RESEARCH

THE REALITY OF A FORENSIC PSYCHIATRIC HOSPITAL ACCORDING TO ITS STAFF: FROM TREATMENT TO SEGREGATION

REALIDADE DE UM MANICÔMIO JUDICIÁRIO NA VISÃO DE PROFISSIONAIS: DO TRATAMENTO À SEGREGAÇÃO

REALIDAD DE UN MANICOMIO JUDICIAL EN LA VISIÓN DE LOS PROFESIONALES: DEL TRATAMIENTO A LA SEGREGACIÓN

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ABSTRACT

The present study aims at analyzing the context of a forensic psychiatric hospital responsible for mental health care, as well as public security. This is a qualitative case study. The study subjects were professionals working at a Psychiatric Hospital for Custody and Treatment (HCT). This institution treats and detains individuals under security measures. Data were collected through interviews and submitted to content analysis. Data analysis emphasized the dual attribute of the HCT: mental care institution and prison. This characteristic revealed the conflicts between institutional interests and duties. The results were grouped in four categories: characterization and objectives of the institution; working in a prison or in a hospital and working conditions; security measures or punishment. The results demonstrated the difficulty to classify this type of institution: forensic, mental institution or both? In the hospital studied the researchers observed inadequate working conditions, difficulty in promoting social reintegration, failure to comply with security measures, and compliance with punitive and repressive objectives to the detriment of health care ones. In conclusion, the professionals' perspective reflects the general representation of the institution as a place of control and exclusion of insanity.

Keywords: Delivery of Health Care; Crime; Patient Rights; Mental Health.

RESUMO

Objetivo: *analisar as condições contextuais de um hospital de custódia e tratamento, focalizando sua organização como instituição responsável por promover a função de assistência à saúde e de segurança pública.* ***Método:*** *optou-se pelo método de estudo de caso de natureza qualitativa como estratégia de investigação que estuda um fenômeno no seu ambiente natural. Os sujeitos foram profissionais que trabalham em um hospital de custódia e tratamento (HCT) cuja finalidade é tratar e privar da liberdade pessoas submetidas à medida de segurança. Os dados foram coletados por meio de entrevistas e submetidos à análise de conteúdo.* ***Resultados:*** *a análise evidenciou a dubiedade do HCT como instituição de saúde e ao mesmo tempo prisional, apresentando incompatibilidade de interesses entre suas funções. Os resultados foram agrupados nas categorias: caracterização e objetivos da instituição; trabalho em uma prisão ou em um hospital? As condições de trabalho; medida de segurança e pena. Os resultados mostraram que não houve consenso sobre a caracterização da instituição, que é relacionada a três diferentes modelos de equipamento social: penal, de saúde e misto. Foram evidenciadas precárias condições de trabalho, dificuldades em promover reinserção social, pouca adesão ao cumprimento de medidas de segurança e objetivos institucionais relacionados a funções punitivas e repressivas em detrimento das funções de atenção à saúde e cuidado.* ***Conclusão:*** *a posição dos profissionais reflete a representação da sociedade sobre a instituição como local de contenção e exclusão da loucura.*

Palavras-chave: *Assistência à Saúde; Crime; Direitos do Paciente; Saúde Mental.*

RESUMEN

El presente estudio busca analizar las condiciones contextuales de un hospital de custodia y tratamiento (HCT), con el foco en su organización como institución responsable de promover la función de servicio de salud y seguridad pública. Se trata de un estudio de caso cualitativo como estrategia de investigación para analizar un fenómeno en su entorno natural. Los sujetos eran los profesionales que trabajaban en un HCT, cuyo propósito era el tratamiento y la privación de la libertad de personas sometidas a medidas de seguridad. Los datos eran recogidos a través de entrevistas y sometidos a análisis de contenido. El análisis pone en evidencia el carácter dudoso del HCT como institución de salud y carcelario al mismo tiempo, con incompatibilidad de intereses entre sus funciones. Los resultados eran agrupados en las siguientes categorías: caracterización y objetivos de la institución; ¿trabajo en una cárcel o en un hospital?; condiciones de trabajo y medidas de seguridad y pena. Los resultados muestran que no hay consenso sobre la caracterización de la institución, que se relaciona con tres modelos diferentes de equipos sociales: penal, de salud y mixta. Se encontraron malas condiciones de trabajo, dificultades para promover la reinserción social, poca adherencia al cumplimiento de medidas de seguridad y objetivos institucionales relacionados con funciones punitivas y represivas en perjuicio de las funciones de atención sanitaria y cuidados de la salud. La postura de los profesionales refleja la representación social de la institución como un lugar de contención y exclusión de la locura.

Palabras clave*: Prestación de Atención de Salud; Crimen; Derechos del Paciente; Salud Mental.*

INTRODUCTION

Criminal lunatic asylums, nowadays called Custody and Treatment Hospitals (HCT), first appeared in the nineteenth century. Their objective was to house monomaniacs and degenerate criminals who threatened the values and functioning of public security. The criminal asylums assumed the characteristics of penal and mental institution, simultaneously: the prison and the asylum spaces overlapping each other. This ambiguous nature is reflected on professional attitudes at cross-purposes: criminal offenders are sent to jail and a hospital receives innocent individuals. Therefore, it is an example of a hybrid institution, an organization with conflicting objectives and difficult to define.[1,2]The criminalization of mental illness, one of the theoretical and technical debates within the psychiatric reform, needs to be studied so the social role of the HCTs can be understood. In theory, penalties and security measures have different objectives, type of implementation and enforcement conditions. Punishment is applied exclusively to those that can be held responsible for their acts and it is built on the culpability of the offender. On the other hand, the HCT is based on the dangerousness of the individual, not the culpability. It is considered ethically neutral, devoid of an afflictive character. However, the stigma of dangerousness becomes associated with that person, who needs a medical evaluation for the suspension of the security measures.[3,4]

The twofold purpose of such institutions - custody and treatment – does not have, in theory, a punitive character but calls into question the length of stay. Islands for the control of individuals banned from society were built in the interests of public safety. Care and treatment for those mentally ill submitted to legal restrictions, were replaced by their civil death. Mental hospitals could not offer anything but its inherent ambiguity.[2]

The dubious social reality of these institutions needs to be understood. Moreover, it would be necessary to offer staff training in order to enable them to deal with the relationship between crime and insanity, considering its symbolic and historical aspects. The development of strategies for analysing perceptions and the institution's socio-political context is also necessary. The study subjects' discourses and the relationship between the institution and society need to be considered in current social practices involving the confinement of people with mental disorders. The authors consider "mental disorder" as a set of clinically recognizable symptoms or behaviours associated with distress and the inability to function in ordinary life.[5]

In the second half of the nineteenth century, the combination of prison and mental hospital - two total institutions created by modern society to control and maintain social order - gave rise in Europe to the criminal lunatic asylum, currently known as forensic psychiatric hospital. The first institution of this kind was founded in the parish of Sandhurst, England, in 1857 and was called Criminal Lunatic Asylum. In other countries this type of institution arrived almost a century after the English experience. In the United States, the first asylum was created in 1855. In Brazil, the first regulations for the construction of criminal asylums - or of special units within detention centres - for the criminally insane were established in the early twentieth century.[6]The establishment of criminal asylums was closely related to the debate between two influential legal schools: the Enlightenment and the Classical Liberal School. The former, from late eighteenth to mid-nineteenth century, is a landmark in the concept of crime. A legalistic approach to the application of punishments based on humanitarian ideals ensured individualization and proportionality between crime and punishment. The latter, named by its positivist successors, is philosophically based on the rationalist, liberal and jusnaturalist conceptions of crime and criminal responsibility.[6,7] The establishment of criminal asylums in Brazil gained relevance thanks to biological determinist notions of the human being and the need for social control and prevention. The criminal lunatic asylum was renamed "psychiatric hospital for custody and treatment" after the 1984 Brazilian penal reform. The asylum was turned into a hospital for treatment and recovery. This does not mean that the government stopped interfering in them: they still have the custody of those admitted for treatment. The so-called "hospital" was never under the supervision of the Department of Health but of the Justice Department instead. This means that those institutions are officially penal institutions that do not follow Unified Health System standards and guidelines.[6,7]

The 2011 census provides most of the data on the HCTs. According to this survey, the country had twenty-three HCTs and three psychiatric treatment wards in jail complexes. A total of 3.989 individuals were institutionalized, 2.839 of which were under security measures; 117 were under security measures due to conversion of sentence; and 1.033 were waiting mental health assessment or court order for the case progress. The international literature on forensic asylums is scarce and poorly detailed, with little information on how they work.[6,7]In this study the researchers aimed at identifying the aspects and policies that characterize the HCTs as health care and public security institutions. The authors also tried to understand the role professionals play in this context. The research considers that the institution and its employees act primarily from the perspective of public security leaving aside the fact that they should also take care about the individuals' health. Therefore, the study analyses the context of custody and treatment focusing in its organization as an institution responsible for promoting healthcare and public safety.

METHODOLOGY

The authors carried out a qualitative case study, a type of research that studies a phenomenon in its natural environment. Such research strategy is used when the investigator has little or no control over a given situation and wishes to know how and why it happened. The case study allows the researcher to deal with conditions of a phenomenon within its real context, when boundaries between phenomenon and context are not well-defined and multiple sources of evidence are used.[8]A single case study of a HCT was carried out. The institution in question aims at providing custodial and health care services, psychiatric and therapeutic treatments, as well as promoting the re-education of detainees.

The study subjects were 20 health professionals (doctors, nurses, psychologists, social workers), administrative and security personnel (prison and administrative agents) of a HCT. The research sought to identify convergences and divergences in the participants' discourse. Prior to data collection, a pilot study consisting of five interviews was carried out. Its objective was to assess the understanding of the interview questions and check the goals and scope of the study. Changes were then made in the research roadmap. The pilot study interviews were not included in the final data analysis. Four interviews were lost due to mechanical problems and mishandle of the recording material. Researchers used convenience sampling. Inclusion criteria were: hired or civil servants occupying a position of trust; working at the institution for no less than six months and in direct contact with the inmates. Data saturation was used as parameter for limiting the sample. Letters and numbers according to the professional category and the order of the conversation identified each interview, i.e. ME01 (Interview Physician 01).

Data was collected in official documents, through observations and interviews with the participants in their place of work between August and September 2012. The interviews were recorded, transcribed and analysed using content analysis. This type of analysis consists of a set of communication analysis techniques, which seeks the essence of the discourses through systematic and objective procedures, as well as through the description of the message content. The object of content analysis is the person's speech and use of language in expression of ideas; it seeks to apprehend the study subject and/or the environment through what is behind the words, as well as different realities through what has been said.[9]

Data analysis consisted of three stages: pre-analysis (organization of material and systematization of the primary ideas); exploration of the material (coding of the ideas identified in the pre-analysis and their categorization); treatment of results, inference and interpretation (categorized data were treated in order to have meaning, provide inferences and interpretations).[9]The results of this study are grounded on literature on the theme and aim at interpreting the reality described by the interviewees. The following categories emerged from the analysis: characterization and objectives of the institution; working in a prison or in a hospital and working conditions; security measures and punishment.[9,10] The research was approved by the Ethics Committee on Human Research of the Federal University of Minas Gerais (COEP/UFMG), according to resolution 196/96, under protocol No. 65593.

PRESENTATION AND DISCUSSION OF RESULTS

The main limitations of the present study were the fact that it was not possible to generalize the findings to other HCTs and the elusiveness of the organization structure and staff (the organization chart and staffing ratio was not made available to the researchers). Therefore, other quantitative studies should be carried out on the Brazilian population under security measures, more comparative studies with other countries at a time of major changes in mental health care and on the guidelines of the Public Security Agencies for HCTs and their funding as well.

CHARACTERIZATION AND OBJECTIVES OF THE INSTITUTION

The first category dealt with the HCTs characteristics according to the professionals. The authors concluded that there was no discernible consensus among them about the institution's characterization and no significant differences were found in the discourses of the three professional groups. Three HCT models were identified: mixed institution, penitentiary and health care institution that even though linked, remained detached.

> *It's mixed, isn't? Its main goal should be healthcare. So it's mixed, but it has that thing about being confined in cells. Cells, to me, have to do with prison (AP01).*

> *The hospital, as the name implies, is a hospital, it's for treatment (EA01).*

> *I'd say it's a penitentiary institution because of its coercive aspect. So it can't be a health institution. (EA01).*

As a mixed institution, its units perform the caring function, whereas its security aspects have a public safety role. The former was characterized mainly by having a healthcare technical team responsible for healthcare and treatment of the inmates. Confinement and social isolation meant that its penitentiary aspect was better identified. The cells, the penitentiary agents, the lack of freedom and the security procedures characterize its penitentiary role; the medical team shaped it as a hospital.

There were no traces of unity between the two faces of the institution; although one depends on the other, only the conflicting aspects of their relationship were evident. Each side acted as if its actions were independent from one another. The reciprocity of the link between opposite sides led to an incompatibility between medical and criminal interests. Such peculiarities suggested that the HCT could not be considered as a single system; there were two systems instead at odds with each other and whose conceptualization was problematic, given that its basic characteristics are a crossing of opposite goals.

The penitentiary physical structure was a set of bars and galleries. A prison produces delinquency; it is an instrument of control and pressure on criminality, a tool of considerable power over bodies.[2,11,12] The professionals' reports reflected what the institution represents to society: containment of people who need to pay for crime and insanity. Their discourses confirmed the institution's social significance as a hospital for the custody of dangerous patients in the service of punishment. Thus, the security measures have lost their focus on care without punitive intent, reinforcing crime as symptom of dangerousness.[3]

Regarding health care, the institution was described as an appropriate place to rescue those socially vulnerable. Such perspective does not account for the vulnerability caused by the social isolation of a HCT. Eighteenth century writers considered mental hospitals to be therapeutic places where mental illnesses were cured. This notion established a clear link between treatment and institutionalization.[13] Other authors, following the principles of the Psychiatric Reform, described the practice and effectiveness of anti-asylum clinics.

The participants also reported the inability of the forensic hospital to achieve its therapeutic objectives, since it emphasizes control and moralization.[14,15]

According to the study participants the social significance of the institution resides in custody and isolation of patients from people outside the HCT.

Although treating the patients, the institution's main purpose was deprivation of liberty. Social protection made treatment look like isolation. Discrimination of what could be considered a menace as well as the stigma of madness was clearly shown in the speech of the respondents: "*You are going to protect society from a dangerous individual, a murderer, right? Society is safe from that individual; he's not going to scare community anymore*" (EA01).

Pioneer in criminal anthropology in the nineteenth century, Lombroso considered crime as distinctive of inferior, animalistic human beings; he made a link between social fear triggered by these criminals and the need for their detention.[16] The respondents' narratives showed remnants of Lombroso's theory - there was no denial. Theories and science of the twentieth and twenty-first centuries have not been overcome for new practices to be applied. The shift of paradigms on dangerousness and treatment of the insane did not step into the forensic asylum.[16]

Regarding the penitentiary issue, the participants' narratives suggested the need for a suitable place for the serving of sentences. According to them the institution objective is to confine individuals who broke the law. It still demands from its patients the atonement for the crimes committed (EAP01). The notion of social justice appears intertwined to the institution: social justice is supposed to be preserved and enforced to ensure public order and punish those outside the law.

The asylum walls isolate completely its premises from the outside world. Isolation is the result of the association between the patients' dangerousness and the need for social protection. In this sense, the HCT can be characterized as a total institution, which withdraws the individual from society and wards off any interaction with the reality beyond its walls.[1]

According to the study participants, the HCT is based on the immutable notion of social protection. It still preserves past psychiatry ideas and the (mis)treatment of insanity. Physical structure, principles and health policy were maintained, despite the existence of new laws ruling over the treatment of mental cases.[17,18]

> *The hospital was built 80 years ago, that is, before I was born ... [...] The institution is sick in every way, the building, the physical apparatus, its architecture... and you can't touch it because it's listed. [...] These are the small things; because it's a public property, it can't be modernized and it doesn't really meet our needs (EP01).*

The above fragment of an interview describes the institution's lack of movement, its immutability. The immutability of the physical structure reflects the immutability of the asylum treatment model; and there are no prospects of change.

The superficiality of movements in favour of changing the treatment of mental illnesses prevented the renovation of HCTs as well as their chance to keep up with paradigms already being socially challenged. The immovability of the hospital physical structures justifies the maintenance of HCT's decades-old procedures. A listed site can be looked after, renovated according to its needs, preserving its architectonic features of historical interest and beauty. The lack of improvements means primarily that the lunatic asylum is stuck in the past, undignified, immutable.

Specialists discuss the need for movements that go beyond the deconstruction of the asylums walls: the symbolic walls and the outdated practices. This prison-like environment clashes with the need of health professionals for a proper workplace. According to the respondents, the organization of this physical space interfered with the treatment, generated inefficiency and maintained its penitentiary objectives.

The uncomfortable feeling caused by prison bars did not prevent their being considered natural and necessary, given the patients potential threat to society.[2,14,19] Additional reports on the inmates re-education, in order to foster conditions for their reinsertion into civil society, had no practical support. The re-education process did not focus on pedagogical issues or intellectual work, but on training and polishing socially deviant behaviour. Ethical issues were perceived according to a Manicheistic philosophy, i.e. what is a morally positive and/or negative behaviour. The ideological purpose of the institution was to standardize the individuals for them to fit the dominant power credo: i.e. an acceptable and a socially unacceptable act.[20,21]Discipline was used as a mechanism of dominance: to be obeyed and to promote a sense of usefulness in the individuals.[20] Coercion, exercised through discipline, is used in the manipulation of behaviours and attitudes, submissive and docile bodies. In the HCT, abandonment and exclusion were the key notes: patients were abandoned by the institutional system, through endless hospital stays; and the relationship between insanity and exclusion produced abandonment. The lack of official protection as well as social rejection or neglect of families endorses the definitive abandonment of those patients:

> *"It is a place of neglect…..they are already labelled as crazy or insane in the mental health assessment. Families abandon them; no one wants them… too much work" (EAS01).*

All but one of the narratives were favourable to the HCTs. According to this participant, the HCT was a place of segregation, taking away the individuals' possessions, making them an "object of manipulation […]" (EP03). *Life imprisonment to those rejected by the social system […]"* (EP03). Still according to this dissenting voice, its extinction would be the only solution to segregation; a long-term process only to be implemented if it managed to raise public interest.

Do I work at a prison or at a hospital? The working conditions

In this category the authors discussed work and the insertion of health professionals in the institution. The first noticeable aspect was the lack of interaction between health professionals. Individual performance and the lack of meetings to discuss work meant that dialogue among professionals was non-existent; furthermore, there was no appropriate planning. Such scenario interfered with work processes; there was no physical or institutional space to discuss their experiences or to make adjustments in interventions and this favoured the creation of parallel groups. As a result, there were no treatment plans and inmates were treated randomly, unsupervised: *"The health teams, responsible for dealing with the patients, lack integration. Every man for himself; it is not a group thing… There is really no teamwork."*(EM02).

The study demonstrated there was no training at all prior to taking the job at the HCT. The participants' responses showed lack of knowledge at the beginning of professional practice and that no training or guidance was given to them on how to deal with their task. They were neither aware of the institution objectives nor its reality. The professionals felt thus helpless and alone. They unanimously agreed on the need for specific training courses that would enable the implementation of interventions according to the needs of the institution.

Lack of material and human resources assumed even greater proportions due to poor workload allocation. Maintaining the institution fully staffed was a problem explained by the low salaries. Respondents complained about the short supply of health professionals (particularly nurses, psychiatrists and experts) and work overload. Work overload, though common in other health institutions is, however, greater in the HCTs, especially in writing expert reports on the dangerousness of psychiatric patients.

The authors of the present study wonder how an institution whose main objective is to offer medical treatment can be run when there is a shortage of physicians and nurses. Lack of an adequate number of health professionals did not justify the lack of service, but was used as an argument for not taking proper care of patients. During an emergency, the professional in charge of helping the patients could not be found. The amount of prison officers demonstrated that they were at the front line of the institution's everyday life. Deviation from agreed duties was also noticed and the patients were not attended to properly. Such issues do not have conclusive answers but emphasize contradictions in the HCTs.[22] The respondents stressed issues related to working conditions. The researchers noticed the effort to provide care, despite the mistakes. Patient monitoring during hospitalization and after was the institution's responsibility and a benefit to the patients. However, throughout the treatment, punishment was the first objective: treatment was merely a supplement to penalty: *"I think that a hospital with such a structure could hardly be able to recover or treat someone. In a closed environment like this. More like a prison than a hospital".* (EM02)

Security measures had a double protection function established by law. The legal system put in place an administrative mechanism that made the execution of the sentence an autonomous entity. The power to punish was relocated and undertook the task of caring for the individual, but did not move away from the power to torment souls.[2,20] The literature shows that the participants' concepts of treatment go against the current mental health therapies influenced by anti-asylum movements. Such movements aim at deconstructing the phys-

ical structure and the symbolism of asylums; they are against social exclusion and focus on the patients' uniqueness and their right to citizenship.[14,15]

The history of mental illnesses demonstrates that the consequence of confinement is the annulment of the patient's subjectivity and stresses the importance of interventions that do not allow mental health to become an instrument of social control.[1,2]

The participants' narratives revealed that treatment procedures used in other penitentiaries were the parameter for their own practices. There was a reversal of values applied to HCT patients. Isolation, compulsory treatment and the strictness of institutional routine were deemed helpful and positive, but only for marginalized individuals. The professionals' knowledge about treatment of psychiatric patients was imprecise. Obsolete practices and concepts were still in use with some adjustments.

Other professionals did not believe in the effectiveness of the HCT treatment. Lack of training and exchange of ideas between them were highlighted as preventing the achievement of health-related objectives, leading to isolated, contradictory and even incompatible interventions.

Working conditions were similar to those in prison environments, thwarting the patients' treatment and recovery. Lack of commitment with treatment was also observed: *"the visit lasts a few minutes; they only check whether the patient is ok or not, you know? [...]"*. (EP02) Trivial procedures that did not meet the patients' needs were the keynote in the institution.

The need for the patients' social reintegration was recognized by the professionals, although there were no effective movements in that direction. The professionals' scepticism on the feasibility of patient reintegration prevented effective actions, despite an incipient movement for the end of permanent institutionalization in the HCT. Amongst well-founded justifications for this vision were: absence of proper structure; lack of government and social organization to guarantee the right to social reintegration (many individuals remain unnecessarily institutionalized).

Literature on patient social reintegration suggests a project built on the ties between the patient and the city and on activities that ensure their engagement in a cultural life.[2, 12]The constant lack of medication was pointed out as a hindrance to the evolution of the cases given that drug therapies were started and then interrupted, causing imbalance in psychiatric patients.

The lack of a personalized drug therapy meant that all patients were on standard medications, with variations on the dosage. According to the study subjects, there was no individual evaluation for the prescriptions: *"The hospital dispensary is deficient; there are no qualified personnel and medication is in short supply"* (EE01).

Some professionals stated that medication was the mainstay of the patients' treatment and a source of security for the health staff, especially physicians. Reports indicated that drug treatment was a priority focused on keeping the patient stable. It was used mainly to relieve psychiatric symptoms. Outside drug therapy, there were few other therapeutic resources.

The literature, discussing some psychiatric treatments still in use today, highlights the contradiction in the same paradigm: on the one hand there is treatment, on the other care.[22] Treatments focused mainly on the eradication of symptoms in order to stabilize patients reducing the occurrence of crisis and aiming at the patient's social re-adaptation. In this sense, drug therapy is seen as a major opportunity to minimize symptoms.[22]

According to one respondent, current, legal, theoretical and technical aspects of mental health care were being overlooked in the HCT. Grounded basically on a pharmacological treatment strongly influenced by a hospital-centred model, the HCT remained oblivious to the fundamental principles of Law No. 10.216, which regulates the protection and rights of people with mental disorders and readdresses the care model in mental health. This Law guarantees, amongst other rights, access to a better treatment in the health system, according to the patients' needs and prioritizing their inclusion in the family, at work and in the community. Law No. 10.216 defines the special care due to long-term patients, without discarding the possibility of punishment for involuntary and/or unnecessary institutionalization.[23]

Security measures and Punishment

This category dealt with the institution's central dilemma: is the inmate insane or criminal? The judge pounds his gavel, the sentence is pronounced: to the criminally insane are left the contradictions of the Forensic Hospital.

The analysis of the interviews enabled the researchers to understand better the context of the institution. The movements reflected accumulations linked to conceptions, preconceptions and social prejudices about the danger insanity poses to society, the power of punishment in the name of social order and the hegemony of the ruling classes. The study found that the health professionals were not aware of the legal definition of security measures and, consequently, ignored the fundamentals of criminal sanctions enforcement.

There was a miscellany of concepts and assumptions that had not achieved the theoretical and practical goals of their application. The study participants were not certain about security measures being criminal sanctions aimed at the authors of a punishable criminal act – and yet not guilty given their unaccountability status:[21, 24] "But I think that justice must be done, you know? And if he committed a crime, he should pay for it; although being unaware of that" (EA01).Even allowing for the patients legal incapacity, the participants expressed the idea of the majority: they were unable to recognise the illegal nature of their acts but, as they had committed a crime, they should be pun-

ished. They reproduced a social paradigm, perpetuating the bases of the punishment of civilized societies. Modern technology of punishment was characterized in the social imaginary through the punitive control created by the ruling classes who made the soul a prison of the convicts' body. The interviewees did not accept the exclusion of guilt, as prescribed by the penal code.

Consequently, the notion of punishment was not wiped out.[20,25] The participants with some knowledge of criminal law also did not recognise guilt as the foundation of punishment and the opposite of strict liability. Although security measures demand the individual's care and treatment without punitive intent, the HCT, like any other prison unit, implemented the deprivation of liberty. There was reciprocity between treatment and punishment therefore the HCT became a privileged space for actions between contradictory procedures. The disagreements between criminal law and criminal sanctions furthered the contradictions of the institution. The term "security measure" given to penal sanctions was understood literally by the professionals: it meant social security. *"Dangerous people" that could jeopardize the social order must be put aside and detained, in the interests of public safety [...]"* (EM02).

Therefore the purpose of hospitalization was to remove the patient from society. The literature describes the historical approach between crime and insanity. Health and security workers maintain this view when they tend to consider crime as a manifestation of mental illness. The intrusion of Psychiatry concepts in the legal machinery meant that human beings were shaped according to specific moral profiles of thought and behaviour. Certain type of behaviours seen as criminal assumed the role of object of reflection and incorporated cruelty, indiscipline and dangerousness to insanity. In this sense, the link between crime and mental illness was reproduced without a critical assessement.[2] The macro and micro-organization of the HCT care model should be reconsidered.

CONCLUSION

The results highlighted ambiguities of the HCT: the institution is responsible for custody and treatment of its inmates; however it is unable to act equitably according to its treatment and custody objectives. The two divergent opposites collided and hindered the work process of health professionals and security personnel. The creation of a criminal and medical institution focused on the shared responsibility of both areas. Their duties, however, complemented each other: there was a clear prevalence of internal surveillance at the expense of health care. Security measures, according to the professionals, work as a common criminal sanction.

The medical and the security areas deal with important social control devices. Medicine, the control over life and death; and Law, control over the freedom of the individual. Such control and authority was acquired through knowledge, recognized by society and essential for social organization. These knowledge areas would have to give up the need to steal the spotlight and share the space. This would mean to give up the control of the situation which may lead to a lack of interest in pursuing the initial objectives. The division of interests mean that there is no middle ground to ensure individual ideologies (in a Marxist sense). Disagreement causes mutual cancellation of movement between the two opposite powers.

Security measures, supposed to be temporary, are often a permanent removal from society. Treatments are not customized, but most of the times the staff resort to drug therapy to minimize undesirable behaviours. The HCT mental health specialists do not believe in the efficiency and effectiveness of treatments that are carried out; they follow routinely with procedures, prescribing medications, performing forensic examinations requested by judges and collaborating with surveillance, oblivious of the inmates, monitored on a permanent basis. Health professionals are present, almost symbolically, but patients do not benefit from their practices and knowledge.

The issues discussed in this article can contribute to the organization, planning and training of the HCT staff. The analysis of such issues may promote a more professional and human attitude towards the patients. Reviewing work and care processes can improve the level of commitment and satisfaction of the health professionals, given that staff, internees and institution are equally abandoned.

The authors recommend further research on forensic psychiatric hospitals; they are little studied and remain in the shadows of a dark history.

REFERENCES

1. Goffman E. Manicômios, prisões e conventos. São Paulo: Perspectiva; 2008.
2. Carrara S. Crime e loucura: o aparecimento do manicômio judiciário na passagem do século. Rio de Janeiro: EDUERJ; 1998.
3. Peres MFT, Nery AF. A doença mental no direito penal brasileiro: inimputabilidade, irresponsabilidade, periculosidade e medida de segurança. Rev Hist Cienc Saúde-Manguinhos. 2002; 9(2):335-55.
4. Barros-Brisset FO. Rede é um monte de buracos, amarrados com barbante. Rev Bras Crescimento Desenvolv Hum. 2010; 20(1):83-9.
5. Organização Mundial de Saúde. CID 10: classificação de transtornos mentais e de comportamento. São Paulo: EdUSP; 1994.
6. Harvey G, Lindqvist P. Forensic psychiatry in Europe. Psychiatr Bul. 2007; 31:421-4.
7. Diniz D. A custódia e o tratamento psiquiátrico no Brasil. Brasília: UnB; 2013.
8. Yin RK. Estudo de caso: planejamento de métodos. Porto Alegre: Bookman; 2005.
9. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
10. Marx K, Engels F. Cartas filosóficas e outros escritos. São Paulo: Grijalbo; 1977.
11. Foucault M. História da loucura na idade clássica. São Paulo: Perspectiva; 2004.
12. Sampaio PC. Passagens. Rev Bras Crescimento Desenvolv Hum. 2010; 20(1):30-5.

13. Pinel JPJ. Biopsicologia. Porto Alegre: Artimed; 2005.
14. Lobosque AM. Clínica em movimento: por uma sociedade sem manicômios. Rio de Janeiro: Garamond; 2003.
15. Amarante P. Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil. Rio de Janeiro: Escola Nacional de Saúde Publica; 1995.
16. Lombroso C. O homem delinquente. São Paulo: Ícone; 2007.
17. Barros FO. Democracia, liberdade e responsabilidade: o que a loucura ensina sobre as ficções jurídicas. In: Conselho Federal de Psicologia. Loucura ética e política: escritos militantes. São Paulo: Casa do Psicólogo; 2003. p.112-36.
18. Silveer E. Punishment or treatment? Comparing the lengths of confinement of successful and unsuccessful insanity defendants. Law Hum Behav. 1994; 18(1):63-70.
19. Barreto BA, Valença AM, Jozef F, Mecler K. Periculosidade e responsabilidade penal na esquizofrenia. J Bras Psiquiat. 2004; 53(5):302-8.
20. Foucault M. Vigiar e punir: nascimento da prisão. Petrópolis: Vozes; 1987.
21. Moran R. Knowing right from wrong: the insanity defense of Daniel McNaughtan. NewYork: The Free Press; 1981.
22. Venturine E, Casagrande D, Toresine L. O crime louco. Brasília: Conselho Federal de Psicologia; 2012.
23. Brasil. Lei 10.216 de 6 de abril de 2001, Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Diário Oficial [da República Federativa do Brasil]. Brasília, 9 abr. 2001, Seção 1, p.2.
24. Jacobina PV. Direito penal da loucura: medida de segurança e reforma psiquiátrica. Rev Direito Sanit. 2004; 5(1):67-85.
25. Cohen C. Medida de segurança. In: Cohen C, Ferraz FC, Segre M, organizadores. Saúde mental, crime e justiça. São Paulo: EDUSP; 2006. p 123-9.