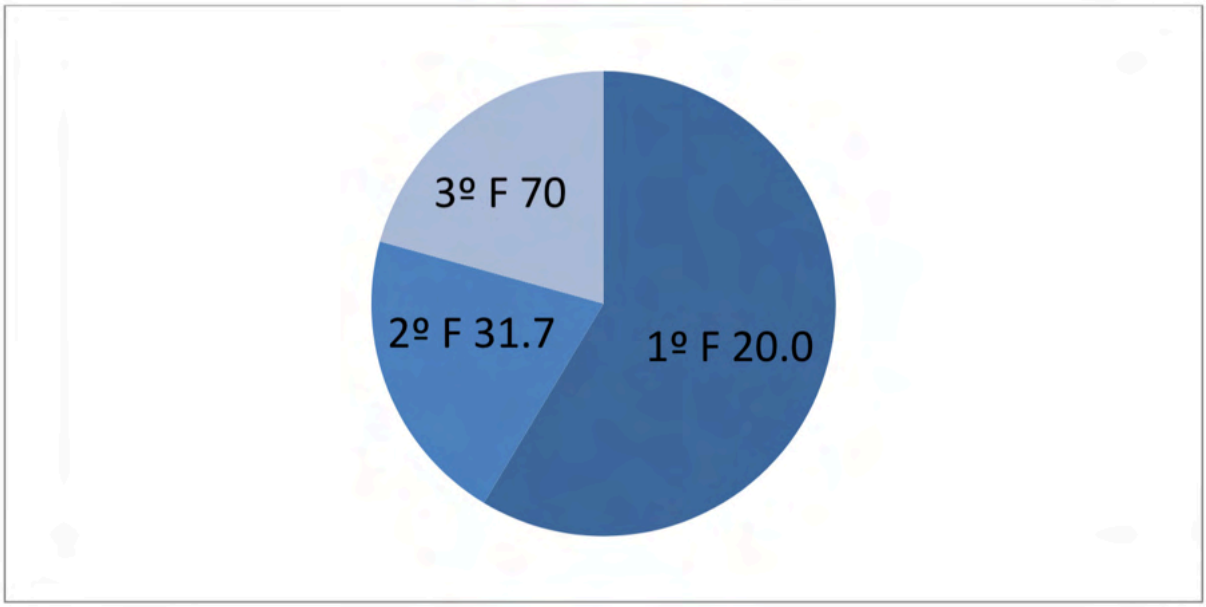

Chart 1.

of a schizophrenic disorder is associated with fundamental distortions and features of thinking and perception at an inappropriate or dull level. Specifically, paranoid schizophrenia (a relevant disorder among patients/inmates) is called delusions, with paranoid frequency, usually being accompanied by hallucinations, sometimes of auditory variety, and perceptual disturbances.

The second highest incidence of mental disorder is F.31.7, classified as Bipolar Affective Disorder, currently in remission, which according to ICD-10 (1993, p.117):

> "This disorder causes the patient to have at least one manic, hypomanic, or mixed affective episode in the past, and in addition, at least one other affective episode of the hypomanic, manic, depressive, or mixed type, but not currently suffering from any significant disturbance of the mood, being passim for several months" (CID-10, 1993, p.88-89).

The third incidence found is F.70, classified as Mental Retardation. For ICD-10:

> "Mental retardation is a condition of interrupted or incomplete development of the human mind, especially characterized by impairment of abilities manifested between the developmental period, which development contributes to the overall level of intelligence. Mental retardation may occur with or without another mental or physical disorder" (1993, p. 221).

And with regard to the Penal Code, article 121, is related to simple homicide – the act of killing someone, not being classified as a qualified or negligent crime; where the sentence can be from six to twenty years. The criminal situation of UCTP patients/inmates is differentiated, as the criterion adopted is imputability or non-imputability (capable or not of understanding the act performed).

From a scientific point of view, it is not possible to obtain relationships between the mental disorder and the crime/crime committed, this is due to the lack of studies on the number of people with mental disorders imprisoned before the deinstitutionalization process. Certainly, ante-hospital-centric mental health care policies play an essential role in crime prevention among individuals with mental disorders.

FINAL CONSIDERATIONS

The study allowed a mapping of the epidemiological profiles of UCTP patients/inmates. Also allowing us to have a deeper contact between the disorders presented by each patient/inmate along with their crime/crime committed, in order to define strategies for future interventions to better qualify humanized and non-hospital-centered care.

It is observed that there is still much to be explored on this topic, aiming at the importance of care policies for the deinstitutionalization of patients/inmates, to 'break' this hospital-centered system, considering that there is a possibility of institutionalization when a patient/inmate needs to change your posture when you get out of a sunbath for example. Such points are what, perhaps, in the future, can not only guide professional practice, but also move the necessary investment for the continuity of research, now in a master's program. After all, it is not known how much longer the judiciary asylum will exist, despite madness being part of the human condition. There is no one without the other.

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