Revista ARACÊ
ISSN: 2358-2472

THE RIGHT TO MENTAL HEALTH IN LEP AND PNAISP: A BRIEF DEBATE

https://doi.org/10.56238/arev7n2-109

Submitted on: 11/01/2025 **Publication date:** 11/02/2025

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ABSTRACT

The right to the mental health of the incarcerated population is evidenced and advocated in the National Policy for Comprehensive Prison Health Care (PNAISP), approved in 2014. However, since 1984, the Penal Execution Law (LEP) presents brushstrokes of the debate in the light of the context of the time, where mental health was little understood as a basic guarantee of rights to populations in general, especially those deprived of liberty. This text seeks to address the various nuances that corroborate the historical construction of this right, as well as to enunciate some of the urgencies of the agenda in question and how it has been faced in terms of public policies in Brazil.

Keywords: Mental Health. LEP. PNAISP. Public Policies. Brazil.

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ISSN: 2358-2472

INTRODUCTION

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The Penal Execution Law - LEP (1984) is a normative document that indicates administrative guidelines for the operation of Brazilian penal establishments, as well as the duties and guarantees of rights of the person deprived of liberty. The document has undergone several changes in its almost 40 years of existence. Like a patchwork quilt, it is possible to observe divergent passages from each other, and gigantic changes since its sanction to the present day. One of them that interests us in this debate is the guarantee of health care, with a specific focus on mental health.

The Penal Execution Law (LEP) of 1984 ensures medical, pharmaceutical, and dental care (Brasil, 1984) to prisoners. However, for a long period, due to the lack of investment in the health of the population deprived of liberty, the expected results and comprehensive health care in prison spaces were not produced. (Brazil, 2016). For about 30 years, the prison population did not have policies aimed at debating health. Politics is a public and political project that demonstrates political will and state commitment to whatever the target audiences of care are. It is the guarantee that you have that parameters, management, and priority planning of care are thought out. Without a policy, the LEP was until then the legal framework that in just two lines alluded to the term "mental health":

> Article 183. When, in the course of the execution of the custodial sentence, mental illness or mental health disorder occurs, the Judge, ex officio, at the request of the Public Prosecutor's Office, the Public Defender's Office, or the administrative authority, may order the substitution of the sentence for a security measure. (Text given by Law No. 12,313, of 2010).

The only comment refers to what is currently known as a judicial asylum. Security measures are intended for those who commit crimes and who, because they have a mental disorder, cannot be held responsible for their actions and, therefore, should be treated and not punished. (Borges, 2014, p.14). It is worth mentioning that the only times that the word "mental" in the document refers to illnesses and mental disorders. Health here is circumscribed in the functionalist plan that defines health as the absence of disease. The World Health Organization (WHO) defines health not only as the absence of disease, but as the situation of perfect physical, mental, and social well-being. This definition, even advanced for the time in which it was made, is, at the moment, unreal, outdated, and one-sided. (Segre; Ferraz; 1997, p.3).

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According to Nascimento et. al (2020, p.6), Soares Filho and Bueno (2016) describe that the historicity of health actions in the prison system dates back to the beginning of religious entities. With the advent of HIV/AIDS in Brazil in the 1980s, some health professionals, especially physicians sensitive to the suffering of the prison population, began actions to prevent and treat this disease. From then on, the issue of prison health became the focus of actions and regulations by national and international bodies. In Brazil, the first regulation of prison health was made by the LEP (Law No. 7,210), of 1984, which postulates in Title II, chapter II, art. 11 that PPL have the right to material assistance, health, legal, educational, social and religious assistance.

Article 14 of the LEP provides that health care for prisoners includes medical, pharmaceutical, and dental care. Taking into account that it was only in 2003 that the National Health Plan in the Penitentiary System - PNSSP, guided the offer of psychological care. This document contains the guidelines for the operation of health care provision as well as the criteria for adherence and monitoring. This is an Interministerial Ordinance, which means that it will be implemented with the partnership of two ministries: the Ministry of Health and the Ministry of State for Justice.

In the description of types of primary care actions, item b contains: *Mental health care: actions to prevent psychosocial problems resulting from confinement; attention to situations of serious damage to health resulting from the use of alcohol and drugs, from the perspective of harm reduction*. The Plan provided for the allocation of resources in the amount of about 20 thousand reais per year, to Municipal Secretariats, in regions where the prison units had up to 100 inmates (Brasil, 2005, p.16).

As main goals, the PNSSP stipulated the implementation of Psychosocial Care Programs in prison units capable of contributing to the prevention and reduction of psychosocial problems resulting from the situation of confinement in 40% of prison units in the 1st year, 60% in the 2nd year, 80% in the 3rd year and 100% in the 4th year; and the care of situations of serious damage to health resulting from the use of alcohol and drugs, with the perspective of harm reduction in 40% of prison units in the 1st year, 60% in the 2nd year, 80% in the 3rd year and 100% in the 4th year. (Brasil, 2005, p.36).

The following organizational chart demonstrates the main differentiations between the three normative documents that dealt with the guarantee of health of people in deprivation of liberty (it includes the age of majority, for juvenile offenders, the Policy implemented is the National Policy for Comprehensive Health Care for Adolescents in

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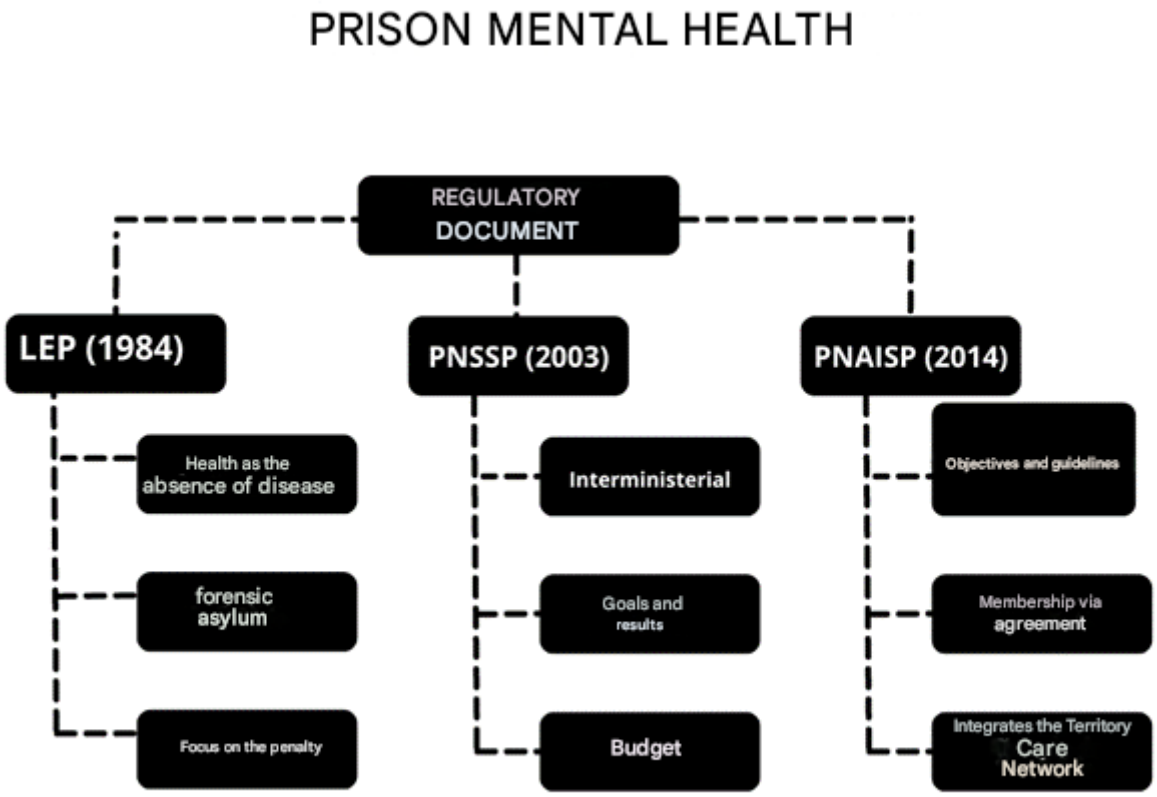
Conflict with the Law (PNAISARI)).

Figure 1: Author's elaboration.



Social rights, provided for in the 1988 Federal Constitution, were not implemented simultaneously for the Brazilian population. The right to health, a right of all and a duty of the State, is guaranteed by Article 196 of this Constitution and by Laws 8.080/90, which established the Unified Health System (SUS), and 8.142/90, which provides for the participation of the community in the management of the SUS, was not guaranteed to persons deprived of liberty (PPL). To guide the social reintegration of prisoners, only in recent years have government measures been adopted to fulfill the State's duty in assisting prisoners through education, work, and health, as provided for in Law 7.210/84, the Penal Execution Law (LEP)? (Vallim; Daibem; Hossne; 2018, p.2). Only later, debates in the field of public health and Human Rights drove the regulation of the National Policy for Prison Health Care - PNAISP, in 2014.

The PNAISP is the result of a Working Group (WG) prepared by the Ministries of Health and Justice, which brought together different actors in the construction of this policy

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between 2011 and 2013. (Domingues, 2012). In 2011, during the PNSSP evaluation, the prison population already reached 400 thousand inmates, with more than 1/3 in pretrial detention. At least 40% of the population remains in pretrial detention, an issue that minimally explains the overcrowding of prisons.[2] The slowness of the penal system is also a real problem and reflects on this imprisonment. If we think that in a decade, it is estimated that there will be an exponential increase of about 150%, reaching the mark of 1 million people in prison, at the very least we should be concerned as a society in solving this social problem that is prison.

One of the main factors in the exhaustion of the PNSSP was the significant increase in incarceration in the country. From 2003 to 2013, there was a 120% increase. Going from about 240 thousand in custody to 600 thousand. And this makes us think about *rights*. What explains this alarming increase? What are the other rights already neglected by these people even before they lose their freedom? Certainly, social inequalities appear in criminological analyses as a founding element of Brazilian incarceration.

Such a scenario pointed to the creation of a health policy that would encompass the entire prison itinerary that would have the power to dialogue with this unprecedented situation of overcrowding.

The PNAISP was born from the evaluation of the twelve years of application of the PNSSP, when the exhaustion of this model and the urgent need to promote the effective inclusion of people deprived of liberty in the Unified Health System were verified, complying with the principles of universality and equity. It was built in a participatory and democratic way, with the presence of managers, prison service workers, academia, and organized civil society. It was agreed upon in the Tripartite Integrated Commission (CIT) and deliberated by the National Health Council (CNS). The big leap is because, with this policy, people deprived of liberty become part of population groups served by the SUS. From then on, the PNAISP would be integrated into the RAS - Health Care Network, complying with the basic principles of the SUS. (Brazil, 2014).

But after all, what are the actions promoted by PNAISP?

[2] Available at: Infopen - National Survey of Penitentiary Information - Datasets - Ministry of Justice and Public Security (mj.gov.br).> Accessed on: June 02, 2022.

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Chart 1 - MAIN ACTIONS OF PNAISP

1) Ensure access to the Health Care Network in the territory with more agility, equity, and quality.
2) Promote actions for the promotion of diseases and prevention of communicable diseases, non-communicable diseases, and injuries resulting from confinement.
3) Improve health surveillance actions in food and hygiene conditions within prison units and ensure environmental health.
4) Operate by extending and deepening the actions of all programs of the Ministry of Health
5) To act in the prevention of alcohol and drug use and the rehabilitation of users.
6) Ensure protective measures, such as vaccination for hepatitis, influenza, and others on the adult calendar.
7) Ensure oral health promotion actions (e.g., lectures, brushing, and oral evaluation) and treatment.
8) Ensure access to general and specific mental health programs.
9) Ensure the acquisition and transfer of medicines from the basic pharmacy to the Health teams and distribution of supplies (condoms, sanitary pads, among others) to prisoners.
10) Multiply the basic prison health units and promote their functioning in the logic of the SUS.

Source: Ministry of Health, 2013.

Santa Catarina has not yet fully adhered to the Policy. And the municipalities that signed the Agreement have adhered to drug treatments, more expressively. Tables 01 and 02 below were extracted from official state documents regarding purchases of pharmaceutical inputs. It is not easy to locate reports that point to the allocation of resources to guarantee psychotherapeutic care, for example.

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Table 01 - Municipalities in Santa Catarina that adhered to the PNAISP by March 2022

Health Macro-region	Municipality - Prison Unit
Greater Florianópolis	Biguaçu - Prison São Pedro de Alcântara - Penitentiary Tijucas - Prison Palhoça - SSP - CAPH Colônia Agrícola
South Santa Catarina	Araranguá - Prison Criciúma - Penitentiary and Prison Imbituba - Advanced Prison Unit (UPA) Laguna - Advanced Prison Unit (UPA)
North and Northeast of Santa Catarina	Canoinhas - Advanced Prison Unit (UPA) Barra Velha - Advanced Prison Unit (UPA) Jaraguá do Sul - Prison Joinville - Penitentiary and Prison Mafra - Prison Porto União - Advanced Prison Unit (UPA)
Itajaí Valley	Blumenau - Penitentiary and Prison Brusque - Advanced Prison Unit (UPA) Rio do Sul - Prison
Itajaí Valley	Itajaí - Penitentiary and Prison Itapema - Advanced Prison Unit (UPA)
Midwest and Serra Catarinense	Rio do Sul - Prison Caçador - Prison Campos Novos - Advanced Prison Unit (UPA) Concordia - Prison Lages - Prison Joaçaba - Regional Prison São Cristóvão do Sul - Penitentiary São Joaquim - Advanced Prison Unit (UPA) Videira - Advanced Prison Unit (UPA)
Great West	Chapecó - Penitentiary and Prison Maravilha - Advanced Prison Unit (UPA) São José do Cedro - Advanced Prison Unit (UPA) São Miguel do Oeste - Advanced Prison Unit (UPA) Xanxerê - Prison

Source: Government of Santa Catarina/ State Department of Health.

Finding a prison unit with psychotherapy offers, as occurs in the women's prison of Itajaí, is not yet a reality in the state's penal establishments. The hiatus present in the official communication of the State Department of Health about the actions promoted by PNAISP is another point that deserves attention and intersectoral articulation in the sphere of civil society. Mental health care must be ensured to inmates.

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Table 02 - Municipalities in Santa Catarina that did not adhere to the PNAISP by February 2022 are agreeing to receive the resource in a decentralized manner

Macrorregião de Saúde	Município - Unidade Penal
Grande Florianópolis	Florianópolis - Casa Albergado
	Florianópolis – HCTP
	Florianópolis – Penitenciária
	Florianópolis – Presídio Feminino
	Florianópolis – Presídio Masculino
	Palhoça – SSP – CAPH Colônia Agrícola
Sul Catarinense	Tubarão – Presídio Masculino
	Tubarão – Presídio Regional Feminino
Norte e Nordeste Catarinense	São Francisco do Sul – Unidade Prisional Avançada (UPA)
Vale do Itajaí	Indaial – Unidade Prisional Avançada (UPA)

Source: Government of Santa Catarina/ State Department of Health, 2022.

During the pandemic, the number of incarcerations in the country worsened, and it is estimated that in a short time, it will reach the mark of 1 million people deprived of liberty. Prison health care in Brazil is something urgent to be considered and expanded in terms of care via the Unified Health System (SUS). And with the COVID-19 health crisis, unhealthiness, invisibility, and state negligence have become routine in Brazilian prisons. For women, the reality is even more frightening. The experience of stress in the prison environment - acute or prolonged - is especially related to depressive symptoms, which are more common among new prisoners and are related to a higher risk of suicide in prison. (Constantine; Assisi; Dick; 2016, p.3).

The prison ministry sent questionnaires to the penitentiary administration secretariats of 19 states, and of these, 13 responded: Santa Catarina, Rio Grande do Sul, Paraná (South region), Amapá, Manaus (North region), Alagoas, Maranhão, Pernambuco (Northeast region), São Paulo, Minas Gerais, Espírito Santo (Southeast region), Federal District, Goiás and Mato Grosso do Sul (Midwest); in the latter, the information is not at the

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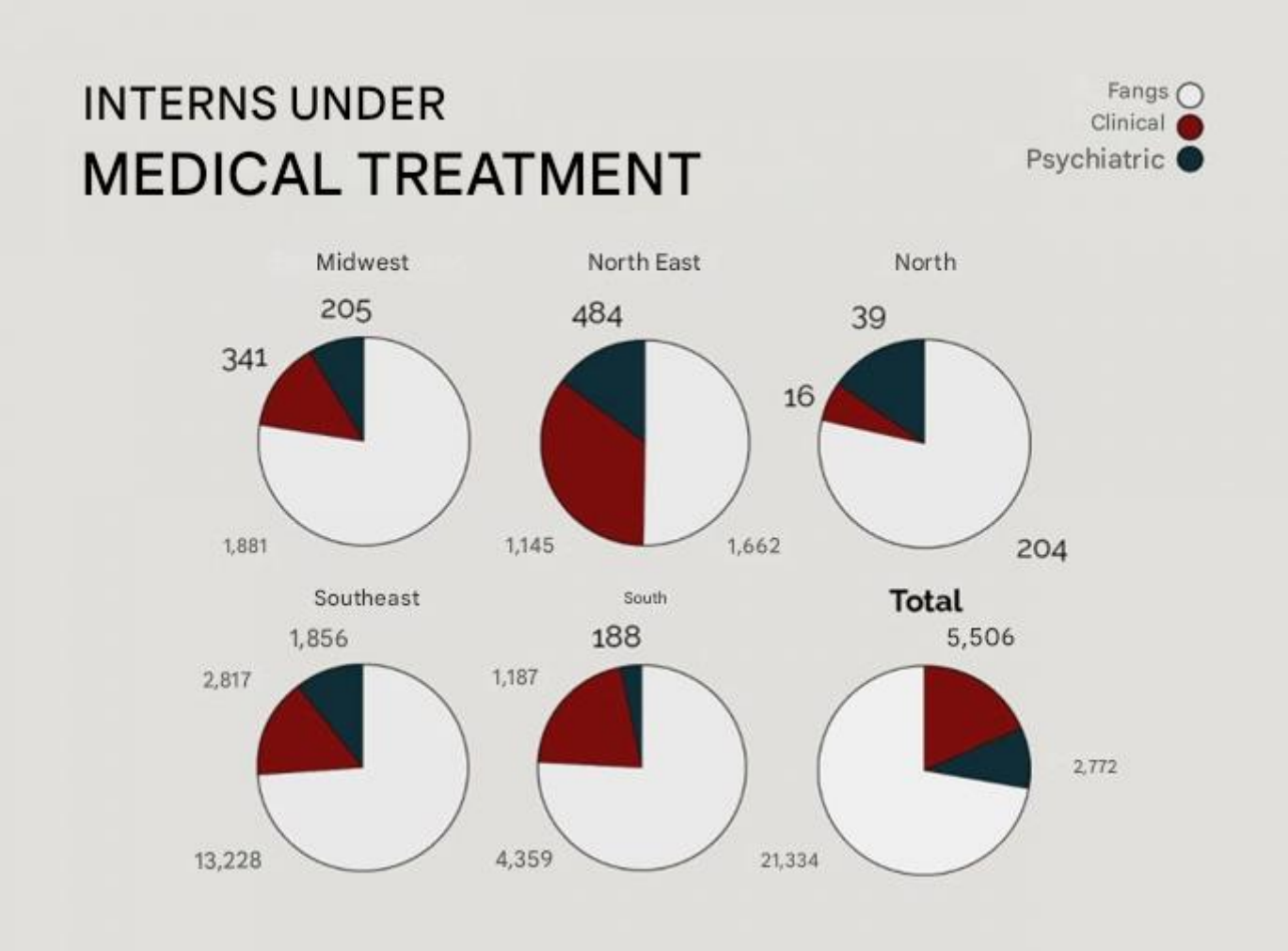
state level, but rather of some units that compose it, unlike the others.[3] When seeking information regarding the percentage of female inmates who are under psychiatric treatment, the South region is the one with the lowest number of inmates under psychiatric treatment, according to the answers to the questionnaires. However, this is not an absolute figure, given that only the Male Custody Hospital and the Santa Catarina Institute of Psychiatry provide care to women in situations of mental suffering and deprivation of liberty.



Source: Prison Pastoral, 2020.

We see so far that the PNAISP was only possible after inter-ministerial and intersectoral efforts to provide quality care to a population that historically suffers the direct and indirect impacts of the culture of "a good criminal is a dead criminal", contrary to what

[3] Available at: PCr Nacional releases research on women prisoners in times of pandemic - Pastoral Carcerária (CNBB) (carceraria.org.br).> Accessed on June 02, 2022.

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is provided for in the Federal Constitution itself. Before the existence of the National Penitentiary Health Plan, the responsibility for guaranteeing medical care was the responsibility of penal establishments. The LEP itself is an important document because it has all the legal guarantees that each user of the Brazilian prison system will have, including enabling decentralized action and ensuring the autonomy of prison and penitentiary units.

PNAISP intends to serve the entire prison flow, from provisional detention (police stations, public jails) to the largest penitentiary prisons (people who are already serving their sentences and are no longer in provisional detention). The teams work from 6 to 30 hours. The 6-hour teams were designed to serve up to one hundred people deprived of liberty. The 20h teams were designed to serve up to five hundred people deprived of liberty. And the 30-hour ones serve from 500 to 1200 people deprived of liberty. The composition of these teams varies between 5, 8, and 11 people. And when there is mental health support, there is an increase of 3 professionals. One of them is a doctor with experience in mental health (being a psychiatrist is recommended, but not a mandatory requirement).

The PNAISP provides for pharmaceutical assistance. The basic component of pharmaceutical services is carried out by the states. This is the only difference between the attribution of the state and the municipality in adhering to the Policy. Prison health can be implemented by both the state and the municipality. And most of the strategies are designed to be implemented in primary care teams. It is a Policy that requires will, to make the state government, and the municipalities take responsibility for their attributions (e.g., machinery, physical structure). The second step requires a license. The criteria are established by the Ministry of Health, which evaluates the transfer of funds.

However, adhering to PNAISP is the order of the day. It is necessary that civil society, researchers, and health and justice workers, act collectively demanding municipalities and states to guarantee this right, which unfortunately is generally in social oblivion. Psychic suffering cannot be ignored under the justification of moral or punitive regulation. Only with public, free, and quality care will we advance in the restoration of physical and mental comfort to subjects deprived of liberty. Without mental health, it is not possible to resocialize people in situations of abandonment and disorderly deprivation of rights.

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