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CHARACTERIZATION OF PATIENTS RESIDENTS IN A PSYCHIATRIC HOSPITAL

CARACTERIZAÇÃO DOS PACIENTES RESIDENTES EM UM HOSPITAL PSIQUIÁTRICO

CARACTERIZACIÓN DE LOS PACIENTES RESIDENTES EN UN HOSPITAL PSIQUIÁTRICO

Nívini Holanda da Conceição Pinto[1], Fernanda Carolina Capistrano[2], Vânia Carvalho de Oliveira[3], Maria de Fátima Mantovani[4], Luciana Puchalski Kalinke[5], Mariluci Alves Maftum[6]

ABSTRACT

Objective: to characterize patients residents in a psychiatric hospital. ***Method:*** descriptive study. Data were collected from the records of 24 patients with mental disorders living in two units for chronic patients in Paraná. The Ethics Committee, CAAE 3659.0.000.091-09, approved the research project. ***Results:*** the age of the participants ranged from 31 and 102 years old and the average time of hospitalization was 28.7 years old. The diagnosis of schizophrenia was present at 41.6% of patients, 28% showed changes in the osteoarticular system and 26% in the sensory. In locomotion 41.7% of residents need help, 42% to eat, 87.5% for hygiene and 75% for physiological eliminations. As for the data of socialization, 92% did not develop any activity. The results reflected a population vulnerable and dependent on specific nursing care for mental health and the related chronic degenerative conditions. ***Conclusion:*** the clinical conditions, aging, time of relocation and abandonment have contributed to these characteristics. ***Descriptors:*** Mental Health; Psychiatric Hospitals; Nursing Care.

RESUMO

Objetivo: caracterizar os pacientes residentes em um hospital psiquiátrico. ***Método***: estudo descritivo. Os dados foram coletados dos prontuários dos 24 pacientes com transtornos mentais residentes em duas unidades para pacientes crônicos no Paraná. O projeto de pesquisa foi aprovado pelo Comitê de Ética, CAAE 3659.0.000.091-09. ***Resultados***: a faixa etária dos participantes variou de 31 e 102 anos e a média do tempo de internamento foi de 28,7 anos. O diagnóstico de esquizofrenia esteve presente em 41,6% dos pacientes, 28% apresentaram alterações no sistema osteoarticular e 26% no sensorial. Para locomoção, 41,7% dos residentes necessitavam de auxílio, para refeição, 42%, para higiene, 87,5% e, para eliminações fisiológicas, 75%. Quanto aos dados de socialização, 92% não desenvolveram nenhuma atividade. Os resultados refletiram uma população vulnerável e dependente de cuidados de enfermagem específicos de saúde mental e os relacionados a condições crônicas degenerativas. ***Conclusão***: as condições clínicas, o envelhecimento, o tempo de internamento e o abandono contribuíram para essas características. ***Descritores***: Saúde Mental; Hospitais Psiquiátricos; Cuidados de Enfermagem.

RESUMEN

Objetivo: caracterizar a los pacientes residentes en un hospital psiquiátrico. ***Método***: estudio descriptivo. Los datos fueron recogidos de los registros de los 24 pacientes con trastornos mentales residentes en dos unidades para pacientes crónicos en Paraná. El proyecto de investigación fue aprobado por el Comité de Ética, CAAE 3659.0.000.091-09. ***Resultados***: el grupo de edad de los participantes variaba de 31 y 102 años y la media del tempo de internación fue de 28,7 años. El diagnóstico de esquizofrenia estuvo presente en 41,6% de los pacientes, 28% presentaron alteraciones en el sistema óseo-articular y 26%, en el sensorial. para locomoción 41,7% de los residentes necesitan de auxilio, para alimentarse, 42%, para higiene, 87,5%, y para eliminación fisiológicas 75%. Referente a los datos de socialización, 92% no desarrollaron ninguna actividad. Los resultados reflejaron una población vulnerable y dependiente de cuidados de enfermería específicos de salud mental y los relacionados a condiciones crónicas degenerativas. ***Conclusión***: las condiciones clínicas, el envejecimiento, el tiempo de internación y el abandono contribuyeron para esas características. ***Descriptores***: Salud Mental; Hospitales Psiquiátricos; Cuidados de Enfermería.

[1]Student, Undergraduate program in Nursing at Federal University of Paraná-UFPR. Scholarship of extension project "Health care of people with mental distress and family".Curitiba (PR), Brazil. E-mail: niviniholanda@yahoo.com.br; [2]Student, Undergraduate program in Nursing at Federal University of Paraná-UFPR. Voluntary Scientific Initiation Scholarship. Curitiba (PR), Brazil. E-mail: fernanda_capistrano@yahoo.com.br; [3]Nurse, Master degree, Graduate Program in Nursing, Federal University of Paraná/PPGENF/UFPR. Capes Scholarship. Curitiba (PR), Brazil. E-mail: vanny_carvalho@yahoo.com.br; [4]Nurse, Ph.D Professor, Graduation Program in Nursing, Federal University of Paraná/PGENF/UFPR. Scholar Productivity 2 CNPq. Curitiba (PR), Brazil. E-mail: mfatimamantovani@ufpr.br; [5]Nurse, Ph.D Professor in Health Science, Vice Coordinator of the Graduate Program in Nursing, Federal University of Paraná/PGENF/UFPR. Curitiba (PR), Brazil. E-mail: lucianakalinke@yahoo.com.br; [6]Nurse, Ph.D Professor, Coordinator of the Graduate Program in Nursing, Federal University of Paraná/PGENF/UFPR. Curitiba (PR), Brazil. E-mail: maftum@ufpr.br

INTRODUCTION

In the history of Psychiatry, the bearer of mental disorder has been marginalized, excluded from society, staying in psychiatric institutions most of the times without receiving any treatment. However, like any citizen, he should have healthcare guaranteed.[1]

In Brazil, after some events such as the creation of Mental Health Workers Movement (MHWM), the archaic way of conceiving the crazy and madness and the treatment, have progressed with the changes raised by the Psychiatric Reform.[2]

The conception of mental health assistance is based on the citizenship and social inclusion which result in the need to reconstruct knowledge, methods of treatment and improvement of therapeutic purposes dealing with and respecting the rights of every individual.[2]

Based on the psychosocial treatment model, Law 10,216, of April 6, 2001 about "the protection and rights of people with mental disorders redirecting the assistance model in mental health", became the reference of the Psychiatric Reform. Associated with other laws and ordinances, it regulates the way of care, avoiding punishments to irregular hospitalizations and encouraging the deinstitutionalization of patient with long years of hospitalization with the creation of new devices from treatment.[3]

Such devices compose an integrated network of services, including those in the extramural community based mode that must provide full treatment to users with mental disorder in the long term. Among this network, there are Psychosocial Centers (CAPS), DIA Hospitals, Outpatient and Residential Treatment Services (SRT). The latter part of the program of "Back Home" 3, configuring a recent therapeutic device.[4]

SRT is an alternative of residence that provides improvements in the living conditions of those people who had a history of prolonged hospitalization in psychiatric hospitals and have family links involved or nonexistent. The focus of this service are individuals´ autonomy and recognition as a citizen, enabling social conviviality, deconstructing the madness as a synonym of threat and reclusion, featuring a tool of social reintegration of people previously excluded.[4-5]

It is understood that sheltered patients are those people who by the extensive length of hospitalization, had their broken links with society and family, therefore, they are destitute and depend on the State to help them in all areas of their lives and provide them with complete care.[4-5] The chronic mental disorder individual is the one that due to the length period of hospitalization and severity of his disorder, has functional disabilities on several primary aspects of life, as self-care and autonomy[6].

Data from the Ministry of Health indicate the low coverage of the Program "Coming Back Home" in which only 1/3 of patients hospitalized for a long period, 3,832 people, benefit from therapeutic residences distributed in 596 units in Brazil.[7]

From 2011, the goal proposed by the Federal Government was to reach the index of 500 people annually included in SRT, together with the gradual reduction of beds in psychiatric hospitals of the Unified Health System (SUS). In 2002, there were in Brazil 51,393 beds in psychiatric hospitals, resulting in the planned reduction in the closure of 18,712 beds. Currently there are still around 32,735psychiatric beds.[7]

Even after the creation and gradual growth of therapeutic modalities assisting in the deinstitutionalization and social rehabilitation of the mental disorder individual, there is still a lot of these individuals that continue hospitalized and staying in psychiatric hospitals. In this sense, it is necessary to pay attention to the fact that the prolonged hospitalization raises the institutionalization causing social and economic losses, broken links and promoting the development of mental disorder.[8]

Despite significant progress in recent years, the political, social and cultural difficulties affect the evolution of SRT. It is worth noting that the task of deinstitutionalization is complex due to several reasons, as the non-hospitalization without the real meaning of Psychiatric Reform and the reduced number of outpatient treatment services inserted in the community, which causes a high demand, weakening the mental healthcare network. The characteristics that this population acquires for this long time of hospitalization, different level of dependency, with a high commitment of autonomy.[4.7]

It is understood that many people spend years isolated from society due to hospitalizations in psychiatric institutions and part of that population had condition to be transferred to the STRs by the loss of their reference, their own identity or by the presence of sequels as a result of various types of treatments offered by the

institutions. Also, in many cases, by the chronic course of the disease or advanced age[4.6].

Founded by the Brazilian Law on Mental Health number 10,216/01, Ministerial Decree number 106/10 and the State Law of Mental Health number 11,189/95, in 2002, in partnership with the State Coordination of Mental Health, the field hospital of this study elaborated a project that aimed to promote the psychosocial rehabilitation and recovery of citizenship of 123 long-stay residents at the hospital, with the average hospitalization of 33 years. Thus, from 2002 to 2010, 43 patients were referred to the Residence Service Therapy (SRT), of which 11 were back to family conviviality, 41 went to a shelter and 04 were dead. Twenty- four patients remained at the hospital with physical and mental conditions highly compromised.

The knowledge of the reality of individuals with mental disorders who still live in conditions of institutional isolation is useful to instigate the reflection of the nurse on the responsibility of his practice next to this clients. To this end, this study was developed with the objective:

- To characterize patients residents of a psychiatric hospital.

METHOD

Descriptive research with quantitative approach developed in 2010, with 24 patients (15 males and 9 females) living in two units of treatment for chronic patients in a psychiatric hospital in the State of Paraná-PR.

The data were obtained through manual search on the records. Patients with mental disorders are considered a vulnerable group and their rights should have respected as Federal Law number 10,216/01, which provides, in its 2nd article, subparagraph IV, ensuring confidentiality of information provided. Thus, the data collection occurred after the authorization of clinical direction and nursing, in accordance with Resolution 196/96.[9-10]

This research is part of the project "Profile and social network of individuals with mental disorders in psychiatric hospital", approved by the Ethics Committee of the Health Sciences of the Federal University of Paraná, under record CEP/SD: 801.136.09.09 CAAE: 3659.0.000.091-09.

The data were analyzed and presented in descriptive mode and with absolute numbers and percentages in tables.

RESULTS

The characterization of the subjects was performed considering the data of age, length of hospitalization, psychiatric diagnosis (Table 1), clinical and physical conditions (Table 2) and conditions of autonomy (Table 3) and sociability.

Regarding the age group (Table 1), ten subjects were less than 60 years old, so they were considered elderly, and 14 of them, although they were less than 60 years old, chronic degenerative pathologies present common characteristics of old age, as the presence of hypertension (9), cataracts (6), arthrosis(4), rheumatism (4), sclerosis (4), glaucoma (3) and diabetes (1). One patient presented more than one pathology.

The average length of stay of patients in the hospital was 28.7 years. The longest time in which the patient resides in the institution is 53 years and the shortest time is 10 years. In the 1950s, a Pavilion for use in the treatment of children with mental disorders was inaugurated in this study field hospital, but disabled in late 1990s. In this area, 2 patients were allocated to the village units, both remaining institutionalized.[11]

In Table 1, it is noticed that some of the participants had more than one diagnosis, with an emphasis on schizophrenia (F-20) in 41.6% (n=10), then, no unspecified organic psychosis (F-29) with 20.8% (n=5). It should be noted that 16.6% (n=4) of patients had mental retardation, three associates, some mental disorders, and only one showed Retardation diagnosis.

The Mental Retardation integrates the neurological group, however, in the history of mental health treatment, the presence of this diagnosis was a reason to many people enter in the psychiatric hospitals. These people received the same treatment provided to those with mental disorder and some of them have never received discharge, as happened with a patient of this study.

Table 1. Age, time of hospitalization, psychiatric diagnosis. Curitiba-Pr, 2010. (n=24)

Variables	(n=24)	(%)
Age group		
31 to 40	3	12,5
41 to 50	5	20,8
51 to 60	6	25
61 to 70	2	8,3
71 to 80	1	4,2
81 to 90	1	4,2
More than 100	1	4,2
Ignored age	5	20,8
Time of hospitalization in years		
10 to 20	5	20,8
21 to 30	9	37,6
31 to 40	6	25
41 to 50	2	8,3
51 to 60	2	8,3
Diagnosis*		
Esquizofrenia (F-20)	10	41,6
No unspecified organic psychosis (F-29)	5	20,8
Other mental disorders due to injury and cerebral dysfunction and to physical disease (F-06)	6	25
Non-specific dementia (F-03)	2	8,3
Bipolar affective disorder (F-31)	2	8,3
Mental Retardation (F-70)	4	16,6

*Diagnosis according to CID-10.
** One patient may have more than one diagnosis.

Table 2 shows the clinical conditions of the subjects of this study classified according to osteoarticular, sensory, cardiovascular, gastrointestinal, hepatic, endocrine, nervous, immune and blood systems.

In addition to the clinical conditions presented in this table, it should be noted that three patients made use of tobacco, one presented obesity, and one had hypercholesterolemia, risk factors that contribute to the development of some changes, such as complications in cardiovascular and stroke, both caused by hypertension.

Table 2. Clinical conditions presented by residents' patients. Curitiba - PR, 2010. (n=24)

Variables	(n=24)	(%)
Clinical condition*		
Osteoarticular system	13	28
Sensory system	12	26
Cardiovascular system	9	19
Gastrointestinal Sytem	7	15
Endocrine system	1	2,2
Hepatic system	1	2,2
Nervous system	1	2,2
Immune system	1	2,2
Blood system	1	2,2

* The same patient may present more than one clinical condition.

Table 3 shows the conditions of patients´ autonomy. With regard to locomotion, 58.3% (n=14) could walk without any help and 41.7% (n=10) needed help to move. Of the total surveyed, 29.1% (n=7) used wheelchairs and two, besides leading his own wheelchair, they presented mobility locomotive to sit down and to leave the wheelchair without any assistance. Among the conditions to the need of help for ambulation, there were the osteoarticular (4) and total blindness (2).

As regards the eating, 58% (n=14) of patients ate without help, although some of them showed difficulties in motor epicritic coordination. However, the motivation for all them to eat alone was part of the prescription of nursing care of these patients in the units, being one of the few activities that most of them performed with some physical autonomy.

Only 12.5% (n=3) of patients were taking a shower without help and 87.5% (n=21) needed help. Only three of them chose clothes and demonstrating the desire to get fix. The data according to physiological eliminations, which can be framed in personal hygiene, reported that 75% (n=018) needed assistance during excretion. This help occurred through specific containers to urinate or guiding the patients into the bathroom, others did it in the diaper.

Table 3. Conditions of autonomy of residentes patients. Curitiba – Pr, 2010. (n=24)

Variables	(n=24)	(%)
Locomotion		
Without help	14	58,3
Without help	10	41,7
Eating		
Without help	14	58
Without help	9	42
Higiene		
Without help	21	87,5
Without help	3	12,5
Physiological eliminations		
Without help	6	25
Without help	18	75

With regard to socialization involving activities planned in the hospitalization unit, all participants could participate in internal commemorative dates festivities as St. John, Christmas and New Year, according to their desire and availability on the day of festivity. However, 92% (n=22) do not develop any other activity, 4% (n=1) of them helped in the activities of the unit and other 4% (n=1) participated in the activities of occupational therapy.

DISCUSSION

As result of long periods of institutional hospitalizations, many people stayed for years isolated from society. More specifically from 1978, changes in therapeutic behaviors applied to the mental disorder individual occurred, such as the creation of SRT and Federal Government programs, such as "Coming Back Home", it has not been possible to deinstitutionalize all this clients.[6.7-12]

The data of this research show the characteristics that compromise the social reintegration of individuals who have been subjected to long periods of hospitalization, mark of traditional psychiatry, whose treatment model was exclusively based on reclusion of these individuals in shelters.[6]

The characteristics found in this research participants confirm other studies on patients in long-stay institutions who have high level of vulnerability caused by deterritorialization, the loss of family and social links, the personality and the reliance gained at the institution, which could interfere with the accomplishment of the daily activities of life and autonomy.[6,7.12]

Among the participants, 14 were under 60 years old and had several chronic conditions of aging characteristics, which may reflect also in the process of the long permanence in psychiatric institution.

In many cases, the psychiatric hospitals represent a secure place, providing basic conditions for survival, such as food, hygiene and comfort, and also ensuring the continuous treatment of resident patients, often making the psychiatric institution with social function of hostels. Besides, the long hospital stay may result in an adaptation of behavior and emotions of the patient, making them inadequate for social coexistence.[12]

Schizophrenia was the higher incidence of psychiatric disorder in the sample of this research. These data confirm with those found in a study conducted in a shelter institution in Rio de Janeiro including 1,494 participants, mostly male, in which the most frequent diagnosis was this same disorder in 53.6% of patients, followed by mental retardation in 26.4%[13]. The mental Retardation, although it is not a mental disorder, many people remained for long periods in psychiatric hospitals for this neurological condition.

A study in a mental hospital of Ribeirão Preto, whose objective was to identify the knowledge and activities of nursing care to the patient with schizophrenia emphasized that nursing staff considers the chronic patient management less complex than acute. This is because patients with mental disorder in chronic state present less communication skills and are controlled by the symptoms of the disorder, the medicines and the institution, requiring less time of the staff.[14]

Research conducted with residents of a psychiatric institution in the interior of São Paulo State adds that among the factors preventing the release of these patients for the social conviviality, there is schizophrenia, which regresses the human being to a disease, becoming a reference able to preclude the deinstitutionalization.[12] In this sense, one of the decisive criteria in the decision of the team to maintain a sheltered therapeutic

patient, among others, is the diagnosis of chronic course disorder.[15]

The emergence of some pathologies is common during the aging process, such as cardiovascular disease, hypertension, stroke, diabetes, cancer, chronic obstructive pulmonary disease, musculoskeletal deficits, decreased visual acuity and mental health conditions, dementia and depression being the higher occurrence. These illnesses involve individuals, families and the State.[16]

Currently, it is known that eight out of ten elderly have at least one chronic disease. In this sense, the clinical conditions presented by the participants of this study may be related to age, because this process is comprised of transformation of the body, often causing the emergence of chronic degenerative diseases. In this case, the advanced age is an aggravating factor for this picture. However, it is worth noting that this condition is not a determining factor in the physical and emotional dependence in the elderly.[17-8]

The morbidities and the inadequate treatment may develop constraints that contribute to the deficit on the quality of life of the elderly. In this sense, the health services must contribute by identifying factors that can minimize the impact of these diseases, seeking recognition by the elderly, of new plans according to their aspirations and their interests, in order to avoid or enhance the complications of these diseases.[19]

Regarding the need for professional assistance for locomotion, eating and personal hygiene of patients, it is found that elderly people have a high risk of loss of functional or mental capacity, causing partial or total dependence for realization of different activities. This dependence can be related to practical helplessness and even with individual disability presented during routine activities, which change depending on the age, gender and social class.[18]

The physical and emotional dependence can occur at all times of life of an individual. However, in old age is something natural and expected, meaning the loss of independence or autonomy[16]. Therefore, the motivation to these individuals becomes an intrinsic ethical component to the process of care and must be constantly urged by the nursing staff. When developing a chronic disease, the subject also develops several limitations that need to be worked, seeking the independence of activities, since, if there is no appreciation, it will be strengthened the dependent subject picture.[20-21]

To this end, it becomes essential to effective care planning by the health team, focusing on the functional capacity of the elderly, because it is understood that the ability to maintain physical and mental skills necessary for a life of independence and autonomy, can be impaired as result of inadequate assistance.[19]

The mental disorder associated with aging of institutionalized patients generates unbalanced situations in social dynamics, making the individual liabilities and insecure.[8] The greater the number of limitations, the greater the negative interference on self-esteem, body image, the quality of life and interpersonal relations of the elderly.[19] Thus, carrying out activities that provide socialization is of utmost importance for the therapeutic process in mental health[8.21].

Social, educational and physical activities, mainly with institutionalized people, become an instrument inherent in psychosocial rehabilitation process. Besides, they favor the rescue and relearning skills lost during the long time of hospitalization, requiring special attention of professionals involved in the care of these patients.[8]

The promotion of activities related to the maintenance of motor and cognitive functions slows the development of disabilities that cause limitations on elderly patients. The elderly need educational actions and individual interventions to be properly and effectively motivated.[19-21]

CONCLUSION

This study fulfilled its objective to characterize the patients residents of a psychiatric hospital regarding age, time of hospitalization, psychiatric diagnosis, clinical, physical conditions, autonomy and sociality. This profile reflects a vulnerable population, with loss of autonomy due to the prolonged hospitalization, the course of mental illness and aging.

This population showed a high average length of stay, representing the greater part of their life and experiences based on the hospital environment. The diagnosis of schizophrenia was the most responsible for the hospitalization.

The difficulties related to the autonomy are exacerbated and may be linked to sensory changes and other consequences of the process of social reclusion. Considering the predominant age group being in the process of aging, it is emphasized the importance of the nursing care to be guided to the specific

characteristics of these patients, with the understanding that this is a different client with peculiarities, exclusive eccentricities.

The clinical conditions that affect the participants but also the time of hospitalization and family abandonment contributed to the characterization found in this participants.

These data confirm those found in the literature, reaffirming that this knowledge about patients residents of psychiatric hospital leads the nurse to assess and plan the care these clients according to their needs.

Although the institution field of this study, like others in the country, has already presented highlighted characteristics of an shelter system, it has a significant process of changes, among them the re-socialization of patients who remained hospitalized for several years, returning them to the family and/or social conviviality by the Therapeutic Residence.

Although the re-socialization of sheltered patients be arduous for regression condition in which the most of them are without receiving the necessary motivation due to the time they were institutionalized, this process should advance with quality, requiring also by the nurse as the remaining member of the multidisciplinary team, awareness, understanding and continuous participation.

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Corresponding Address

Mariluci Alves Maftum
Rua João Clemente Tesseroli, 90
Bairro Jardim das Américas
CEP 81520-190 – Curitiba (PR), Brazil