Cadernos Brasileiros de Terapia Ocupacional
Brazilian Journal of Occupational Therapy

ISSN 2526-8910

Original Article

Comprehensive care perspectives for the "mentally ill offender" in the Psychosocial Care Network (RAPS)

Perspectivas de atenção integral ao "louco infrator" na Rede de Atenção Psicossocial (RAPS)

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How to cite: Melo, T. C. P., Oliveira, I. B. S., Ponte, A. B. M., Silva, L. A., & Santos Junior, H. C. F. (2025). Comprehensive care perspectives for the "mentally ill offender" in the Psychosocial Care Network (RAPS). *Cadernos Brasileiros de Terapia Ocupacional, 33*, e4051. https://doi.org/10.1590/2526-8910.cto414340512

Abstract

Introduction: Ensuring the rights of people with mental disorders remains a challenge within the scope of public policies. This scenario becomes even more complex when it involves offenders. The reality of care for the so-called "mentally ill offender" reveals a historical path marked by the gradual rupture of traditional psychiatric paradigms, allowing for progressive advances in actions aimed at this population. **Objective:** To understand how the conception of Psychosocial Care Network (RAPS) workers regarding deprivation of liberty influences the mental health care offered to this population and to map the support offered to people with mental disorders under security measures within RAPS. **Method:** An exploratory, descriptive, and qualitative study conducted through interviews with RAPS professionals and thematic analysis of the data. **Results:** The findings were discussed across three units of meaning and reveal the historical recurrence of the stigma of dangerousness, the absence of shared development of Singular Therapeutic Projects (PTS) among the network's facilities, and the infrequency of intersectoral meetings to discuss cases, indicating weaknesses in network-based work. Nevertheless, participants described a type of care that neither blames nor stigmatizes individuals with mental disorders who have committed offenses. **Conclusion:** Care based on freedom is essential, even in the context of a RAPS weakened by structural limitations and shortages of human and material resources. The articulation between health and justice sectors, through dialogue and intersectoral actions, is a fundamental element for providing humane and welcoming care to the "mentally ill offender," aiming at rehabilitation and social reintegration.

Keywords: Occupational Therapy, Mental Health, Mental Health Services, Criminal Law, Justice, Prison.

Received on Feb. 9, 2025; 1st Revision on Mar. 18, 2025; Accepted on Sept. 29, 2025.

Resumo

Introdução: A garantia de direitos das pessoas com transtorno mental ainda representa um desafio no âmbito das políticas públicas. Esse cenário torna-se ainda mais complexo quando se trata de indivíduos em conflito com a lei. A realidade do cuidado ao chamado "louco infrator" evidencia um percurso histórico marcado pela ruptura gradual de paradigmas psiquiátricos tradicionais, possibilitando avanços progressivos nas ações destinadas a essa população. **Objetivo:** Compreender de que modo a concepção dos trabalhadores da Rede de Atenção Psicossocial (RAPS) acerca da privação de liberdade influencia o cuidado em saúde mental ofertado a essa população e cartografar o suporte às pessoas com transtorno mental em cumprimento de medida de segurança no âmbito da RAPS. **Método:** Estudo exploratório, descritivo e qualitativo, realizado por meio de entrevistas com profissionais da RAPS e análise temática dos dados. **Resultados:** Os achados foram discutidos em três unidades de significação e apontam a recorrência histórica do estigma da periculosidade, a ausência da elaboração de Projeto Terapêutico Singular (PTS) de forma compartilhada entre os dispositivos e a pouca frequência de reuniões intersetoriais para discussão de casos, o que indica fragilidades no trabalho em rede. Ainda assim, os participantes relatam um cuidado que não culpabiliza nem estigmatiza os sujeitos com transtorno mental que cometeram um delito. **Conclusão:** O cuidado pautado em liberdade é essencial, mesmo diante de uma RAPS fragilizada quanto aos aspectos estruturais, de recursos humanos e materiais dos serviços. A articulação entre saúde e justiça, por meio de diálogos e ações intersetoriais, constitui elemento fundamental para o acolhimento e o cuidado humanizado ao "louco infrator", visando à reabilitação e à reinserção social.

Palavras-chave: Terapia Ocupacional, Saúde Mental, Serviços de Saúde Mental, Direito Penal, Justiça, Cárcere.

Introduction

Ensuring the rights of people with mental disorders remains a challenge within the scope of public policies. This scenario becomes even more complex when it involves offenders who are subjected to Security Measures (SM), a situation in which multiple stigmas overlap and severely hinder access to care networks. The urgent need to reaffirm the right to comprehensive care within the Unified Health System (SUS) for this population under custody reveals a historical trajectory of exclusion and prejudice, intensified by the stigma associated with supposed dangerousness (Pará, 2025; Simas et al., 2021).

In this context, Ordinance No. 94/2014 (Brasil, 2014a), issued by the Ministry of Health, constitutes a legal milestone in promoting adequate care for individuals under custody with mental disorders through the creation of the Evaluation and Monitoring Team for Therapeutic Measures Applicable to Offenders (EAP). This initiative emerged from the project of a technical group that intended to establish a mechanism of connection between the justice system, SUS, and the Unified Social Assistance System (SUAS) (Soares Filho & Bueno, 2016).

Ten years later, the publication of a new ordinance, GM/MS No. 4.876, dated 18 July 2024, changed the team's name to EAP-Desinst and removed it from the scope of the National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (PNAISP), transferring it to the Psychosocial Care Network (RAPS) within SUS. This measure reaffirmed its connection to deinstitutionalization actions, since the team became part of the Ministry of Health's Deinstitutionalization and Human Rights Program, while also functioning as the main mechanism linking the justice system to RAPS as well as to SUAS (Brasil, 2024).

In the state of Pará, the work conducted by EAP-Desinst has contributed to the deactivation of the former Custody and Psychiatric Treatment Hospital (HCTP), later renamed the Penitentiary General Hospital (HGP). Located in the metropolitan region of Belém and inaugurated in 2007, the facility operated counter to the principles of the Brazilian Psychiatric Reform. Currently, the HGP, which, despite its name, does not function as a hospital but as a standard penal unit, still houses 27 individuals under custody.

The HGP operates according to the logic of a total institution: a closed environment where care is not the central objective, constituting a space of confinement directly subordinated to the facility's security staff (Silva, 2015).

The enactment of the Anti-Asylum Law No. 10.216, in 2001, ensured rights for people with mental disorders by emphasizing the importance of less invasive treatment approaches in the context of mental health care. Thus, HCTP became susceptible to gradual extinction, since RAPS was identified as the most suitable structure for implementing SM modalities, enabling comprehensive, territory-based care with support from diverse services and facilities (Brasil, 2004).

To modify the asylum-based scenario at HGP, the EAP-Desinst in Pará has coordinated actions aimed at caring for offenders with mental disorders, contributing to the dismantling of institutional and societal paradigms.

These measures, intended to transform the landscape of institutional violence and confront violations of the right to health, are essential in the hundreds of Brazilian prison units, particularly regarding the deinstitutionalization of people deprived of liberty with psychiatric disorders.

Therefore, the systematization of laws and the strengthening of social debate surrounding the so-called "mentally ill offender" constitute essential steps toward ensuring the right to health for all, including people deprived of liberty who continue to experience profound stigma and exclusion (Pará, 2019, 2025; Simas et al., 2021).

Accordingly, this study analyzed the organization of the RAPS in Belém (PA) in developing psychosocial rehabilitation actions directed at offenders with mental disorders. Specifically, it sought to understand how RAPS workers' conceptions regarding deprivation of liberty influence the health care offered to this population and to map the forms of support provided to offenders with mental disorders subjected to SM within RAPS.

Method

This is a qualitative study with an exploratory and descriptive design. According to Almeida (2021), the qualitative method consists of analyzing the intrinsic relationships between the subject and the real world, in which phenomena arise that cannot be quantified or translated into numbers, requiring subjective and contextualized interpretation.

The study was approved by the Human Research Ethics Committee of the Center for Biological and Health Sciences (CCBS) at the State University of Pará (UEPA), under protocol no. 5.615.428.

The methodological pathway is described in detail in Table 1.

Table 1. Research method.

Type of study	Exploratory, descriptive, with a qualitative approach.
Data production instrument	Semi-structured interview guide conducted with RAPS workers, containing eight questions, described in the analyses, which sought to identify how professionals understand the offender with a mental disorder, their needs, and how this understanding affects the care provided.
Research setting	RAPS services that care for this population in the municipality of Belém, state of Pará, including five Psychosocial Care Centers (CAPS), two type III and three type II, and two Alcohol and Drug CAPS (AD), one type II and one type III, in addition to the Evaluation and Monitoring Team for Therapeutic Measures Applicable to Offenders with Mental Disorders (EAP-Desinst), linked to the State Health Department of Pará (SESPA).
Research participants	The sample consisted of nine professionals who, at some point since the creation of EAP-Desinst in Pará in 2014, had assisted offenders with mental disorders. Sampling was non-probabilistic and based on convenience. All participants agreed to participate by signing an Informed Consent Form (ICF). Three participants were affiliated with EAP-Desinst and six with CAPS units in the metropolitan region of Belém.
Data production procedures	Interviews were conducted between September and October 2022, in individual meetings with each participant at their workplace. The interviews were audio-recorded and later transcribed in full. The guide addressed the care model adopted by the professionals, the available services, examples of Individual Therapeutic Project (PTS) development, and workers' individual experiences.
Data analysis	After transcription and reading of the interviews, the data were analyzed through the identification of convergent aspects in perceptions regarding the care provided within RAPS, with the aim of constructing thematic units. The thematic analysis involved identifying recurring patterns of meaning in the data (Rosa & Mackedanz, 2021). The names of the meaning units were drawn from excerpts of the interviews, and participants were identified with alphanumeric combinations. Three discussion categories were defined based on the material produced and aligned with the study objectives: "This is SUS, isn't it? We must provide equitable care to everyone [...] regardless of what they have done in life": mental health care based on professionals' understanding of deprivation of liberty; "Each case is different": citizenship, prevention of offense recidivism, and nondifferentiation in psychosocial support; "It is not for me to judge, they have already been judged": RAPS professionals' perceptions of the "mentally ill offender."

Source: Prepared by the authors.

Results

Regarding the profile of the nine study participants, the following professional distribution was identified: four occupational therapists, two nurses, one physical educator, one social worker, and one administrative support professional, the last working in the deinstitutionalization process at EAP-Desinst, performing functions similar to those of a therapeutic accompanist.

Among the participants affiliated with the CAPS units (n = 6), all were women, with three working in type II and III CAPS units and three in type II and III AD CAPS units. The remaining participants (n = 3), from EAP-Desinst, were two men and one woman.

All professionals reported having more than six years of experience in the mental health field.

The results are presented below in three Units of Meaning:

1) *"This is SUS, isn't it? We must provide equitable care to everyone* [...] *regardless of what they have done in life": mental health care based on professionals' understanding of deprivation of liberty*

This Unit includes the first two interview questions, which aimed to understand the possible effects of deprivation of liberty on the mental health of people subjected to SM, as well as to grasp professionals' perceptions regarding that condition.

When asked about their understanding of the situation of an offender with a mental disorder, most interviewees described the effects resulting from losses in several social indicators that affect this population, as illustrated below:

> *It involves the issue of the social network, the support network that these people often do not have. It is a fragile network. These people become much more exposed to more vulnerable situations* [...] (P1).

> *We take the opportunity to speak about some gaps in public policies* [...] *public policies mainly aimed at giving this man or this woman the opportunity to pursue their dreams, to also be seen as a person who has a history, who is a subject of rights* [...] (P9).

Some professionals directly associated this population with the social prejudice arising from the stigma of dangerousness, as illustrated in the following statements:

> *I believe that the person who is an offender is strongly associated with the issue of dangerousness* [...] *society, and sometimes even the workers in mental health services, when they realize that the person committed some type of offense, it already causes turmoil in the service* [...] (P4).

> *And when I had no experience, it frightened me, I had no desire to provide care or help, because for me that place was already defined* [...]. *It was a dangerous person, a person who perhaps did not deserve my attention, and unconsciously I thought 'how am I going to care for someone who may assault me around the corner?' There were many possibilities, and it echoed within my own experiences too* [...] (P8).

The professionals reported that the population deprived of liberty with mental disorders still does not receive adequate attention from the Judiciary, especially concerning their health needs. This understanding reinforces the notion that the Prison System remains insufficient in offering appropriate care to people under custody with mental disorders:

> *In a way it makes* [treatment] *very difficult, because I do not know what it is like in the hospital where they stay... whether it is actually a hospital, whether there is any treatment* [...]. *And in the end, there is no treatment. And what I have noticed when we receive these people is that they are not treated in that place where, in theory, they should be. The space* [custody hospital] *only functions as a shelter. The impact must be significant, because there is no treatment and the person is still deprived of liberty* [...] (P2).

It is worth noting that only months after data collection was completed, Resolution no. 487 of the National Council of Justice (CNJ) was enacted, known as the "Psychiatric Reform Law of the Brazilian Judiciary" (Brasil, 2023).

Some participants also believed that offenses committed by people with mental disorders are linked to a certain "pathophysiology" of mental suffering, combined with deficiencies in the assistance network:

> *This usually happens because of a breakdown in psychic functions, often caused by inadequate treatment or lack of treatment* [...]. *When we speak of a mental disorder linked to substance use, for example, these changes cease to be only behavioral and often become conduct changes because of this use, because of criteria related to chemical dependence* [...] (P6).

Furthermore, it is essential to consider the historical context of exclusion and social segregation experienced by people with mental disorders, regardless of whether they committed an offense:

> *Even in the 18th century, everything was based on the biological characterization of madness, in which they were understood as 'born criminals.' At that time, people believed that there were offenders with phenotypes characterized by traits associated with criminality, and among them were the mentally ill and Black people. That was when institutions were created to 'keep' these individuals* [...] (P3).

When asked whether deprivation of liberty would cause harm to the mental health of a person subjected to inpatient SM, the interviewees unanimously answered yes:

> *It does influence, in everything… in the way the person behaves, acts, views the world, and our experience has shown that. It increases suffering because of isolation itself, since these institutions only have the name of hospital, but are actually penal institutions that operate with procedures based on the penal system, so this only worsens the person's suffering* (P3).

> *Certainly, without a doubt it has an impact. Regardless of having a disorder, I do not believe that depriving someone of liberty will contribute in any way to improvement, whether related to criminality or to a health problem they may have...* (P8)

Some professionals stated that total institutions, such as prisons or psychiatric hospitals, are strongly linked to the violation of human and social rights, causing, among other harms, psychological suffering, including among "common prisoners":

> *Exclusion from social life ends up chronifying psychological suffering, and when access to dignified treatment is not ensured, when access to humanized treatment for this psychological suffering is not ensured, the impact is often devastating in that individual's life, because they will remain excluded from society. In many cases, even family ties are restricted or abruptly broken* (P5).

> *And the other side of the coin: people who entered 'as fine as can be,' who, after three months of incarceration, began to develop anxiety—the first condition they develop... because of insomnia, confinement, the environment itself, the harassment from correctional officers, and many other situations* (P7).

2) *"Each case is different": citizenship, prevention of offense recidivism, and nondifferentiation in psychosocial support*

This Unit presents the findings related to the forms of mediation adopted in the care provided by RAPS to the population deprived of liberty with mental disorders, as well as the possible adoption of specific strategies to prevent offense recidivism.

Most of the professionals interviewed reported that they do not employ specific actions directed at preventing recidivism, as they believe that such an approach could result in a differentiated type of treatment compared with other users of the service.

The issue of the risk of offense recidivism emerges as a legal objective, often mentioned by judges in psychosocial assessments conducted by EAP-Desinst, for example. Although the nature of recidivism varies and its prevention is complex and subject to debate, some professionals reported adopting specific strategies, even though these were not detailed in their accounts.

One professional, however, referred to self-knowledge, resulting from adherence to treatment, as a factor that assists with the early perception of mental health destabilization and the consequent search for support before a new offense occurs, which, in their view, would constitute a form of prevention of offense recidivism:

> [...] *For each person, there is a specific strategy. We work case by case, observing the person's needs, observing what is possible for that person at that moment, and observing the support network available for adherence to treatment. One of the elements of the PTS is precisely to prevent the person from reoffending. What is essential is adherence to both medication and therapeutic activities at the CAPS, so that the person can know themself, can understand when they are destabilizing. Self-knowledge is very important for the person to recognize when they are losing balance, knowing they are not well, and therefore should not interact with certain people, because they may argue or possibly commit another offense* (P1).

The CAPS professionals who participated in this study emphasized that committing an offence should not interfere with the psychosocial support offered, as such conduct results from multiple factors and cannot be attributed solely to a mental disorder.

Thus, they do not identify the need to differentiate this user—or the care directed to them—from other individuals experiencing psychological distress without a history of offending.

In a certain way, the study participants apply the general legal principle of equality, according to which all individuals are equal before the law, and no distinction should be made between those in the same situation (Silva et al., 2021).

> *Regardless of whether the person has been in a total institution or in a custody hospital, they are equal to all other people who are here at the CAPS and in the street. It is where we coexist. They are people equal to others in every respect* (P1).

> *I believe that we must consider them as citizens with rights like any other. For me, when they arrive at the CAPS, I do not make any distinction between one person and another, in the same way that I care for any patient and care for any person who is an offender or who has previously been involved in an offense. They have the right to the same treatment and access to the same interventions* (P2).

Nonetheless, it is important to consider that the provision of care within RAPS is guided by the PNSM, which establishes the construction of the Individual Therapeutic Project (PTS). This enables mental health care based on personal history, preferences, and the singularity of each subject, allowing for tailored psychosocial care:

> *We try as much as possible to understand the user's history. Both the initial reception and individual follow-ups are intended to identify which needs will be addressed and how we can support the person. Thus, based on what they present, we determine what can be recommended, since care is individualized, as the Policy establishes, singular. I try to ensure that the user feels human again, because many lose this sense of humanity. Many no longer see themselves as people. Many no longer see themselves as resocialized or rehabilitated* (P6).

Comprehensive and continuous follow-up is a fundamental strategy for identifying care needs, reducing suffering, and planning therapeutic interventions. RAPS offers services with different purposes, capable of responding to users in crisis or users with severe and recurrent disorders, through strategies involving the Federal Government, states, and municipalities.

Regarding the mediation of care directed at this population, professionals from EAP-Desinst and CAPS reported that interventions focus on guaranteeing access to documents, as well as access to services and rights previously neglected because of the mental disorder associated with the experience of incarceration.

The AD CAPS professionals reported that their interventions focus on rehabilitation related to harmful alcohol and drug use, highlighting the importance of considering factors related to mechanisms of chemical dependence when there is consumption of psychoactive substances, even within a harm reduction perspective:

> *We do not consider very much this condition of being an offender; it does not become the central issue. It becomes treatment for chemical dependence with that detail included. I discuss quality of life, I discuss treatment and its importance,*

> *I try to identify whether the person has insight regarding dependence and drugs as factors that predisposed them to be in that situation and to have engaged in criminal behavior* (P8).

> *For example, if the offense is associated with cocaine or cannabis use, we intervene to prevent craving, so the person can identify triggers that lead to substance use* (P6).

Additionally, most participants mentioned the strengthening of the family support network as an essential factor for positive treatment outcomes and the stabilization of psychological conditions:

> [...] *together with his family we were able to ensure his release from the prison where he was, and he returned for treatment here* (P1).

> *Thus, we intervene together with the user and, when possible, with family members. In some cases, yes; in others, no. For example, we had a case from the HCTP in which we had no contact with relatives, so we could not rely on family support* (P1).

> *What concerns me most is family dynamics; how does it function? This is something one must know. As with any user with a mental disorder, family dynamics are sometimes compromised because of several factors. And I believe that a person who is an offender needs more support in this area* (P2).

Some interviewees reported experiences that involved intersectoral action, which broadened the range of possibilities:

> *We proceed according to what was determined by the judge, and we conduct our work by providing guidance and mediating communication with the judge, referring to the rules established in Law 10.216* (P8).

> *We talk and provide guidance so that the user fulfills the judicial measures required and may then be effectively in freedom* (P6).

Conversely, one participant emphasized that the lack of adequate structure within RAPS results in inconsistency in the care provided to this population, which limits interventions:

> *We cannot conduct the type of follow-up that should be provided, so we usually follow up only with the family to assess their situation* (P5).

The EAP-Desinst professionals highlighted a specificity of their role:

> *I believe that the distinguishing feature of our team is the relational aspect, the way we interact with the patient and their family, moving away from a strictly technical position of the specialist who holds knowledge and instead seeking to convey a logic of care toward that person* (P1).

> [...] *it is important to work toward building this bond, to show how essential trust is. We do not see this person as a product or an object who committed a certain offense. EAP is a strategic initiative, a strategic device within SUS that was created to contribute to offering these people an opportunity to reinterpret their lives* (P9).

> *We seek to identify, as a multidisciplinary team, which skills this person has that may have been neglected during incarceration* (P4).

As for strategies for preventing recidivism during EAP-Desinst interventions, one participant mentioned:

> *I believe our perception is influenced by our long experience in mental health; most of us came from CAPS, so we have a more directed perspective. Offenses are generally related to affective dynamics. These are issues we try to work on extensively, strengthening ties that have been weakened, bringing the person back to their home and family, understanding that this is necessary so that they do not commit another offense* (P4).

3) *"It is not for me to judge; they have already been judged": RAPS professionals' perceptions of the "mentally ill offender"*

This Unit comprises the last two interview questions, which aim to understand RAPS professionals' impressions of the person with a mental disorder who commits offenses during a psychotic episode and how these circumstances influence the therapeutic relationship and the provision of psychosocial care.

When asked whether a mental disorder could facilitate the commission of offenses, most professionals disagreed with this statement.

> *No. Any one of us may commit an offense regardless of having a mental disorder. It depends on the situation. The mental disorder makes the person more vulnerable, unfortunately, but I do not believe that the disorder incites anything* (P2).

> *No, no. The theoretical framework we use here assumes that any person may commit an offense. In our eight years of experience, we observed that very few people reoffended after being discharged from the custody hospital. What we see is that the lack of care is dangerous* (P3).

However, some interviewees highlighted social determinants of health—such as social factors, living conditions, work, and education—which, when marked by inequality, influence mental disorders and increase vulnerability to adverse circumstances. Nevertheless, participants did not mention social markers of difference, such as race, gender, gender identity, or intersectional relations.

Professionals working in type III CAPS units attributed some offenses to family conflicts, which destabilize mental health conditions because of the absence of solid support networks. Meanwhile, participants from AD services associated offenses committed by their users with loss of control related to the use of psychoactive substances:

> *Aggressiveness and violence are issues for all people. At some point in life, this may occur, correct? One does not necessarily need to have a mental disorder to commit an offense or an act of violence. And people living in socially vulnerable situations have a greater tendency, correct? Perhaps because they do not have access to education, work opportunities, food, or dignified living conditions* (P1).

> *No. I believe that the failure lies in the network's ability to identify the person's problem and their treatment needs, and in informing the community and those around them. I believe this entire care network is essential so that the person does not commit an offense because of a psychotic episode* (P4).

> *Often, I believe that when a mental disorder is not treated, it predisposes the person. Sometimes aggressiveness, impulsiveness, or even hallucinations are symptomatic, such as hearing command voices. What I can say is this: I do not know if the correct word is "incite," but I believe that in this sense, yes, the person becomes more predisposed* (P8).

When asked whether they experience discomfort or personal difficulties when approaching or treating this population, one professional responded:

> *Without judgment and with the understanding that I am not here to judge; I am here to treat. Our service exists to treat. He has already been judged. As I said at the beginning, this is a user with a mental disorder who needs follow-up like any other citizen who seeks a CAPS and has the right to be treated here. That is how I see it. I treat everyone the same way* (P2).

Some professionals described the repercussions of the stigma of dangerousness faced by this population, including within the health network, which in some ways also affects the care provided:

> *I admit that in the beginning it caused some estrangement, discomfort, and even some fear, because I had never dealt with the issue of the mentally ill offender. So, at the beginning, yes, there was some apprehension* (P3).

> *Sometimes it is difficult to detach from that idea, right? But we try to work on this. With time, we mature in relation to this. It is a daily process. It frightens me, it draws my attention, but at the same time I feel a sense of calm. So, one needs strategies to deal with it* (P8).

However, some professionals acknowledged the importance of understanding and intervening in the user's reality through a biopsychosocial perspective, considering their health demands and the devices available within RAPS. Based on this understanding, they emphasized that care should be qualified and centered on the user, not on personal convictions:

> *Here the focus is not my personal judgment. The focus is the mental health care that person needs at that moment, the reason they came to the service. Is this neutrality difficult? Yes, but it is necessary; otherwise, many people would be left*

> *without care. Many people have done things that, in one's own judgment, would be considered wrong. Would you stop providing care for that reason? Part of my ethical, political, and clinical training involved not allowing my personal judgment to become an obstacle or something between the user and myself* (P1).

> *We must distinguish the professional from the personal dimension. In relation to intervening with users facing issues related to deprivation of liberty, there is no difficulty at all. We are there for that purpose; we are there to provide qualified listening, conduct proper anamnesis, and respond to the user's needs. So, not at all. This is SUS, right? We must treat everyone equally, we must respect the other, seeing them as human, regardless of what they have done in life* (P6).

Discussion

Based on the interviewees' accounts regarding care directed at the so-called "mentally ill offender", it is possible to observe that the historical trajectory marked by the rupture of traditional psychiatric paradigms, intensified after the enactment of Law No. 10.216/2001, enabled progressive advances in actions directed at this population, offering improved conditions for treatment and psychosocial follow-up. At the same time, there has been a strengthening of therapeutic relationships that are less bound to the stigma of dangerousness.

Such progress has been sustained, above all, through the formulation and institutionalization of laws, ordinances, and guidelines that orient mental health practices nationwide, such as the recent National Council of Justice (CNJ) Resolution No. 487 (Pará, 2025; São Paulo, 2021).

The change in the conception of people with mental disorders who are deprived of liberty is evident in the interviewees' statements, which are aligned with contemporary discussions about the application of SM. When these measures do not involve inpatient treatment, they consist of State strategies directed at offering specialized care to offenders whose actions were related to their mental health condition, through therapeutic interventions within RAPS, especially in CAPS units, which play a central role in mental health care for severe and persistent cases. These services provide territory-based follow-up with multidisciplinary teams and therapeutic support appropriate to each user's needs (São Paulo, 2021; Brasil, 2022).

Moreover, the PNAISP reinforces essential SUS principles such as equity and universality, without rights-based discrimination and unrelated to moral judgment. These principles facilitate approaching the singularities of users who remain incarcerated, which may consequently influence the reduction of offense recidivism.

All interviewees recognize that care based on freedom constitutes a fundamental element for psychosocial rehabilitation. However, they also report that this premise has been compromised by the dismantling of RAPS observed over the last decade, a process intensified during the Bolsonaro administration.

This dismantling is reflected in legislative changes introduced by official documents such as Technical Note No. 11-CGMAD/DAPES/SAS/MS of 2019 and Ordinance GM/MS No. 3.752 of 2021, which distorted the psychosocial model previously adopted and reinstated a logic aligned with total institutions (Brasil, 2019, 2021).

The current situation of psychosocial services within SUS reveals fractures imposed upon RAPS, intensified between 2019 and 2022, with consequences for structural conditions, physical infrastructure, and the availability of human and material resources.

These setbacks in SUS legislation and the weakening of the psychosocial network reinforce the outdated conception of the mentally ill as inherently dangerous, whose reintegration into social circles after committing an offense would be undesirable. Historically, the belief that danger is intrinsic to madness was used to justify the maintenance of segregated institutional spaces under the claim that these structures could contain the unpredictability of the mentally ill (Brasil, 2014b, 2022).

According to Junqueira (2021), dangerousness constitutes the main legal foundation for maintaining SM for long periods. Thus, it is necessary to recognize dangerousness as an epistemic axis of the legal category: while culpability justifies penal sanctions, dangerousness legally justifies the application of long-term inpatient SM.

Prolonged institutionalization in penal units tends to exacerbate mental disorders, perpetuate psychological suffering, and restrict the possibilities of rehabilitation. It also contributes to the weakening or rupture of social ties outside the institution, intensifying processes of exclusion.

Thus, confinement in HCTPs is not therapeutic and favors practices of torture and violations of fundamental rights, given the difficulty this population presents in asserting their rights, which makes them even more vulnerable. Custodial psychiatric practice developed in opposition to the Brazilian Psychiatric Reform, which since 2001 has called for the deinstitutionalization of psychosocial treatments and the end of total institutions (São Paulo, 2021). Only in 2023, through CNJ Resolution No. 487, was the Anti-Total Institution Policy of the Brazilian Judiciary finally enacted, establishing, among other measures, the closure of HCTPs nationwide (Brasil, 2023).

In this context, EAP-Desinst, one of the devices discussed in this study and where some participants work, was created to mediate these issues. It is also governed by RAPS Consolidation Ordinance No. 2/2017, which is based on supporting network-based actions that identify SUS, SUAS, and citizenship programs needed to provide care to people with mental disorders, whether they are offenders or not (Simas et al., 2021).

Among the deinstitutionalization strategies adopted by EAP-Desinst in Pará for individuals discharged from HGPs, the participants highlighted actions ranging from obtaining or recovering personal documents to sensitizing families about the possibility of gradual reintegration, including applying for social benefits, developing action plans within RAPS services, and mapping available service networks (G1 Pará, 2020; Pará, 2025).

Beyond ensuring rights and strengthening support networks, Mielke et al. (2011) state that participation in community activities and experiences—such as dance groups, football training, and other physical, cultural, or leisure activities—enables RAPS users, including those discharged from judicial total institutions, to circulate and occupy the city, being recognized by the community as citizens. This not only ensures broader social participation but also promotes care in freedom, described by interviewees as essential.

Leão & Salles (2016) argue for the reconstruction of the everyday lives of individuals experiencing intense psychological distress, emphasizing the territory as a fundamental element within the framework of the Expanded Clinic and the development of PTS.

In this regard, CAPS units play a central role in transforming everyday life, as they are community-based psychosocial care services.

Mielke et al. (2011) highlight the construction of user autonomy as a distinguishing feature of mental health care offered in CAPS, a fundamental aspect of psychosocial rehabilitation directed at social reintegration.

In summary, the Units of Meaning demonstrate that the professionals participating in this study describe a type of care and understanding that does not blame, standardize, or stigmatize offenders with mental disorders. Instead, they emphasize community life as a space of care, where stigma and the idea of dangerousness lose strength as the subjects' possibilities for social interaction expand.

Thus, the results indicate a psychosocial perspective sustained by political guidelines rooted in the principles of the Brazilian Psychiatric Reform and the anti-total institution paradigm, producing mental health care based on receptiveness and understanding of users' complexities (Melo & Constantinidis, 2024).

Finally, when interviewing participants, the aim was to map the support provided to people with mental disorders subjected to SM within RAPS devices (including CAPS II, CAPS III, CAPS AD, and EAP-Desinst) and their integration with other services in the territory. However, the narratives did not show shared development of the PTS with other devices, nor frequent intersectoral meetings for case discussions, indicating weaknesses in implementing network-based care. Additionally, one participant noted that inadequate structural conditions in their workplace compromise the quality of care and hinder coordination across teams.

The PTS is described by Ferigato & Silva (2016) as a clinical management tool composed of combined therapeutic proposals and procedures for everyone, resulting from the collective dialogue of the network supporting their care. Thus, when this network is not well structured or connected, the PTS tends to lose its essential function, a situation reflected in the accounts analyzed.

Final Considerations

This study reveals a complex reality in which the participants' statements demonstrate the historical recurrence of the stigma of dangerousness that shapes the social relations of offenders with mental disorders.

The findings indicate that, in the context investigated, care based on freedom is understood as essential, even within a RAPS weakened by structural limitations, shortages of human resources, and limited material conditions in its health services.

The connection between the health and justice sectors, through dialogue and intersectoral actions involving psychosocial care services, ombudsman offices, and bodies of the Judiciary and the Public Prosecutor's Office, constitutes a fundamental element for ensuring humane and welcoming care for the "mentally ill offender". These actions aim at rehabilitation and social reintegration for this population, which has been historically excluded from community-based care, a core principle of the Psychiatric Reform and of deinstitutionalization policies.

In the field of public health, it is fundamental to strengthen discourses and practices that ensure universal, comprehensive, and equitable access to health services. Furthermore, promoting coordination among different levels and sectors of care is

crucial to guarantee continuity and effectiveness. It is equally important to value the voices, experiences, and lived realities of professionals and users, contributing to the development of more democratic and socially sustainable policies and practices.

Although understanding health–disease processes through social markers of difference and from an intersectional perspective is relevant, the participants did not include these elements in their accounts. Future studies with this population are encouraged to address this dimension.

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Author's Contributions

Thays Cristina Palheta Melo was responsible for study design, data production and analysis, writing and revision of the manuscript. Ingrid Bergma da Silva Oliveira was responsible for study supervision, data production, writing and revision of the manuscript. Amélia Belisa Moutinho da Ponte was responsible for study development and manuscript revision. Letícia Alves da Silva was responsible for manuscript revision, formatting, and verification of information sources. Helder Clay Fares dos Santos Junior was responsible for manuscript revision, formatting, and verification of information sources. All authors approved the final version of the text.

Data Availability

The data that support the findings of this study are available from the corresponding author upon request.

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