Emergency psychiatric service in general hospitals: a retrospective study

SERVIÇO DE EMERGÊNCIA PSIQUIÁTRICA EM HOSPITAL GERAL: ESTUDO RETROSPECTIVO

SERVICIO DE EMERGENCIA PSIQUIÁTRICA EN HOSPITAL GENERAL: ESTUDIO RETROSPECTIVO

Fernando Sérgio Pereira de Sousa[1], Cezar Augusto Ferreira da Silva[2], Eliany Nazaré Oliveira[3]

ABSTRACT

The Emergency Psychiatric Service in General Hospitals (SEPHG, acronym in Portuguese) is a service included in the psychiatric reform movement. The purpose of the present study was to characterize patients with psychological distress treated at the Dr. Estevam SEPHG, located in Sobral, Ceará state. This exploratory study was performed using documental analyses with a quantitative approach, and involved 191 clients treated at the referred SEPHG from January to December 2007. Data collection was performed using a client register book, which contained information obtained from the patients' medical record. There was a predominance of male patients (70.15%), aged 30-49 years (48.71%) and single (74.86%). Most patients were from the city of Sobral (69.64%). In 42.40% of cases, the diagnosis was of alcohol use/abuse. Most clients (66.50%) sought the service voluntarily. After being evaluated at the SEPHG, 43.45% of patients were referred to the local Center for Psychosocial Care -Alcohol and other Drugs. The results emphasize the importance of mental health.

KEY WORDS

Mental health.
Mental Health Services.
Psychiatry.
Psychiatric nursing.

RESUMO

O Serviço de Emergência Psiquiátrica em Hospital Geral (SEPHG) é uma proposta articulada com o movimento da reforma psiquiátrica. Objetivou-se caracterizar os clientes com sofrimento psíquico assistidos no SEPHG Dr. Estevam, em Sobral-CE. Este é um estudo do tipo documental, com abordagem quantitativa, envolvendo 191 clientes atendidos no SEPHG no período de janeiro a dezembro de 2007. Os dados foram coletados a partir de um livro de registro, cujas informações nele contidas foram retiradas dos prontuários dos clientes. Observou-se predomínio de pacientes do sexo masculino (70,15%), com idade entre 30-49 anos (48,71%) e solteiros (74,86%). A maioria era proveniente da cidade de Sobral (69,64 %). Em 42,40% dos casos, o diagnóstico foi transtorno do uso de álcool. Grande parte da clientela (66,50%) deu entrada no serviço por demanda espontânea. Após avaliação do SEPHG, 43,45% desses clientes foram encaminhados ao CAPS-ad. Pelos resultados, depreende-se o quão imprescindíveis são os serviços de saúde mental.

DESCRITORES

Saúde mental.
Serviços de Saúde Mental.
Psiquiatria.
Enfermagem psiquiátrica.

RESUMEN

El Servicio de Emergencia Psiquiátrica en Hospital General (SEPHG) es una propuesta vinculada al movimiento de la reforma psiquiátrica. Se objetivó caracterizar a los pacientes con trastornos psiquiátricos atendidos en el SEPHG Dr. Estevam, en Sobral-Ceará-Brasil. Estudio de tipo documental con abordaje cualitativa, involucrando 191 pacientes atendidos en el SEPHG entre enero y diciembre de 2007. Los datos fueron recogidos a partir de un libro de registro, cuyas informaciones fueron extraídas de las historias clínicas de los pacientes. Se observó prevalencia de pacientes de sexo masculino (70,15%), con edad entre 30-49 años (48,71%) y solteros (74,86%). La mayoría provenía de la ciudad de Sobral (69,64%). En el 42,40% de los casos, el diagnóstico fue trastorno provocado por abuso de alcohol. Una gran cantidad de pacientes (66,50%) se presentó en el servicio en forma espontánea. Con posterioridad a la evaluación del SEPHG, 43,45% de tales pacientes fueron derivados al CAPS-ad. Se desprende de los resultados cuán imprescindibles son los servicios de salud mental.

DESCRIPTORES

Salud mental.
Servicios de Salud Mental.
Psiquiatría.
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[1] Nurse at Centro de Atenção Psicossocial Geral de Sobral. Sobral, CE, Brazil. fernando_sergio_1@hotmail.com [2] Mental Health Specialist by Escola de Formação em Saúde da Família Visconde de Sabóia and Universidade Estadual Vale do Acaraú. MD at Centro de Atenção Psicossocial Geral de Sobral. Sobral, CE, Brazil. jubaxxx@hotmail.com [3] Nurse. PhD. in nursing by Federal University of Ceará. Professor of the Nursing Course at Universidade Estadual Vale do Acaraú. elianyy@hotmail.com

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INTRODUCTION

Our interest in the study arouse from our experience at the Psychiatric Emergency Service at General Hospitals (SEPHG, abbreviation for *Serviço de Emergência Psiquiátrica em Hospital Geral*) in Sobral, Ceará, when we realized the importance of knowing the clientele being assisted as well as some of the characteristics of the care that is delivered. From our understanding, deep changes have been made to the concepts of psychiatric care. Therefore, new knowledge and practices have been outlined, which require constant reviewing and studies considering the context of the situation at the location involved, thus making it possible to made advancements in the development of strategies that could provide greater support to the mental health demand.

The history of psychiatry in Brazil, in harmony with global psychiatry, was written through the seclusion of the mentally patient in places where violence, depersonalization of the individual and intolerance reigned, changing the person into a thing and, as such, without any individual needs or rights. Hence, those individuals were no longer seen as citizens[1].

For decades, the care to mental patients in Brazil followed the hospital-centered model, and the treatment it offered was limited to prolonged hospital stays, keeping the patient away from his or her family and social environment. In the 1970s, the change of the asylum model was discussed and implemented through the battles and conquests of the psychiatric reform, which is, day-by-day, consolidated in mental health policies. Historically, deinstitutionalization permeates the field of mental health among workers, families, and community as a whole[2].

In Brazil, the main axes of work of the mental health policy is to reduce the number of psychiatric beds, improve the control over hospitalizations, organize the network of substitutive mental health services and the acknowledgement of the citizen rights of people with mental disorders. These strategies configure a new form of understanding and treating mental disorders that remain dependent on health care structures guided by the perspective of comprehensiveness, herein understood not only referring to the thorough understanding of subjects, but also to the new values and technical devices[3-4].

Nowadays, after the movements to criticize the psychiatric institution, the Brazilian mental health policy, based on the presuppositions of the psychiatric reform, predicts a progressive substitution of psychiatric hospitals by extra-hospital services. Those services include Psychosocial Care Center (CAPS, abbreviation for *Centro de Atenção Psicossocial*), Mental Health Outpatient Clinic, Day-Hospital, Mental Health Services at General Hospitals, Centers for Community Living, Therapeutic Residence, Protected Boarding Home, Shelter Homes, mental health care in the primary health care network, in addition to other services that seek to reintegrate individuals with mental problems in society and to rescue their citizenship[5].

Our presupposition is that the change required by the new health policy is made effective in institutional working processes, whose analysis permits to reveal the qualities that the reform assumes to create a new Mental Health Care Model. The former corresponds to a category that synthesizes the understanding of the dynamic relationship in policy, which informs its guidelines and the form of organizing the services, which is where the practice to make the policy effective takes place [6].

As informed, the movement for deinstitutionalization proposes a new health care model, whose priorities are to maintain and integrate the patient in the community. In that perspective, Psychiatric Emergency Services at General Hospitals appear as one of the care pillars in this context of mental health care, provided with a network of diversified care services, decentralized and integrated with the health service network[7].

As predicted, the movement for psychiatric reform in Brazil aims at the deconstruction of the asylum reality – beyond physically *breaking down the asylum walls* – and constructing new realities, in harmony with new epistemological, political and social bases, operating transformations of a whole culture that supports violence, discrimination and the imprisonment of insanity. To do this, it is necessary to disassemble the psychiatric culture and structure that separated *a scientific object, the disease, from the complex and concrete global existence of patients and from the social body*[8].

Psychiatric emergency is, therefore, marked by a situation of crisis, unbalance, rupture, disturbance, conflicts, and disorder at the individual and collective levels.

This emphasis on extra-hospital treatment generated an increase in the number of patients subject to decompensations in the community. This context includes psychiatric emergency services, by means of an interface between the community and mental health institutions, offering agile care, with a view to characterizing clinical and psychosocial diagnoses of the patient's situation. Hence, the services provide immediate intervention and seek to give orientations about the best type of treatment for the case in the mid and long terms. The demand for immediate intervention and the role to decide to refer a case have specific characteristics regarding the handling of emergency situations, in terms of patient evaluation and the conduct proposed for the case[9].

Because the psychiatry crisis is characterized as a moment in life in which suffering is something so intense that it eventually causes a destruction not only in the psychic and social life of the subject, but also in that of his or her family, emergency services would become a place that would understand and offer the crisis a new meaning [10].

Psychiatric emergency is, therefore, marked by a situation of crisis, unbalance, rupture, disturbance, conflicts, and disorder at the individual and collective levels. It is an event

that emphasizes the dynamic and the movement of certain knowledge and practices concerning insanity[11].

In this context, immediate intervention by a multidisciplinary team is indispensible, with a view to avoid any further harm to the individual's health or to eliminate possible risks to theirs and others' lives.

In agreement with the proposition, the specific aim of the SEPHG concerns the prompt care to individuals who are in an acute existential situation that is above their personal ability of adaptation. It also aims at contributing to reduce the number and length of hospital stays, by rationalizing hospitalization criteria, treating acute mental disorders capable of remission or stabilizing in an average period of 72 hours. Furthermore, psychiatric treatment, including emergency treatments, should reintegrate the patients to their original social environment, as opposed to being the mere beginning of a custodial treatment. To do this, the health system must be organized with its extra-hospital components.

The general hospital offers an array of specialties for immediate consultation as well as the resources for appropriate diagnoses to make a precise identification of organic disorders that could be the cause for the psychiatric disorder. In addition, it also offers the opportunity to avoid the isolation of psychiatry, as it integrates it to the general health care service. In the meantime, it also avoids discrimination and stigmatization of mental patients.

Before the implementation of the Mental Health Network in Sobral – Ceará, emergency psychiatric care was mainly performed by *Casa de Repouso Guararapes* and by *Santa Casa de Misericórdia de Sobral*, which did not actually make the procedure official.

The current Psychiatric Emergency Service in Sobral – Ceará, developed at *Hospital Geral Dr. Estevam Ponte*, has floating beds, where clients stay for observation for up to 72 hours. During that period, clients are evaluated by the psychiatrist, who analyzes the client's mental state and determines the form of treatment. Depending on the case, the client continues the treatment at the extra-hospital facility, stays for observation, or is hospitalized at the psychiatric unit available at the aforementioned general hospital. Everyday experience shows that the clientele is most usually referred from their original municipalities or brought in directly by a family member[12].

The hospital is a reference in emergency psychiatric care on weekends, holidays, and daily after 6 pm, when extra-hospital services have closed. In those circumstances, the clinician on duty is usually the one responsible for providing first care and deciding if the patient should be discharged, stay for observation or be hospitalized, until being evaluated by the psychiatrist. This environment defends a professional practice that aimed at the identified situation.

In this view, by performing the present study, we will contribute with the construction of that practice, by increasing the discussion about the issue and favoring a practice that values and strengthens multidisciplinary and interdisciplinary care, consolidating a network of health care services, especially those regarding care in psychiatric crisis situations.

We, therefore, established that the objective of the present study was to characterize the assisted clientele and observe some of the aspects of the care delivered at the SEPHG of *Hospital Dr. Estevam Ponte* in Sobral-Ceará, by means of a retrospective study based on the survey of some demographic and clinical variables of the clinics where the care was provided.

METHOD

This is a document study using a quantitative approach. Data was collected from a registry book, from which the information on client patient records was extracted. Nonprobability convenience sampling defined the sample size. It was detected that 191 clients were assisted (with a request for psychiatric evaluation) on the observation beds of Hospital Geral Dr. Estevam Ponte from January to December 2007. Located in the City Center of Sobral-Ceará, it has three observation beds, where the client stays up to 72 hours for observation, and is evaluated by the psychiatrist, who analyzed the client's mental state and then determines if the treatment will be continued at the extra-hospital facility. The observation beds are intended for short permanence of users, and are indicated as a final resource for people in crisis, whose assistance at home or at the local outpatient clinic is not possible.

The study complied with all ethical regulations concerning research involving human beings (Resolution 196/96) and, hence, data collection was initiated after receiving the necessary approval from the directors board of UIPHG Dr. Estevam Ponte, which was officially provided after the Ethics Committee at Universidade Estadual Vale do Acaraú gave formal permission by means of the Certificate of Presentation for Ethical Considerations (Certificado de Apresentação para Apreciação Ética-CAAE): 0551.0.000.039 – 06. The authors also guaranteed that the information would be used only and exclusively for the academic-scientific purposes stated in this study.

Data organization and processing were performed using the Epi-Info 6.04. software, followed by a quantitative analysis of the information from the registry book.

RESULTS AND DISCUSSION

Regarding the sociodemographic characteristics of the clients, we observed that 70.15 % were male, with age between 30 and 49 years (48.71%), as shown in Table 1.

Table 1 - Sociodemographic characteristics of clients assisted at the SEPHG, Sobral-Ceará, from January to December 2007

Variables	N	%
Gender		
Male	134	70.15
Female	57	29.85
Total	**191**	**100**
Age		
10 – 19	30	15.71
20 – 29	46	24.08
30 – 39	62	32.47
40 – 49	31	16.24
50 – 59	13	6.80
60 or more	09	4.70
Total	**191**	**100**
Marital status		
Single	143	74.86
Married	42	21.98
Widowed	5	2.61
Divorced	1	0.52
Total	**191**	**100**

According to the World Health (WHO)[13], age is an expressive determinant of mental disorders. It is observed that the predominant age group consists of people who, despite the limitations caused by the psychic disease, are in an active age. Generally speaking, in this age group, disorders usually affect people's lifestyles, especially because it interrupts their productivity, as a consequence of the disabilities that some diseases may cause.

As shown in Table 1, the number of single clients was significant, because, according to the Year 2000 demographic census performed by the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística* - IBGE), in Brazil, the number of one-person families was grown about 32.5% from 1991 to 2000. The IBGE also states there has been a 4.5% drop in the number of registered civil marriages per year. In 1990, the marriage rate per 1000 people older than 15 years was 7.5, and it dropped to 5.7 in 2001[14].

According to the literature, about two-thirds of patients hospitalized in psychiatric hospitals in the city of Rio de Janeiro were single, i.e., they had never been in a long-term relationship. In addition, the proportion of single individuals was greater among men: similar to the present study results[15].

In terms of the origin of the clients assisted at SEPHG Dr. Estevam, 69.64 % were originally from Sobral. The other 30.36 % were from neighboring cities.

This is justified because the SEPHG is a reference for Sobral, a city where a great number of people need mental health care.

The maximum observation time for clients at the SEPHG was 24 hours. This finding shows there was a concern to not keep the client hospitalized for too long, different from that observed in the practice of old psychiatric hospitals. As discussed at the 3rd National Conference on Mental Health, the time of hospitalization criterion should be reviewed and it should be guaranteed, by means of institutional supervisions and inspections, that it be as short as possible, considering the psychiatric conduct and the evaluations performed by the multiprofissional team that follow the person being assisted [16].

Table 2 shows the proportion of diagnostic hypothesis considered according to the WHO International Classification of Diseases 10th Revision (ICD 10). As mentioned before, the most frequent diagnosis was referred to as mental and behavioral disorder due to the use of alcohol (42.40%) (ICD-10 F- 10).

Table 2 – Diagnostic hypotheses found in most of the clients assisted at the SEPHG, Sobral-Ceará, from January to December 2007

Diagnosis	ICD-10	N	%
Mental and behavioral disorders due to the use of alcohol	F 10.0	81	42.40
Depressive Episode	F 32.0	20	10.47
Dissociative disorders	F 44.0	19	10.00
Schizophrenia	F 20.0	16	8.40
Mental and behavioral disorders due to multiple drug use	F 19.0	12	6.28
Unspecified nonorganic psychosis	F 29.0	12	6.28
Mental disorder, not otherwise specified	F 99.0	9	4.71
Bipolar affective disorder	F 31.0	5	2.60
Schizoaffective disorders	F 25.0	3	1.57
Other anxiety disorders	F 41.0	3	1.57
Acute and transient psychotic disorders	F 23.0	2	1.04
Delirium not induced by alcohol and other psychoactive substances	F 05.0	1	0.52
Other mental disorders due to brain damage and dysfunction and to physical disease	F 06.0	1	0.52
Mental and behavioral disorders due to the use of alcohol + depressive episode	F 10 + F 32	1	0.52
Recurrent depressive disorder + Specific disorders	F 33 + F 60	1	0.52
Mental and behavioral disorders associated with the puerperium, not elsewhere classified	F 53.0	1	0.52
Habit and impulse disorder	F 63.0	1	0.52
Mild mental retardation	F 70.0	1	0.52
Severe mental retardation	F 72.0	1	0.52
Emotional disorders with onset specific to childhood	F 93.0	1	0.52

In our study we observed that alcohol is the most consumed drug among clients. In Brazil, the Brazilian Center for Information on Psychotropic Drugs (CEBRID, *Centro Brasileiro de Informações sobre Drogas Psicotrópicas*) performed the broadest epidemiological studies on the general population's use of alcohol. The study involved the 24 largest cities in the State of São Paulo, and performed 2,411 interviews. According to the results, 6.6% of the population was dependent on alcohol. Two years later, the same population was studied again and it was found that the number of dependents had suffered a statistically significant increase to 9.4%. Another domiciliary study involved 107 cities with over 200,000 inhabitants, corresponding to 47,045,907 people, i.e., 27.7% of the total Brazilian population. The sample comprised 8,589 interviewees. The rate for alcohol use in the population was 68.7%[17].

Table 3 shows the distribution of referrals to the SEPHG from January to December 2007.

Table 3 - Distribution of referrals to the SEPHG, Sobral-Ceará, from January to December 2007

Referrals	N	%
Spontaneous demand	127	66.50
Hospital Santa Casa de Sobral	20	10.50
SAMU*	8	4.18
Family Health Program of Sobral	6	3.14
CAPS-ad of Sobral	4	2.09
Family Health Program of Forquilha	4	2.09
Others	22	11.50
Total	**191**	**100**

*SAMU: Acronym for *Serviço de Atendimento Móvel de Urgência* (Mobile Emergency Care Service).

According to Table 3, most clients attended the service spontaneously (66.50%). Rating second were those referred by Santa Casa de Sobral (10.47%).

There are, undoubtedly, many impediments for user accessibility to the mental health area, because, traditionally, the basic health centers have responded for less than 10% of the demand, when they should be the primary place of embracement. In view of this limitation, they keep the emergency psychiatric service and hospital from becoming the entrance door to the services. This situation confirms the difficulty of including mental health in primary care as well as the centralizing role of the psychiatric hospital in the health care network[18]. As for the distribution of the referrals after the evaluation at the SEPHG between January and December 2007, we turn to Table 4.

Regarding the types of referrals after evaluation, it is observed in Table 4 that 43.45% of the clients were referred for outpatient treatment at the Center for Psychosocial Care – Alcohol and other Drugs (*Centro de Atenção Psicossocial-Álcool e outras Drogas* - CAPS-ad) in the city of Sobral – Ceará. This demonstrated there is a Mental Health Network that provides clients with comprehensive care.

Table 4 - Distribution of referrals after evaluation at the SEPHG, Sobral-Ceará, from January to December 2007

Referrals	N	%
CAPS-ad of Sobral	83	43.45
General CAPS of Sobral	27	10.50
PSF of Procedência	24	12.56
PSF of Sobral	19	10.00
Preceptoria em Saúde Mental	13	6.80
CAPS of Procedência	13	6.80
Psychiatry Outpatient Clinic of CEM*	8	4.18
Others	4	2.09
Total	**191**	**100**

*CEM = Center for Medical Specialties (acronym for Centro de Especialidades Médicas)

According to the Ministerial Norm 224, of January 29, 1992, health care services must follow specific guidelines: organize services based on the principles of universality; hierarchization; regionalization and integrality of tasks; diversity and methods of therapeutic techniques at the different complexity levels of health care; guarantee continuing care at different levels; multiprofissional team providing services; emphasis on social participation, from creating mental health policies to controlling their execution; defining local administrative departments as responsible for complementing the rule and for controlling and evaluating the delivered services.

Even clients from other cities, who are not assisted by the CAPS-ad of Sobral, may be referred to the CEM psychiatry outpatient clinic, which serves as an entrance door to the network for the other cities that refer to Sobral. Therefore, it is possible to screen hospitalizations that are possibly unnecessary and guarantees ambulatory follow up, with an aim to avoid the chronification caused by recurring hospitalizations[19].

CONCLUSION

Our attempt, through this study, was to intensify the discussion on Psychiatric Emergency Service at General Hospitals, mainly because of the scarcity of studies addressing those aspects. Therefore, we believe a challenge was set before us, and we appear to have been successful at it.

As evidenced by the data, there were a significant number of psychiatric emergency cases due to the use of alcohol. This fact draws attention because alcohol is considered to be a usual drug commonly used at the household environment, parties, and sometimes in public. In this sense, society is permissive by encouraging the referred consumption through advertisements. We herein develop a critique. In view of its decisive influence on society, the means of communication, such as advertisements, should alert about alcohol dependence as being a serious disease, a cause of disastrous consequences.

This problem clearly shows there is a need for greater intervention from public policies on substance dependence, not only illicit drugs, but, particularly, in relation to alcohol. Because its consumption is licit, alcohol has been used in excess and without any restrictions. It, therefore, becomes a dangerous drug because it causes numerous clinical, psychological, family and social complications.

Regarding the entry referrals at the SEPHG, most clients arrived at the service spontaneously, showing the service is a reference in mental health in the city, and is being used as the entrance door for mental health care. Because the SEPHG offers support in the moment of psychiatric crisis, the spontaneous demand is, therefore, justified if it meets this profile. However, in all other situations, the initial entrance door should be primary care, followed by extra-hospital mental health services. For us, this greater integration of mental health in primary care represents a conquest, because, due to the hospital-centered culture that is still present in the health system, the initial entrance door is primary health care service.

There is an urge for deeper knowledge about the quality of the service being delivered, and the practices at the location, i.e., the strategies that could be adopted by primary care services so that this mental health demand could find the solution already at the primary care center, thus avoiding the need of turning to the psychiatric hospital.

We observed that, after being evaluated at the SEPHG, most clients were referred for ambulatory treatment at the Center for Psychosocial Care – Alcohol and other Drugs, an extra-hospital service that provides care to individuals with substance dependence. This is evidence of the greater articulation between the services of the Comprehensive Mental Health Care Network of Sobral-Ceará.

In this sense, the care plan for crisis situations, as is the case of the psychiatric emergency discussed herein, clearly plays the role of a service rather than of the place with exclusive responsibility for the complete process of mental health care. That care is continued in an extra-hospital network, consisting of services that are substitutive to those of the conventional model.

An emergency service that is not part of any other service network tends to crystallize as a reference in itself: the care to patients essentially in crisis. If that were the case, where should the other patients, who need continuing care, support, or have been discharged from the hospital and form psychiatric emergency itself turn to?

Therefore, the psychiatric emergency service analyzed in this study complies with its function of being a reference in differentiated care to crisis, standing before the traditional hospital structure.

We believe that mental health services that have as characteristics the treatment and rehabilitation of people with psychiatric suffering are indispensible. In this setting, we should highlight the psychiatric reform, a movement that has guided mental health policies with the aim of training and humanizing the care in this sector.

The study, in our opinion, permitted to improve the knowledge about the SEPHG. Based on this knowledge, it is possible to indicate working strategies that are more in line with the current situation and policies that are more effective to measure psychiatric crises in the municipality. To do this, great effort is needed from the team as well as from someone fully-responsible for the various views of the clinic – as well as administrators to develop a mental health policy that aims at integrating other extra-hospital services, substitutive to asylums. Above all, it is necessary to provide psychosocial rehabilitation, thus comprising a mental health care network.

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Correspondence addressed to: Fernando Sérgio Pereira de Sousa
Rua Maria Tomásia, 813 - Centro
CEP 62011-240 - Sobral, CE, Brazil