



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

REFLECTIVE ANALYSIS ARTICLE

CONTEXTUAL ANALYSIS OF THE CARE OF PSYCHIATRIC EMERGENCIES ANÁLISE CONTEXTUAL DO ATENDIMENTO A EMERGÊNCIAS PSIQUIÁTRICAS ANÁLISIS CONTEXTUAL DE URGENCIAS PSIQUIÁTRICAS

Francisco Rafael Ribeiro Soares¹, Francisco Arnaldo Nunes de Miranda², Soraya Maria de Medeiros³

ABSTRACT

Objective: to analyze the contextual aspects of the care of psychiatric emergencies in the health care network from the municipality of Mossoró/RN/Brazil. **Method:** It is a critical and analytical essay based on the theoretical contribution of the context analysis, namely: immediate, specific, general and metacontext. **Results:** the reflection on the phenomenon denominates the care of psychiatric emergencies as the immediate context; the technical and operational aspects that influence with the care, as the specific/general context; and the Brazilian mental health policies are identified as metacontext. We have identified important aspects of the history of the Psychiatric Reform and its influence with the construction and consolidation, in the micro-space, of the local and regional operationalization of a mental health care network. **Conclusion:** it requires a reflection on the mode of organization of replacement services and general care services to the population with respect to the reform precepts, by recognizing that some challenges need to be overcome with respect to the care of psychiatric emergencies. **Descriptors:** Psychiatric Emergency Services, Mental Health, Nursing.

RESUMO

Objetivo: analisar os aspectos contextuais do atendimento às emergências psiquiátricas na rede de saúde do município de Mossoró/RN. **Método:** ensaio crítico e analítico fundamentado no aporte teórico da análise de contextos, a saber: imediato, específico, geral e metacontexto. **Resultados:** a reflexão sobre o fenômeno denomina o atendimento às emergências psiquiátricas como contexto imediato; os aspectos técnicos e operacionais que influenciam no atendimento, como contexto específico/geral; e as políticas de saúde mental no Brasil são identificadas como metacontexto. Identificaram-se aspectos relevantes da história do movimento da reforma psiquiátrica e sua influência na construção e consolidação, no espaço micro, da operacionalização locorregional de uma rede de atenção à saúde mental. **Conclusão:** urge a reflexão sobre o modo de organização dos serviços substitutivos e dos serviços de atendimento geral à população em respeito aos preceitos da reforma, reconhecendo que alguns desafios precisam ser superados no que diz respeito ao atendimento das emergências psiquiátricas. **Descritores:** Serviços de Emergência Psiquiátrica; Saúde Mental; Enfermagem.

RESUMEN

Objetivo: analizar los aspectos contextuales de la atención a Urgencias psiquiátricas en la red de salud de la ciudad de Mossoró/RN. **Método:** ensayo crítico y analítico: basado en el aporte teórico de análisis de contexto: inmediata, específico, General y meta contexto. **Resultados:** la reflexión sobre el fenómeno limita la asistencia a Urgencias psiquiátricas como contexto inmediato; los aspectos técnicos y operacionales que influyen en la asistencia, como contexto de generales y concretos; y políticas de salud mental en Brasil se denominará meta contexto. Identificar aspectos relevantes de la historia del movimiento de reforma psiquiátrica y su influencia en la construcción y consolidación en el micro del espacio, la puesta en marcha de local en una red de atención de salud mental. **Conclusión:** instar a la reflexión sobre la organización de servicios de sustitución y servicios generales a la población con respecto a los preceptos de la reforma, reconociendo que algunos desafíos necesitan ser superados con respecto a la atención de Urgencias psiquiátricas. **Descriptor:** Urgencias psiquiátricas; Salud mental; Enfermería.

¹Nurse, Professor, Master's Student, Post-Graduate Nursing Program, Federal University of Rio Grande do Norte /PPGENF/UFRN. Natal (RN), Brazil. E-mail: xicorafa@yahoo.com.br; ²Nurse, Professor and PHD in Nursing, Post-Graduate Nursing Program Coordinator, Federal University of Rio Grande do Norte /PPGENF/UFRN. Natal (RN), Brazil. E-mail: farnoldo@gmail.com; ³Nurse, Professor and PHD in Nursing, Post-Graduate Nursing Program, Federal University of Rio Grande do Norte /PPGENF/UFRN. Natal (RN), Brazil. E-mail: sorayamaria@digicom.br

INTRODUCTION

The study of madness is considered, in a systematized and summarized way, relatively new in the field of modern medicine, dating from the beginning of the XIX century, being that Phillipe Pinel is its major milestone. But, the social construction of madness is as old as the mankind itself, respecting the different ways over time, spaces of construction and human explanations. The so-called “zero degree” of the history of madness is characterized by the lack of differentiation between madness and reason that had as its benchmark the use of a common language to both stages of the human psyche.¹

In ancient times, the madness was not understood as a disease, but as a manifestation of the power and the will of the gods as a resource used by them to prevent men from challenging their wills. The fact of being linked to an epiphany made the society, rather than segregating and marginalizing the mad subject, unaware, to the point of keeping a respectful, tolerant and, sometimes, dogmatic attraction about the things that were manifested.²

With the advent of the Middle Ages in the western world, considering the socioeconomic viewpoint, based on the feudal mode of production, economically ruled by agriculture and commerce and ideologically under the progressive and dominant power of the Catholic Church and its dogmas, the madmen and the manifestations of madness started to be seen as economic burdens, by being subjects who hamper the trade, hence, they do not pay taxes and, therefore, prevent the development. From the ideological viewpoint, the church starts to gradually develop a social imaginary of madness, which both reveals feelings of charity and portents of evil. During this period, the conception of madness was restricted to the different ways of working of demons on the affective life and the knowledge.²

In the late Middle Ages, the extinction of leprosy in Europe, not resulting from medical practices, but from the segregation and the break with the Eastern foci of infection in the post-crusades period, consequently, leads to an idleness of the structures of leprosaria. The society and its governments allocated these areas to the exclusion of patients with certain diseases, respecting the historical periods, but with a certain linearity, where leprosy was initially replaced by venereal diseases and, subsequently, transferred these spaces to the vagabonds, prisoners and

madmen. Thus, they assume the role abandoned by leper people.^{1,3-4}

In the periods of the Renaissance, characterized by anthropocentrism and the primacy of freedom of thought [“Cogito, ergo sum” (I think, therefore I am)], selected as the only ways of man to solve its existential and survival-related problems in a changing world, the madness becomes an obstacle for being unproductive and deterrent to the good social development from the ratio as an explanation of man in the world. In this conception of rationality, the man goes away from the religious and mythical conception, by becoming the object of the “unreason”, and thus it is plausible to admit the mad through compulsory seclusion as justification for the deviation from the existing guidelines and social agreements.¹

The admission of madmen, now, called alienated, becomes the main structure, which has the longest lasting in secular form and for being the most outstanding in the history of madness. This model is disseminated, spread and becomes popular in European societies and globally. It is established as a practice prevalent in the society since the general hospitals created in France, in the XVII century, until the houses of correction in the England of the XVI century. The admission is configured as a less medical and healthy structure for the alienated subjects, and more as a “semi-juridical structure, i.e., a kind of administrative entity that, alongside the already constituted powers, and beyond the law courts, decides, judges, and executes”.^{1:57}

In the XVII and XVIII centuries, the scientific progress based on the mechanistic knowledge seminal to the thought of Descartes, also called Cartesian, causes a turnaround in the concept of madness for welcoming the new social skills and practices. The madness was conceptually redefined; it was no longer a form of moral deviation or transgression, but rather a mental disease.

The madness ceases to be explained by the magical-religious conception and start to be hosted in the field of science, particularly, in the psychiatric field, consequently, in the medicalization of bodies. Even under the shelter of conceptual change, the mythological and positivistic viewpoint of science, endorsed by the traditionalism of the psychiatric clinic as a medical specialty, the admission has been established as a care option for the mad subject, from the perspective of institutionalization and of hegemonic knowledge from the medicine, turning it into a mentally ill patient, thereby

expanding the radius of psychiatric intervention, inside and outside the walls, with the support of medicalization. Thus, medicalization, asylum and the power of psychiatry are established.²

In Brazil, psychiatry emerges through the arrival of the Royal Family in a measure of sanitation of the city of Rio de Janeiro, then capital of the kingdom, which included a diagnosis of madmen. In 1852, there was the inauguration of the first hospice that ratifies the official policy of State supervision and the segregation of the mentally ill patient.^{3,5}

During the Republic, under the aegis of exclusion and segregation of madmen, various mental institutions were created, consolidating them as a State Policies, which were intensified in the 1960s, through the creation of the National Institute of Social Welfare (INPS) that starts and opens the mercantilization of madness by means of the purchase of health care services, including psychiatric, by private entities. Thus, the medicalization of madness is established, to the extent that the mental illness starts to be the object of obtaining profits and the madness begins to be a commodity.^{3,5}

In the next decade, i.e., during the 1970s, it emerges a growing insurgency against the model of health care in force in the country, due to the reforms and proposal of treatments experienced in some western countries. Moreover, there was the social pressure for opening to democracy. In the democratic zeal, the Brazilian Sanitary Reform was born in conjunction with the criticism and the pursuit of the Psychiatric Reform. This enthusiasm, subsequently credited to the Mental Health Workers Movement as an embryo, was inspired by the movement of the Italian Democratic Psychiatry that also questioned itself about the *modus operandi* of treatment in hospices in the country, as well as the mental health policy itself and the model of psychiatry in force, focused on the institutionalization/hospitalization and on the medicalization of patients.^{5,6,7}

With reformist character and socialist and social-democratic connotation, the movement proposed a new model of intervention that could enable the deinstitutionalization of the mentally ill patient through the deconstruction of the psychiatric institutions' apparatus, the construction of a different conception of mental disease and reinvention of the care practice of the sick people, in order to enable the rescue of its citizenship, as well as to promote its social reintegration.^{6:544}

The process of dehospitalization implemented in Brazil, from the Law 10.216, of April 6th, 2001, results in the progressive replacement of large psychiatric hospitals by different treatment modalities in the community, but these replacement services are still below the social demand for them.

It should be inferred that the reformist movement has partially reached its goals, since, in addition to the reduction of psychiatric beds, an arsenal of replacement proposals was provided and exemplified in the Back to Home Program, Therapeutic Residency Services, among other devices grounded on the psychosocial issue.

Once partially resolved the issue of deinstitutionalization, because it faces resistance in the supply of psychiatric beds in general hospitals, new challenges and demands are raised in function of the return to social life, for example, increased cases of AIDS and viral hepatitis, comorbidity, misuse of alcohol and other drugs, aggravated by the crack consumption, which destabilize the model adopted in Brazilian Psychiatric Reform. The access to social equipment was also strengthened by the social security benefits accrued by individuals with mental disorders.

Thus, by reducing the length of hospital stay associated to the lack of alternative care, the warranty of dispensation and distribution of psychotropic drugs, among others, the appearance of crises will not be less unusual.⁸

It should be observed that there is an operational gap in dealing with crises in the Brazilian mental health policy, which has led to situations of wear in relation to the process of producing a humanized care in mental health, taking into consideration that patients are often served in an improvised way, in non-specialized services, or even in non-medical approaches, such as in police services.⁹

OBJECTIVE

- To analyze the contextual aspects of the care of psychiatric emergencies in the health care network from the municipality of Mossoró/RN.

METHOD

It is a critical and analytical essay based on the theoretical contribution of the context analysis. Among the various perspectives of contextual analysis available in the literature, such as the multicontextual logic or the decontextualization method, we opted for the use of contextual analysis by understanding

that this method is able to clarify us (critics) and improve the understanding and comprehension of a given phenomenon.¹⁰⁻¹¹⁻¹²

In the customized situation of contextual analysis, we will make use of the context as a dynamic and producer source of data to the extent that its intersectoral and interlinked nature seeks to describe, analyze and correlate the carrier of mental and behavioral disorders with the involved aspects. Thus, the context analysis is not just a background to the discussion, but, above all, allows directly incorporating contexts, interpretations and results of the study.¹²

In this conceptual modality, the context is subdivided into four layers that interact with each other, but that differ from each other by their extension, whose the meaning is shared, due to the time on which it focuses and also due to the speed through which the change in each layer might occur and be perceived: immediate, specific, general and metacontext.¹²

The understanding of these dimensions, in their aforementioned levels, involves a progressive gaze of the phenomenon, which ranges from the more contiguous aspects that describe its operation in the present time, advancing on the study of the relevant circumstances acting in the more immediate past in relation to the event, their cultural, social and economical insertions to reach the broadest aspect, which has a macro-nature, circumscribing it until the strands of political and conceptual nature of the study object.

From this understanding, we have addressed the care of the psychiatric emergencies in the municipality of Mossoró/RN, such as the immediate context; the technical and operational aspects that influence with the service, such as the specific/general context; and the Brazilian mental health policies as the metacontext.

♦ THE IMMEDIATE CONTEXT: the phenomenon of caring of psychiatric emergencies

The process of privatization of health implemented from the 1960s, and intensified in the next decades, is characterized by the purchase, by the National Institute of Medical Care and Social Welfare (INAMPS), of health care services with sights to ensure the social security coverage to working classes, which, in turn, also were reflected on the psychiatry. The privatistic logic proposed the enlargement of the social security coverage to the Brazilian workers, reinforced by the institutionalization of madness and its medicalization, caused the

mercantilization of madness, turning it into a profitable business that generates a sure income at low costs. In this period, there was a significant increase of asylum beds, especially in relation to the private ones.¹³

Equally to the historic course of the national psychiatry, happened, *pari passu*, in the Brazilian Northeast, particularly in the Rio Grande do Norte State and, similarly, in the municipality of Mossoró, through the foundation, in 1968, of the São Camilo de Lellis Health House, under the paradigm of the biologicist and technicist model of health intervention, focusing on the classical psychiatry, which advocated the social exclusion and segregation from long periods of confinement.

It should be agreed that, gradually, professionals have performed the breakdown of this model, despite the large political and economic resistances, besides the discredit in the ideological and operational precepts of the Brazilian Unified Health System (SUS) and of the Brazilian Psychiatric Reform Movement, which required the reorganization of services, practices and skills of the health sector, introducing new stakeholders in the scope of the processes of care in mental health from the perspective of social reintegration from “a extra-hospital services network of growing complexities”.^{9:13}

In fact, there was the inauguration of a new model of mental health care, which is based on the Basaglian Model (Franco Basaglia) or Italian (Italian Psychiatric Reform), by proposing the deinstitutionalization and dehospitalization of people with mental and behavioral disorders through a new care model grounded on the maintenance and integration of the patient in the community. Thus, the community-based psychosocial care model is introduced.¹⁴⁻⁵

It is noteworthy that despite the achievements arising from the Psychiatric Reform, the replacement services network is overloaded, since other problems are added to the mental health system, exemplified by the increasing use of alcohol and other drugs; the vulnerability in STD/AIDS; the increasing demand for care by patients affected by the dehospitalization, by the adherence to the treatment of continuous and prolonged use, by the shortage of caregivers and relatives, among others, and the increased demand affected by a global tendency of expanded psychiatry in which the previously considered common aspects of the everyday life began to be objects of psychiatric intervention.¹⁶

It should be inferred that the emphasis on

the extra-hospital treatment, associated to the imbalance between supply and demand for replacement mental health services, has increased the number of patients subjected to decompensation of their clinical picture and consequent appearance of crises at the community level.^{8,14} Allied to this factor, there is the fact that the other structures of the SUS network in the municipality and region are not sensitized and organized to integrate the mental health care network.

It should be observed *in loco* that the high demand for mental health services and psychiatric emergencies has, preferably, as its main focus the sole general public hospital in the city of Mossoró /RN, which, in turn, also contributes to this problem, by not having qualified staff, neither suitable structure for the establishment of integral care beds.

In addition to the issue at stake, we see the incompleteness of the local and regional network, which has no CAPS III or CAPS AD III, despite having population index that justifies the implementation as a way to help this supportive service.¹⁷ Furthermore, there is the fact that the primary care attached to an interventionist and medicalizing perspective of the mental health care, making use of traditional clinical approaches, often being responsible only for the registration of users, distribution of psychotropic drugs and prescription books of controlled circulation.^{18,5}

Moreover, as a characteristic of this immediate context, it should be observed the bureaucratization of the care of psychiatric emergencies identified from a flowchart imposed to meet the complicated situations. The situations that are characterized as emergencies are initially sent to the general hospital of the city, where the patient is often excessively sedated, for subsequent forwarding to a mental health outpatient clinic to perform a psychiatric evaluation and, ultimately, be referred to a specialized hospital unit.

The situation is worsened when, in the weekends, before the unavailability of care by the outpatient unit, patients usually remain in the general hospital during the lawfully established period. This disparity is credited to the lack of medical specialty of psychiatry in the institution's staffs, as well as qualified professionals and suitable structure to receive these patients in crisis; it is common to let the patient sedated or in total mechanical containment during the period of stay in the general institution.

◆ THE SPECIFIC/GENERAL CONTEXT: the technical and operational aspects that

influence with the phenomenon

The psychiatric emergencies might basically be defined in two different ways. The first is characterized as a “disorder of thought, emotions or behavior, in which a medical care becomes immediately necessary, aiming at avoiding further damages to the psychological, physical and social health of the individual or eliminate potential risks to its life and the lives of other people”.^{9:72}

As to the second, it is defined as “any change in behavior that cannot be quickly and appropriately managed by health, social and judiciary services existing in the community”.^{9:72}

In psychiatry, the term “psychiatric crisis” is used to characterize the psychiatric emergencies and urgencies that encompass several situations, ranging from psychosis, ideations, suicide attempts, depressions and organic brain syndromes. It is marked by moments in which the psychological suffering becomes so intense that the individual or the system starts to be unable to maintain the homeostasis, causing disruption of social, family and psychic life aspects of the subject, so that there is a break with the socially accepted reality.¹⁹

The reason for attendances due to psychiatric emergencies in relation to the totality of performed attendances in a general hospital in Brazil is around 3%, being that a quarter of these admissions are related to violent or agitated behaviors, while in the U.S.A. this index reaches 5%.²⁰

The medical care of psychiatric crises, before isolated from society and hidden behind the walls of asylums, has gained more notoriety in the social space, because of the process of dehospitalization. This factor has generated the need to reorganize the mental health care services network, by creating new services and giving new responsibilities to the already existing ones. It should be recognized that the psychiatric crisis has been considered as one of the critical nodes of the Psychiatric Reform, because of its proximity and manifestation of stigma and prejudice, both linked to madness and that reflect on the attendance to these emergency situations.^{19,21}

The use of first-aid procedures of the general hospitals as Psychiatric Emergency Services (SEP) has support in the National Mental Health Policy, while avoiding the isolation of psychiatry at the same time in which we try to reduce the discrimination and the stigmatization of the mentally ill subjects.¹⁴ In this context, the SEPs linked to general hospitals should incorporate the proposal of a

broader approach that involves not only the psychological aspects, but seeks the management of clinical comorbidities.⁹

This therapeutic approach requires, in one hand, a common space for supplying hospital services, by integrating the evaluation of the general practitioner and, in the other hand, understanding the mental sick as a patient from the general health care system. Seen in this way, it is necessary a careful evaluation, taking into account the high rate of comorbidities that has led these patients to die, on average, 25 years earlier. It should be attributed, partially, to the difficulties of accessing the health care services.⁸

The absence of psychiatrists in the SEPs associated to general hospitals has caused a set of inadequate or, even, excessive therapeutic conducts in the management of complicated situations, especially, that one which is related to the full sedation of the patient in crisis. Anciently recommended in the management of agitated patients, currently, it is considered an unwanted side effect, since it interferes “in the initial medical evaluation, in the establishment of the therapeutic alliance, in the elaboration of the primary diagnosis and in the observation of the clinical picture evolution”.^{20:99}

It should be emphasized another controversial aspect in the field of mental health, i.e., the practices of physical restraints and mechanical containments that are widely used in SEPs, mainly those linked to general hospitals and mobile pre-hospital services. The use of these techniques refers to the history of psychiatry in the hygienist model. Therefore, they have a coercive/punitive nature. In some European countries, these practices are prohibited by law, while in the U.S.A. their association together with pharmacological interventions are judiciously used.^{20,19}

The application of the techniques of physical restraint and mechanical containment should only be used when the therapeutic communication strategies, environmental changes and elimination of external factors that can adversely influence with the behavior, the listening and the approach to the subject in crisis have no longer effect and its behavioral manifestations remain being exacerbated, presenting risks to itself or to other people. The procedures should be done in teams of at least four professionals (preferably five) and, in every moment, one of the members should reassure the patient and explain the reason why it is being held.^{21,22}

The use of therapeutic procedures, such as sedation, physical restraint and mechanical containment, requires from the professionals and the health care services a constant monitoring, in order to verify clinical signs indicating complications, such as: cyanosis, pressure on body areas, occlusion of members and vomiting, since they might result in severe clinical problems, including death. Added to these therapeutic effects, we can cite the psychological trauma caused by an aggressive approach and without permission.^{20,21}

Often, these conditions are caused by conditions and situations of crisis in the reality of the immediate context of general hospitals. The physical and functional structures are insufficient for a high demand for urgent care, which makes these technical actions of monitoring are relegated to a secondary place.

♦ THE METACONTEXT: the Brazilian mental health policies and their operationalization in the immediate context.

The process of construction and consolidation of the current Brazilian mental health policy is the result of a dialectical, social and historical construction that involves several reformist lines present in the world from the second half of the XX century.

For decades, the care of the mentally ill patient in Brazil was based on a hospital-centered model, where the figure of the asylum or the hospice was emblematic in the process of producing mental health services. In these locations “violence, intolerance and depersonalization of the individual prevailed, transforming it into a thing and, as such, with no individual needs or rights. Hence, he was no longer seen as a citizen”.^{14:797}

From the Brazilian Psychiatric Reform, the mental health policy is based on the construction and consolidation of a wide health care services network, primarily focused on the care outside the asylum environment, by having as main goals the reduction of psychiatric beds, greater control over the admission, family co-participation and the rescue of the subjects' autonomy, thereby promoting citizenship.²⁴ From this reorganization of the mental health system, we should work to integrate and maintain the patient in the community, enabling its reintegration in the social and family environments, as well as its insertion in the labor market itself.²⁵

It should be assigned to this new dynamic a

relevant role of psychiatric emergency services regarding the decision-makings that directly affect the development of the therapeutic over the course of the crisis. In addition to the SEP functions, we see the function of evaluator of new cases, giving resoluteness and targeting the cases to other mental health network services, as well as a supportive function, when patients are already included in the mental health care system.¹⁵

It should be emphasized the important role of general hospitals in this context, which serves, in most cases, and in the immediate context of the study of this work, as the gateway to the patients in crisis. Furthermore, it should be highlighted the need to match the hospital beds to receive this portion of the population, at the same time that one should invest in health continuing education with sights to support the produced care on the principles of the care humanization.²⁶

FINAL CONSIDERATIONS

The analysis of contextual levels of the study object has identified important aspects of the history of the Psychiatric Reform, with regard to the processes of caring in the psychiatric work, as well as the operational and human aspects before the public mental health policies and their influence with the construction and consolidation, in the micro-space, of the local and regional operationalization of a mental health care network.

It should be recognized and deduced that some challenges need to be overcome with regard to the care of psychiatric emergencies, from the process of reducing hospital beds and the monitoring and control of admissions. Furthermore, we have observed important gaps, mainly with respect to the organization of the mental health care network, the bureaucratization of the patients' flow, the poor structure in general hospitals for care of patients with mental and behavioral disorders in situation of crisis and the lack of knowledge and ability by health care professionals to deal with these situations.

We draw attention to the conduction of further studies on the phenomenon, taking into account the mode of organization of replacement services and general care services to the population in situations of crisis, from a therapeutic schedule and mechanisms for welcoming and dealing with psychopathological manifestations in an appropriate and humanized manner, thus

eliminating punitive-coercive procedures, such as: full sedation, physical restraint and mechanical containment.

REFERENCES

1. Foucault M. História da loucura na idade clássica. São Paulo: Editora Perspectivas; 1978.
2. Pessotti I. A loucura e as épocas. São Paulo: Editora 34; 1994.
3. Silveira LC, Braga VAB. Acerca do conceito de loucura e seus reflexos na assistência de Saúde Mental. Rev Latino-Am Enfermagem [Internet]. 2005 July-Aug [cited 2012 Nov 6];13(4):591-5. Available from: <http://www.scielo.br/pdf/rlae/v13n4/v13n4a19.pdf>
4. Torre EHG, Amarante P. Michel Foucault e a "História da Loucura": 50 anos transformando a história da psiquiatria. Cadernos Brasileiros de Saúde Mental [Internet]. 2011 Jan-June [cited 2012 Nov 6];3(6):41-64. Available from: <http://portal.incubadora.ufsc.br/index.php/cbsm/article/view/1502/1725>
5. Ribeiro LM, Medeiros SM, Albuquerque JS, Fernandes SMBA. Saúde mental e enfermagem na estratégia saúde da família: como estão atuando os enfermeiros? Rev Esc Enferm USP [Internet]. 2010 Mar-Apr [cited 2012 Nov 4];44(2):376-82. Available from: <http://www.scielo.br/pdf/reeusp/v44n2/19.pdf>
6. Randemark NFR, Jorge MSB, Queiroz MVO. A Reforma Psiquiátrica no olhar das famílias. Texto & contexto enferm [Internet]. 2004 Dec [cited 2012 July 14];13(4):543-50. Available from: <http://www.scielo.br/pdf/tce/v13n4/a06.pdf>
7. Silva AE, Paula BS, Aquino JM, Monteiro EMLM, Almeida LM, Silva FP et al. O cuidar em saúde mental no hospital psiquiátrico: percepção da equipe de enfermagem. J Nurs UFPE on line [Internet]. 2012 Mar [cited 2012 Nov 5];6(4):571-7. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2357/pdf_1014 DOI: [10.5205/reuol.2163-16218-1-LE.0603201211](https://doi.org/10.5205/reuol.2163-16218-1-LE.0603201211)
8. Brasil MAA. Serviços de emergência psiquiátrica: peça-chave da rede assistencial. Rev bras psiquiatr [Internet]. 2010 Oct [cited 2012 July 14];32(supl. II):69-70. Available from: <http://www.scielo.br/pdf/rbp/v32s2/v32s2a02.pdf>
9. Barros REM, Tung TC, Mari JJ. Serviços de emergência psiquiátrica e suas relações com a rede de saúde mental brasileira. Rev bras

- psiquiatr [Internet]. 2010 Oct [cited 2012 July 14];32(supl. II):71-7. Available from: <http://www.scielo.br/pdf/rbp/v32s2/v32s2a03.pdf>
10. Gil MAB. Cuidado policontextual de la salud: bases filosóficas. Texto & contexto enferm [Internet]. 2006 no.spe [cited 2012 July 14]; 15(Esp):142-5. Available from: <http://www.scielo.br/pdf/tce/v15nspe/v15nspea16.pdf>
11. Friberg F, Dahlberg K, Petersson MN, Ohlén J. Context and methodological decontextualization in nursing research with examples from phenomenography. Scand J Caring Sci. 2000 Jan [cited 2012 July 17];14(1):37-43.
12. Hinds PS, Chaves DE, Cypress SM. Context as a source of meaning and understanding. Qual Health Res. 1992 Feb [cited 2012 July 17];2(1):61-74.
13. Dal-Poz MR, Lima JCS, Perazzi S. Força de trabalho em saúde mental no Brasil: os desafios da Reforma Psiquiátrica. Physis (Rio J.) [Internet]. 2012 Apr-June [cited 2012 Nov 9];22(2):621-39. Available from: <http://www.scielo.br/pdf/physis/v22n2/12.pdf>
14. Sousa FSP, Silva CAF, Oliveira EN. Emergency psychiatric service in general hospitals: a retrospective study. Rev Esc Enferm USP [Internet]. 2010 Sept [cited 2012 Nov 9];44(3):796-802. Available from: http://www.scielo.br/pdf/reeusp/v44n3/en_35.pdf
15. Del-Ben CM, Teng CT. Psychiatric emergency: challenges and vicissitudes. Rev bras psiquiatr [Online]. 2010 Oct [cited 2012 July 14];32(supl. II):68-9. Available from: http://www.scielo.br/pdf/rbp/v32s2/en_v32s2a01.pdf
16. Caponi S. Loucos e Degenerados: uma genealogia da psiquiatria ampliada. Rio de Janeiro: Editora Fiocruz; 2012.
17. Brasil. Ministério da Saúde. Gabinete do Ministro. Portaria n. 130, de 26 de janeiro de 2012: Redefine o Centro de Atenção Psicossocial de Álcool e outras Drogas 24 h (CAPS AD III) e os respectivos incentivos financeiros. Brasília (DF): Ministério da Saúde; 2012.
18. Campos RO, Gama CA, Ferrer AL, Santos DVD, Stefanello S, Trapé TL et al. Saúde mental na atenção primária à saúde: estudo avaliativo em uma grande cidade brasileira. Ciênc saúde coletiva [Internet]. 2011 Dec [cited 2012 July 15];16(12):4643-52. Available from: <http://www.scielo.br/pdf/csc/v16n12/13.pdf>
19. Santos MS, Coimbra VCC, Ribeiro JP. O atendimento de urgência psiquiátrica realizado pelo enfermeiro do serviço de atendimento móvel de urgência. J Nurs UFPE on line [Internet]. 2011 Nov [cited 2012 Nov 6];5(9):2197-205. Available from: <http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/1890/pdf/689> DOI: 10.5205/reuol.1262-12560-1-LE.0509201117
20. Mantovani C, Migon MN, Alheira FV, Del-Bem CM. Manejo de paciente agitado ou agressivo. Rev bras psiquiatr [Internet]. 2010 Oct [cited 2012 July 14];32(supl. II):96-103. Available from: <http://www.scielo.br/pdf/rbp/v32s2/v32s2a06.pdf>
21. Kondo EH, Vilella JC, Borba LO, Paes MR, Maftum MA. Abordagem da equipe de enfermagem ao usuário na emergência em saúde mental em um pronto atendimento. Rev Esc Enferm USP [Internet]. 2011 Mar-Apr [cited 2012 Dec 20];45(2):501-7. Available from: <http://www.scielo.br/pdf/reeusp/v45n2/v45n2a27.pdf>
22. Paes MR, Borba LO, Brusamarello T, Guimarães AN, Maftum MA. Contenção física em hospital psiquiátrico e a prática da enfermagem. Rev enferm UERJ [Internet]. 2009 Oct-Dec [cited 2012 Dec 20];17(4):479-84. Available from: <http://www.facenf.uerj.br/v17n4/v17n4a04.pdf>
23. Bonfada D, Guimarães J. Serviço de Atendimento Móvel de Urgência e as urgências psiquiátricas. Psicol estud [Internet]. 2012 Apr-June [cited 2012 Nov 9];17(2):227-36. Available from: <http://www.scielo.br/pdf/pe/v17n2/v17n2a05.pdf>
24. Silva DS, Azevedo DM. A Reforma Psiquiátrica na visão de quem cuida: percepções de profissionais do serviço residencial terapêutico. Esc Anna Nery Rev Enferm [Internet]. 2011 July-Sept [cited 2012 Nov 9];15(3):587-94. Available from: <http://www.scielo.br/pdf/ean/v15n3/a21v15n3.pdf>
25. Azevedo EB, Ferreira-Filha MO. Práticas inclusivas na rede de atenção à saúde mental: entre dificuldades e facilidades. Revista Ciência & Saúde [Internet]. 2012 July-Dec [cited 2012 Nov 9];5(2):60-70. Available from: <http://revistaseletronicas.pucrs.br/ojs/index.php/faenfi/article/viewFile/10657/8205>
26. Carvalho CRA. As unidades psiquiátricas em hospitais gerais e seu papel na rede de

serviços em saúde mental. Saúde debate [Internet]. 2011 Jan-Mar [cited 2012 Nov 10];35(88):148-56. Available from: http://www.sumarios.org/sites/default/files/pdfs/014_sdv35n882011.pdf

Submission: 2012/01/14

Accepted: 2013/04/07

Publishing: 2013/05/15

Corresponding Address

Francisco Rafael Ribeiro Soares
Universidade do Estado do Rio Grande do
Norte / Departamento de Enfermagem
Rua Des. Dionísio Filgueira, 383 / Centro
CEP: 59600-000 – Mossoró (RN), Brazil