Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

MOBILE SERVICE ATTENDANCE OF URGENCY TO PSYCHIATRIC URGENCIES AND EMERGENCIES

SERVIÇO DE ATENDIMENTO MÓVEL DE URGÊNCIA ÀS URGÊNCIAS E EMERGÊNCIAS PSIQUIÁTRICAS

SERVICIO MÓVIL DE ATENDIMENTO DE URGENCIA A LAS URGENCIAS Y EMERGENCIAS PSIQUIÁTRICAS

Ana Cristina Teixeira Santos[1], Yanna Cristina Moraes Lira Nascimento[2], Tâmara Silva de Lucena[3], Patrícia Maria da Silva Rodrigues[4], Mércia Zeviani Brêda[5], Girleane Feitoza dos Santos[6]

ABSTRACT

Objective: characterizing the services conducted by SAMU to psychiatric urgencies and emergencies. ***Method:*** a descriptive and exploratory study with a quantitative approach, performed in two steps: query to 18820 records of attendances of SAMU from Maceio – Alagoas, and application of questionnaire to 48 professionals working in the service: nursing technicians, nurses and doctors. There were used IBM SPSS Statistics Version 20 and Excel, analyzing absolute frequency to 95%, confidence interval. The research project was approved by the Ethics Committee, Protocol 17181813.5.0000.5013. ***Results:*** from the attendances, 5,2% of which were conducted are psychiatric; of these, 67,4% are sent to psychiatric hospitals, and 81,2% are made with military police; 87,5% of professionals have difficulties in providing psychiatric care and 58.4% require training in mental health. ***Conclusion:*** psychiatric attendances need communication between services and professional technical preparation, indicating that investments in continuing education and networking are priority measures for a better assistance. ***Descriptors:*** Epidemiological Profile; Mental Health; Psychiatry; Emergency Medical Services.

RESUMO

Objetivo*:** caracterizar os atendimentos realizados pelo SAMU às urgências e emergências psiquiátricas. ***Método*:** estudo descritivo e exploratório, de abordagem quantitativa, realizado em duas etapas: consulta a 18820 fichas de atendimentos do SAMU de Maceió (AL) e aplicação de questionário a 48 profissionais atuantes no serviço: técnicos de enfermagem, enfermeiro e médicos. Utilizaram-se IBM SPSS Statistics Versão 20 e Excel, analisando frequência absoluta a 95%, intervalo de confiança. O projeto de pesquisa foi aprovado pelo Comitê de Ética, Protocolo 17181813.5.0000.5013. ***Resultados*:** dos atendimentos, 5,2% dos que foram realizados são psiquiátricos; destes, 67,4% são encaminhados aos hospitais psiquiátricos e 81,2% são efetuados com polícia militar; 87,5% dos profissionais possuem dificuldades em prestar assistência psiquiátrica e 58,4% necessitam de treinamentos em saúde mental. ***Conclusão*:** os atendimentos psiquiátricos carecem de comunicação entre os serviços e preparo técnico profissional, apontando que investimentos em educação permanente e articulação em rede são medidas prioritárias para uma melhor assistência. ***Descritores: Perfil Epidemiológico; Saúde Mental; Psiquiatria; Serviços Médicos de Emergência.

RESUMEN

Objetivo: caracterizar los servicios prestados por el SAMU a las urgencias y emergencias psiquiátricas. ***Método:*** un estudio descriptivo y exploratorio, con abordaje cuantitativo, realizado en dos etapas: la consulta a 18.820 registros de las visitas por el SAMU de Maceió – Alagoas, y el uso de cuestionarios a 48 profesionales que trabajan en el servicio: técnicos de enfermería, enfermeras y médicos. Se utilizaron IBM SPSS Statistics Versión 20 y Excel, en el análisis de la frecuencia absoluta a 95%, intervalo de confianza. El proyecto de investigación fue aprobado por el Comité de Ética, Protocolo 17181813.5.0000.5013. ***Resultados:*** de los casos, 5,2% de los cuales se realizaron son psiquiátricos; de éstos, el 67,4% son enviados a los hospitales psiquiátricos y el 81,2 % se hizo con la policía militar; 87,5% de los profesionales tienen dificultades para proporcionar atención psiquiátrica y el 58,4% requieren capacitación en salud mental. ***Conclusión:*** las consultas psiquiátricas necesitan de comunicación entre los servicios y la preparación técnica profesional, indicando que las inversiones en la educación continua y la creación de redes son las medidas prioritarias para mejorar la asistencia. ***Descriptores:*** Perfil Epidemiológico; Salud Mental; Psiquiatría; Servicios Médicos de Emergencia.

[1,6]Egresses Nurses, Federal University of Alagoas / UFAL. Maceió (AL), Brazil. Email: anacristinateixeira.90@gmail.com; girleanefeitoza@hotmail.com; [2]Nurse, Master Teacher of Nursing, School of Nursing and Pharmacy, Federal University of Alagoas / ESENFAR / UFAL. Maceió (AL), Brazil. Email: yanna_cristina@hotmail.com; [3,4]Students, Nursing Course, Federal University of Alagoas / UFAL. Maceió(AL), Brazil. Emails: miminha_lucena13@hotmail.com; paty_msrodrigues@hotmail.com; [5]Nurse, Professor of Nursing, Postgraduate Program of Nursing, School of Nursing and Pharmacy, Federal University of Alagoas / ESENFAR / UFAL. Maceió (AL), Brazil. Email: merciazb@gmail.com

INTRODUCTION

Urgency is defined as an unexpected occurrence of health problem with or without potential risk of life whose person needs quick assistance. To the concept of emergence is attributed conditions of health problem involving imminent risk of life or intense suffering, thus requiring immediate intervention.[1] Thus, Emergency in mental health refers to any disorder of thought, feelings or actions requiring an immediate intervention to protect the person or third party from risk of death.[2]

Attendance to situations of urgency and emergency in mental health must be a quick attendance, which should objective a positive response to the crisis that aims to prevent damage to physical and mental integrity of the person in suffering, and are at these times that some health services, such as SAMU are sued.[1-5]

The service of SAMU to psychiatric events is initially based on the concept of psychiatric urgency and emergency defined for this service by the failure presented by a person to cope with stress by usual mechanisms when faced with a new problem or unbearably harrowing, often responding with behaviors inherent in a state of emotional imbalance that endangers his own life, to others and to the aid team.[6]

For SAMU, a framework for psychiatric emergency and urgency is identified, when people with mental illnesses have extreme attitudes, such as aggression, risk of suicide and homicide that cause disturbances in feelings or actions, being necessary immediate therapeutic interference.[6-7]

Acute psychological disorders are included within the urgencies and emergencies attended by the SUS, and account for about 10% of all emergency and urgency attendances of general hospitals and the first aid.[1] Studies claim that the total care provided by SAMU, in the last five years in the Brazilian territory, approximately 5 to 10% were referent to psychiatric urgencies and emergencies.[8-10]

In the case of mental disorders that also present aggressive, externalized violent behavior by the person in crisis causes fear, anxiety and insecurity on those around you and especially in those professionals who provide care. Excessive fear of professionals undermine the clinical trial leading to inadequate therapeutic approaches, such as preterm use and in large amounts of sedatives and physical aggressive constraints.[2]

In Maceió, in the year 2012, there were performed approximately 20,250 urgency attendances by SAMU. Of these, 5,9% were related to psychiatric urgencies, which corresponds to1195 annual attendances.[4]

Comparing the 2012 data with those of the year 2011, we find the remarkable growth of attendances rendered to this type of urgency, as in 2011 were conducted 770 attendances, and in 2012, 1195, what represents an increase of approximately 55% from one to another year.[4]

The attendance to psychiatric urgencies shall also be of the technical competence of the urgency services, and so to the SAMU, since 2003 from the Ordinance 1864/GM who founded the pre-hospital mobile component in national territory, performing psychiatric care when activated, by setting up as a gateway, which articulates the flow regulator of Mental Health to forward the service most adequate.[1,10]

The service performs urgency and emergency care anywhere: homes, workplaces and public roads. The rescue begins with free call made to the telephone number 192. The call is served by technicians who identify the emergency and transfer the call to a doctor who makes the diagnosis of the situation and starts the service at once, guiding the patient or the person who made the call on the first actions. After evaluated the need, forwards to the scene, a Unit of Basic Support (USB) or Advanced Support Unit (USA).[11]

With the reformulation of the National Policy for Urgency Care, from the publication of the decree 1600, SAMU becomes a part of the Network of Urgency Care at SUS, which establishes as one of its guidelines for attention: increasing access and hosting to cases defendants acute health services at all points of care, and ensuring the universality, fairness and integrity in emergency service be clinical, surgical or psychiatrical.[11] Being strengthened its responsibility for the 3088 publication of the decree establishing the Network for Psychosocial Care (RAPS) for people suffering or mental disorder and needs arising from the use of crack, alcohol and other drugs within the SUS.[12]

Thus, it becomes important to characterizing the attendances of SAMU Maceió - Alagoas, since this information may serve as a situational analysis to identifying the critical nodes which are able to collaborate in the planning of continuing education and improved care in emergency psychiatric performed by SAMU in Alagoas. So, considering this vulnerability to mental illness and the need for a greater understanding of

the care provided by the staff of SAMU to psychiatric urgencies and emergencies, is that this study sought to characterize the services performed by SAMU to psychiatric urgencies and emergencies.

METHOD

Article compiled from the Monograph << Characterization of the services performed by SAMU to psychiatric urgencies and emergencies >> Presented to the Coordination of the Graduate Nursing Course of the School of Nursing and Pharmacy, Federal University of Alagoas.

This is a descriptive and exploratory study with a quantitative approach, held at the Mobile Medical Urgency Service (SAMU) in the city of Maceió in Alagoas / Brazil.

SAMU Maceió counts with 96 nursing assistants or technicians, 23 nurses and 35 doctors; it has seven BHUs, three USAs and one USA NEO (specific to care in neonatology); being the BHU composed by a first responder driver and two nursing technicians and the USAs by a doctor, a nurse, a technician or nursing assistant and one conductor first responder.

The research was conducted in two stages: in the first we analyzed 18820 registration file services performed by SAMU from March 2012 to March 2013. Of these, 977 were matched to psychiatric urgency or emergency care. However, due to the lack of information from the underreporting of the study there were aborted 166 records, being selected 811 for analysis. The variables investigated were: place of the Care of occurrences; characteristic of the person assisted in Approach; place of care; gender of the person served; age range of the person served and support of the Military Police in attendance.

In the second step we applied a questionnaire (adapted from that used by Katita Jadim[13] in 2008) to 48 professionals, including physicians, nurses and nursing technicians. For this sample it was performed a calculation through the Siqueira Campos method, using a standard deviation of 20% and a confidence interval of 95%. The selection of subjects was randomly being included in this sample, the professionals involved in a SAMU Maceió exercises that were in the service and had done some service to the urgency and emergency service. We excluded those who were on vacation or on leave and those who refused to sign the Instrument of Consent (IC).

The data were tabulated using Epi Info TM, transcribed in Excel so that they were generated graphs of an appropriate format. To calculate the percentage and absolute frequency for each variable, it was used the program IBM SPSS Statistics in Brazilian Portuguese language (version 20) and transcribed in tables created and edited in Microsoft Word 2007 for an easier analysis and subsequent discussion.

The study was approved by Urgency Mobile Medical Service (SAMU) Maceió/AL and the research project was approved by the Research Ethics Committee of the Federal University of Alagoas (UFAL), under Opinion No. 17181813.5.0000.5013.

RESULTS

Of the 18,820 visits conducted by SAMU in the period under study, 5,2% (n = 977) were provided to individuals with psychiatric urgency frames. The results show, as table 1,that these services were provided mostly in the homes of the needy (57,2%, n = 464), with the support of the military police-PM (81,2%, n = 659), 46,6% (n = 370) were contained and transported to the Psychiatric Hospital reference of the State of Alagoas, and that 50% of the people rescued were described as agitated and/or aggressive (n = 402).

Table 1. Characterization of the occurrences in psychiatric urgencies and emergencies undertaken by SAMU of Maceió-Alagoas, 2013. N = 811.

Variable	n (%)	Variables	n(%)
Place of attendance		**Transport and Forwarding**	
Home	464(57,2)	Psychiatric Hospitals	547(67,4)
Public pathways	47 (5,8)	Mini first aid	9(1)
Other	27 (3,3)	Non transported	183(22,6)
Did not inform	173(21,3)	Non informed	2(0,24)
		Military police support	
Characteristic of the person assisted in addressing		Yes	659(81,2)
Agressive	137(17)	Non informed	152(18,7)
Agitated	104(13)		
Agressive and agitated	161(20)		
Calm or cooperative	132(16,3)	**Performed procedures**	
Contained with rope or wire	20(2,5)	Administration of medicines	66(8,1)
Non informed	257(31,7)	Containment and transportation	370(45,6)
		Other	73(9)
		Non informed	302(37,2)

Regarding the characterization of the persons assisted, 58,3% (n = 473) were male, 26,3% (n = 213) were aged between 21 and 30 years old, and 65,3% (n = 530) had a history of psychiatric evaluations as shown in Table 2.

Table 2. Characterization of people assisted by SAMU Maceió/Alagoas in psychiatric cases regarding gender, age and psychiatric clinical follow-up, 2013. N = 811.

Variable	n(%)
Gender	
Male	473(58,3)
Female	283(35)
Non informed	55(6,8)
Age (in years)	
0 to 10	5 (0,6)
11 to 20	84 (10,4)
21 to 30	213 (26,3)
31 to 40	194 (24,0)
41 to 50	150 (18,0)
>50	95(11,7)
Psychiatric counseling	
Yes	530 (65,3)
No	239 (29,5)
Non Informed	22 (2,7)

Regarding the characterization of professionals, Table 3 shows that 72,9% (n = 35) of the professionals are female, 62,5% are aged between 31 and 40 years old, and 89,6% (n = 43) are acting in the SAMU for 10 years or less.

Table 3. Characterization of professionals linked to SAMU Maceió-AL paying attention to psychiatric urgencies, 2013. N = 48.

Variable	n(%)	Variable	n(%)
Profession		**Age**	
Nursing technician	26(54,2)	20 to 30	2 (4,2)
Doctor	10(20,8)	31 to 40	30 (62,5)
Nurse	12 (25,0)	>50	8 (10,5)
		41 to 50	3 (6,3)
		Non Informed	5 (16,7)
Gender		**Length of service**	
Female	35(72,9)	0 to 10 years	43 (89,6)
Male	2(4,2)	11 to 20 years	1 (2,1)
Non informed	11(22,9)	Non informed	4 (8,3)

It was observed that 58,3% (n = 28) of the professionals who responded to the questionnaires are unaware about the principles of psychiatric reform legislation and the National Mental Health Policy (PNSM), 81,5% (n = 39) are unaware of the strategies used by the service to put into practice the guidelines of PNSM. Within this context, 33,3% (n = 18) of subjects defined psychiatric urgency and emergency as a situation where the patient is predisposed and/or predisposes others to life threatening (Table 4).

Table 4. Knowledge of professionals of SAMU Maceió-AL, on definitions and practices of psychiatric urgency and emergency, Psychiatric Reform and PNSM, 2013. N = 48.

Variable	n (%)
Concept of psychiatric urgency	
Agitation, aggressiveness and unconsciousness	8 (16,7)
Psychiatric crisis, psychotic break	10 (20,8)
Motor Skills Disorder	7 (14,6)
Life-threatening to the patient and/or society	8 (33,3)
Did not answer	5 (10,4)
Knowledge of Psychiatric Reform and National Policy on Mental Health (PNSM)	
No	28 (58,3)
Yes	20 (41,7)
Knowledge or implementation of any strategy of PNSM	
No	39 (81,5)
Yes	7 (14,6)
Did not answer	2 (4,2)
Sufficiency of vocational training	
No	42(87,5)
Yes	4(13,5)
Participation in training in mental health	
Yes	14(20,2)
No	34(70,8)

The data also showed that 87,5% (n = 42) stated that their professional training, whether at middle school or graduate level and average in service while technician of SAMU, is insufficient to meet an adequate and a properly psychiatric demand. Of these 70,8% (n = 34) say they have participated in any training in the area and, as seen in Table 4.

Even before this unpreparedness reported by professionals of SAMU, 77,1% of those professionals said they had not refused to meet urgencies or emergencies of psychiatric situations, however, 62,5% (n = 30) defined their experience as poor and 87,5% (n = 42) reported difficulties in effecting service. As the strategies used most in attendance revealed the use of physical restraint (47,9%, n = 23) and 58,4% (n = 28) reported a need for mental health training to improve service SAMU as checks shown in table 5.

Table 5. Refusal of professionals in psychiatric care, perform characterization of experience, techniques used during service and needs to improving the attendance according to the SAMU Maceió-AL, 2013. N = 48.

Variable	n (%)
Refused to meet a psychiatric urgency or emergency situation	
Yes	9 (18,75)
No	37 (77,1)
No answer	2 (4,2)
Experience when performing urgent and emergency psychiatric service	
Good	8 (16,7)
Bad	30 (625)
Horrible	8 (16,7)
No answer	2 (4,2)
Presented difficulty in performing the service	
Yes	42 (87,5)
No	6 (12,5)
Techniques used in attendance	
Physical restraint	23 (47,9)
Chemical restraint	19 (9,6)
Electric containment with teaser of Military Police	1 (2,1)
No answer	1 (2,1)
Need to improve customer service	
Integration between the network of the County psychiatric attention	7 (14,7)
Team specialized in Psychiatry	5 (10,5)
Improved cooperation of PM	28 (58,4)
Training in mental health	3 (6,3)

DISCUSSION

The results, in general, has been similar to other studies,[5,14-22] as they relate to emergency and urgent care. The growing number of people who experience the process of mental illness in recent years has often led to the need to trigger SAMU to intervene in situations of psychiatric emergency and urgency.[5,6.11] Such growth may be a result of immersion in contemporary society in a culture of stigma, values and risks, which exposes the self to a higher chance of getting mentally sick.[3,5.13]

The aid of this service, in most cases, are requested by their own families in their homes, in view of SAMU allow professionals to come to the place where the person is suffering quickly, welcoming family in crisis, avoiding in moments admissions and enabling more effective and potent referrals.[5]

It should be emphasized that not always cases of urgency and emergency psychiatric

crises are linked to psychomotor agitation and hetero-aggressiveness. However, epidemiological studies reveal that people diagnosed with mental disorders are more likely to develop frameworks aggression and agitation than those with no history of mental illness.

The data show that, among those with a psychiatric disorder, 10 to 45% even showed aggressive behavior and stirred threatening in some cases, such symptoms of acute psychotic states and increasing tensions.[14] These tables are manifested in most cases in people with psychiatric disorders who discontinue treatment, leading them to develop bouts of acute mental illness needing an urgent or emergency care, which often calls SAMU.[15]

In this study it has been found that psychiatric consultations are being conducted only with the aid of the PM, even knowing that its participation in psychiatric urgencies and emergencies attendances, meets the ideas defended by the Psychiatric Reform process.

Act violently during a person's psychic crisis, shows that the fear of madness is who is dictating the direction of the assistance given and in these cases, assistance must be offered by professionals with training and adequate knowledge.[8] This knowledge becomes essential so that professionals do not transfer responsibility for the PM during the intervention in mental crises, based only on fear and a biased interpretation of the ordinance 2.048/GM, pointing to the possibility of intervention of that corporation.[11]

Although this decree was published more than a decade, it still remains in force, often leading to radical interpretations of the incorporation of this type of police service. It is noticed that there is a need to offer a more humane care in accordance with the recommendations of the psychiatric reform process, being the subject of debate since the last century, as Goffman argued since 1974 that if the professional acted in a manner contrary to the least resources invasive and repressive, would strengthen the condition that "the psychiatric team shares with the police the peculiar professional task of intimidating and moralizing adults." [16]

This discussion becomes important to alert health professionals of SAMU, which deal with these extreme situations, not to transfer responsibility to the other military corporations. In this sense, it is necessary to take into account the uniqueness of each person served, so do not happen omissions or exaggerations, nor seek the imposition of a stronger fear and not on the task of being builders of moral agency.

Pressing the police should be restricted to situations where the danger to staff and contractors were demonstrably related to the use of objects that provided risks to life, however, one realizes that the intervention of the military police has been requested indiscriminately, as if every crisis situation implied in concrete risk to the team.[5]

Having the PM present in most attendances, is to persist in advocating that all psychiatric patients is potentially dangerous, this may reflect the lack of preparation of professionals to provide this type of care and creating a dependency relationship with the police, contributing to omission of care.

Regarding the procedures performed in the approach the person in distress or psychiatric emergency, it was found that the most frequently performed procedure was the containment followed by transport, where approximately 50% of professionals reported using physical restraint in the care they provide.

The physical restraint should be used in situations where the patient is in intense agitation and with manifestation of aggressive behaviors, but should only be used when the verbal intervention attempts are not sufficient, being indicated primarily for patients at risk of aggression. Such placement allows you to correlate the data from two variables under study, since most people were agitated and aggressive and may have been that the justification of the prevalence of physical contentions.[14]

Physical restraints are therefore not filled a gap in care for people with mental disorder, given that it is standard practice in everyday professionals and emergency services often are not prepared to perform the procedure correctly, nor exists in the service routine a protocol on how to perform the technique, the care that should be performed before, during and after retention, as well as who gets to decide and conduct of the same.[17]

Among the techniques used, in addition to other physical restraint were cited as: chemical restraint and restraint with taser of PM. The Taser is a device used to inhibit the lawbreakers, through an electric shock. Use of this equipment in every way disagree with what instructs the Psychiatric Reform, reinforcing concepts and principles manicomial.[5]

Another fact worth mentioning is the centralizing role played by psychiatric hospital

in the city under study, even after measures of progressive reduction of beds in psychiatric hospitals adopted from the implementation of the National Program for the Evaluation of Hospital Services (PNASH).

SAMU should not act only as an instrument of transport characteristics asylums, but must intervene forcefully in contemplating retirement Psychiatric guidelines should articulate their interventions require assistance in health, making no sense to continue thinking in the psychiatric hospital as priority destination for people in psychic crisis.[5]

One must consider that the Network for Psychosocial Care (RAPS) is still under implementation in capital of Alagoas. Care services that make up the psychosocial network are not yet complete. The municipality does not have CAPS III nor has reserved beds in general hospitals for people with mental illness. Existing CAPS, as well as other points of attention are not prepared to receive patients in acute distress, which makes the psychiatric hospital as the main routing option.

In relation to care provided by SAMU, it is important to highlight that in 31.7% of the chips analyzed, there was no record of the characteristics of the person at the time of the tour that reveals the considerable percentage of chips underreported occurrence. Wonders what the real reasons for such determination, may be the lack of knowledge about the information the records contain, as well as lack of training for its correct use. This result is similar to those found in other studies, because the survey data obtained in the care given by SAMU is fundamental information in health to assist in action planning, human resources and materials.[15,18]

With regard to the prevalence of males in crisis served by the SAMU, corroborate previous studies that showed that men are the main victims because of the level of adherence to treatment of diseases men is lower than women, making that men initiate a more aggressive psychiatric crisis easily.[19-21]

The data that differ from statistics found in Brazil considering the man-woman relationship with some form of mental disorder be 1 to 2. This increased predisposition of women in developing mental disorders, can be explained by some scholars, by the accumulation of multiple roles the modern woman has taken today, the responsibility associated with being a mother, wife and educator, in addition to the mood swings associated with the reproductive period facing hormonal changes.[22]

Age is also a determinant expressive mental disorder. It is noticeable that the most affected age group comprises people who are active in age from 21 to 30 years old. This refers to the presentation of frames of acute mental illness in this age group, influences the way of life of these people, especially by interfering with the physical and social productivity as a result of disability, resulting from a crisis that has evolved in a detrimental manner to the welfare of these people physical and mentally.[15]

With regard to the characterization of professionals linked to SAMU in a study that provided care to psychiatric emergencies, this research is similar to the results described by Bonfada, where he stated that most professionals are female and aged below 50 years old for being generally from a predominantly female professional class, nursing. It was also found that most of the services rendered are performed by professional nursing assistants, also found this to study.[5]

The secondary courses do not offer enough that these professionals perform contention of an adequately training. The professional higher education supposedly possess qualifications for such, but represent a minority of professionals who provide this type of care, but that does not prevent them from trying to qualify your team for such a procedure, in view of the roles of the nurse be educator and one of those responsible for the continuing education of the nursing staff.

Regarding the length of service of professionals, the result points to the importance of professional experience; the service time of influence in the application of the experience as a way of learning and application of more adaptive strategies in the context of the work which will facilitate the performance of activities. The beginner, in turn, requires a monitoring and more judicious training so you can develop skills for handling each call. On the other hand, younger professionals bring new theoretical and practical knowledge that will certainly contribute beneficially to the development of their activities and techniques.[21]

As for the lack of these professionals SAMU in relation to the operationalization of RAPS, authors claim that the lack of understanding of the organization of territorialized network affects mental health assistance and emergency rescue to crisis psíquica.5 It is necessary that SAMU and RAPS is to articulate and promote full coverage from the attention

to the crisis in its mobile component to the service complexity appropriate to each case.

The responsibility of articulation is not only of SAMU. The network itself is facing problems of substitute services for operational guidelines of the National Mental Health Policy (PNSM), they still persist asylums ideal admission. One can cite as an example of this deficiency, the lack of a CAPS III in the city of Maceió. This service has incisive power in the care for people in mental crisis, since it operates 24 hours every day of semana.[23]

Regarding the knowledge of professionals in the SAMU study on definitions and psychiatric practices similar to other studies, [17] was that the prevalence of psychiatric urgency and emergency situations are in need of professional help when the person has serviced risk to himself and society .

It is noticed that some studies show a small impact that the process of psychiatric reform has had on improving assistance in emergency and mobile emergency services. This is a result of ignorance by most professionals on the significance and proposals of the Psychiatric Reform and PNSM, about the performance of substitute services, and disbelief in the functionality of CAPS as a substitute service that contributes to the spread of doubts and tensions constant practice of pre-service of hospital professionals.[5]

Regarding training, the lack of preparation during the course, either at the undergraduate or middle level, and the lack of training to meet the person with mental disorder were found in this survey data, as well as in the study by Kondo.[17] Such difficulties can be generated by a number of factors, such as lack of unpreparedness to deal with specific situations of mental health generating fear, suspicion, anger, pity and insecurity; lack of sufficient and appropriate to carry out the physical containment equipment; the lack of training in mental health; the completion of treatment in inappropriate places and the lack of skilled professionals in equipe.[17, 24]

Much of subjects reported difficulties and said need training to enhance the care provided in emergency and psychiatric emergency corroborate other studies.[5, 17] These studies confirm that ongoing mental health education should include knowledge about the political changes that have occurring in this area as well, caveat about the transition of the practice of hospital care aimed at curbing the behavior to incorporate principles of interdisciplinary practice, aiming to educate and qualify both new employees and more experienced on the role professional as a changing agent.[5,17]

Regarding availability conduct a psychiatric care most not refused, but said they had difficulties and described the experience as bad. It can be noticed that the number of professionals who reported having had some type of difficulty during this type of care and the percentage of those that characterized the experience as bad is above 50%. Again it is possible to relate the lack of technical preparation with difficulties, which in turn makes the experience uncomfortable for professional compromising the quality of care provided. If the trader does not have sufficient technical training to provide care, increasing the chances of making the traumatic experience both for themselves and for the person that is receiving care.[5]

The data revealed a reality that had not yet been discussed in service and study space. Characterize the practices of attendances in the urgencies and emergencies in Psychiatry revealed existing needs that for long had been overshadowed that has collaborated for the non-adherence of liberating practices and greater social inclusion.

CONCLUSION

This study enabled us to characterize the care provided by SAMU - Maceió/Alagoas to the emergency room and psychiatric emergencies, highlighting settings and emergency staff about mental health, having revealed some challenges that society must confront to experience mental health nowadays.

Reflection on the information analyzed revealed the main difficulties that impair assist a person in acute mental distress that needs the care provided by SAMU. The Psychiatric Reform seeks to deconstruct a secular institution: psychiatry in asylums characteristics. Therefore, they must be created strategies for successfully implementing structured on the ideals of the Reform actions.

The consolidation strategies of continuing education that prioritize the urgent care and psychiatric emergencies, focused critical discussion of cases, could contribute to overcoming the hospital-centered model as a basis for professionals on promotion of conceptual changes proposed by the Psychiatric Reform.

It should be noted that the substitutive services of attention to mental health are realities resulting from the movement of the psychiatric reform of social, political and

economic character that fights for the deconstruction of the asylums and the paradigm that sustains it. And redirection of mental health assistance requires evaluations, reevaluations and reflections contained in the services created and adapted to work in a non-inclusive perpetuating the image of people in mental illness are filthy, dangerous, ignorant, aggressive and violent and therefore should be kept away from people living in society.

It also revealed the lack of articulation between the SAMU and the new devices of attention to mental health, noting the permanence of the psychiatric hospital as the central point of referrals. The rapprochement between the SAMU and a network of psychosocial services can contribute to the strengthening of comprehensive interventions for mental crises, as well as on centrality break taken by hospitals specialize in psychiatry. Therefore, it becomes necessary to take on a challenge in the search to find potential within the characteristics of the service itself, to make it compatible with the ideals proposed by the Reform.

Facing this issue, it is visible the need for a greater intervention on the part of public policies as well as strategies for articulation between SAMU and RAPS. Thus, it is necessary to understand that this device of care for psychiatric emergencies now under discussion is so punctual as a service and not as the sole responsible for the whole process of mental health assistance during the crisis. There is continuity of care in a network consisting of extramural services replacing the conventional model.

It is hoped that this study can intensify the discussion in relation to attendance at psychiatric urgencies and emergencies, especially since research on these aspects are minimal and necessary.

REFERENCES

1. Brasil. Política Nacional de Atenção as Urgências: Diretrizes e mecanismos para a implantação do componente Sala de Estabilização –SE da Rede de Atenção às Urgências. Brasília: Ministério da Saúde; 2011.

2. Kaplan HI, Sadock BJ. Compêndio de Psiquiatria. 9th ed. Porto Alegre: Artmed; 2007.

3. Lemos P M, Freitas SC. Os contornos tardo-modernos do sofrimento e do adoecimento psíquico: proposições éticas para o Centro de Atenção Psicossocial. Psicol rev [Internet]. 2011 [cited 2013 Oct 15];17(2):303-19. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-11682011000200010

4. Ministério da Saúde. Seminário Nacional da Rede de Atenção às Urgências e Emergências. Brasília; 2012.

5. Bonfada D. Serviço de Atendimento Móvel de Urgência (SAMU) e a assistência às urgências psiquiátricas. Natal [cited 2013 Nov 10] 2010. Dissertação (Mestrado) Universidade Federal do Rio Grande do Norte [Internet]. Available from: http://repositorio.ufrn.br:8080/jspui/bitstream/1/9273/1/DiegoB_DISSERT.pdf

6. Ministério da Saúde. Curso de Atendimento em Emergência Pré- hospitalar Móvel. Brasília; 2010.

7. Giddens A. Modernidade e Identidade. Rio de Janeiro: Ed. Jorge Zchar; 2002.

8. Pitteri JSM, Monteiro PS. Caracterização do Serviço de Atendimento Móvel de Urgência (SAMU)- Palmas- Tocantins, Brasil, em 2009. Com Ciência Saúde [Internet]. 2010 [cited 2013 Oct 17]; 21(3):227-236. Available from: http://www.dominioprovisorio.net.br/pesquisa/revista/2010Vol21_3art5CaracterizacAO.pdf

9. Marques GQ, Lima MADS, Ciconet RM. Agravos clínicos atendidos pelo Serviço de Atendimento Móvel de Urgência (SAMU) de Porto Alegre (RS). Acta paul Enferm [Internet]. 2011 [cited 2013 Oct 20];24(2): 185-91. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002011000200005.

10. Brasil. Portaria 1.864/GM de 29 de setembro de 2003. [Internet] Brasília: Ministério da Saúde, 2003 [cited 2013 Nov 15]. Available from: http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2003/GM/GM-1864.htm.

11. Ministério da Saúde. Portaria n° 2048. [Internet]. Brasília: 2002 [cited 2013 Nov 16]. Available from: http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2002/Gm/GM-2048.htm.

12. Brasil. Gabinete do Ministro. Portaria nº 3088 de 23 de dezembro de 2011. Institui a rede de atenção psicossocial para pessoas com sofrimento ou transtorno mental, incluindo aquelas com necessidades decorrentes do uso de crack, álcool e outras drogas no âmbito do Sistema Único de Saúde – SUS. Brasília: Diário Oficial da União. 21 Oct 2013; 1(96):37-40.

13. Jardim KFSB. O serviço ambulatorial móvel de urgência (SAMU) no contexto da reforma psiquiátrica: em análise a experiência de Aracaju/SE. Natal; 2008 [cited 2013 Nov 22]. Dissertação (Mestrado) Universidade Federal do Rio Grande do Norte [Internet]. Available from:

ftp://ftp.ufrn.br/pub/biblioteca/ext/bdtd/KatitaFSBJ.pdf

14. Araújo EM, Martins ES, Adams CE, Coutinho ESF, Huf G. Inquérito sobre o uso de contenção física em um hospital psiquiátrico de grande porte no Rio de Janeiro. J bras psiquiatr [Internet]. 2010 [cited 2013 Nov 24];59(2):94-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0047-20852010000200003&lng=en&nrm=iso .

15. Sousa FSP, Silva CAF, Oliveira EN. Serviço de Emergência Psiquiátrica em hospital geral: estudo retrospectivo. Rev esc Enferm USP [Internet]. 2010 [cited 2013 Nov 22];44(3):796-802. Available from: http://www.scielo.br/scielo.php?pid=S0080-62342010000300035&script=sci_arttext .

16. Goffman E. Manicômios, Prisões e Conventos. São Paulo: Perspectiva; 2008.

17. Kondo ÉH, 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 [cited 2013 Nov 22];45(2):501-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342011000200028.

18. Duarte SJH, Lucena BB, Morita LHM. Atendimentos prestados pelo serviço móvel de urgência em Cuiabá, MT, Brasil. Rev Eletr Enf [Internet]. 2011 July/Sept [cited 2013 Nov 23];13(3):502-7. Available from: http://revistas.ufg.br/index.php/fen/article/view/10977.

19. Pitteri JSM, Monteiro PS. Caracterização do Serviço de Atendimento Móvel de Urgência (SAMU)- Palmas- Tocantins, Brasil, em 2009. Com Ciência Saúde [Internet]. 2010 [cited 2013 Nov 23];21(3):227-36. Available from: http://bvsms.saude.gov.br/bvs/artigos/caracterizacao_servico_atendimento_movel.pdf.

20. Michels NA, Arcoverde MAM. Perfil dos casos psiquiátricos atendidos em um serviço de atendimento móvel de urgência (SAMU). In: VII Seminário de Ensino, Pesquisa e Extensão do Centro de Educação e Letras da Universidade Estadual do Oeste do Paraná. Campos. Foz do Iguaçu. Anais VII, SEPECEL [Internet]. 2012 [cited 2013 Nov 24]. Available from: http://cac-php.unioeste.br/eventos/sepecel/docs/resumos_expandidos/naira_akemi_michels.pdf

21. Santos AMCC. Articular saúde mental e relações de gênero: dar voz aos sujeitos silenciados. Rev Ciência e Saúde Coletiva [Internet]. 2009 [cited 2013 Oct 25];14(4):1177-82. Available from: http://www.scielo.br/pdf/csc/v14n4/a18v14n4.pdf.

22. Santos GF, Nascimento YCML, Veríssimo RCSS, Cavalcante JC, Brêda MZ, Holanda JBL. O perfil epidemiológico dos usuários de um centro de atenção psicossocial. J Nurs UFPE on line [Internet]. 2013 Mar [cited 2013 June 20];7(3):679-87. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/3154

23. Moraes GFS, Mendes JCL, Mendes DP. Análise da gestão de risco no trabalho de enfermagem em uma. Rev Trabalho & Educação [Internet]. 2011 [cited 2013 June 20]; 20(1): 73-84. Available from: http://www.portal.fae.ufmg.br/seer/index.php/trabedu/article/view/624 .

24. Kerrison SA, Chapman R. What general emergency nurses want to know about mental health patients presenting to their emergency department. Accid Emerg Nurs [Internet]. 2007 Jan [cited 2013 June 30];15(1):48-55. Available from: http://www.ncbi.nlm.nih.gov/pubmed/17198753.

Submission: 2013/12/19
Accepted: 2014/04/26
Publishing: 2014/06/01

Corresponding Address

Yanna Cristina Moraes Lira Nascimento.
Unidade Acadêmica ESENFAR/UFAL - Campus A. C. Simões
Av. Lourival Melo Mota, s/n
Bairro Tabuleiro dos Martins
CEP 57072-900 — Maceió (AL), Brazil