Luta Pro Pac Psi

Fabio Gomes de Matos e Souza

Professor titular de Psiquiatria - Universidade Federal do Ceará

Coordenador do PRAVIDA

PhD in Psychiatry – Edinburgh University

Conflitos de Interesses

* Estudos Clínicos: Janssen, IQVIA, Novartis

* Speaker e materiais científicos: Janssen, Takeda, Lundbeck, Daiichi-Sankyo, Cristália, Momenta, Pfizer, EMS, Torrent, Ernst & Young, CCM Congresses, MD Health, FQM (Farmoquímica), Biolab, Moksha8, Editora Guanabara Koogan (Grupo GEN), Mantecorp/Farmasa, Zodiac

* Empregado: Não

* Comitê científico: Janssen

* Acionista de companhias farmacêuticas: Não

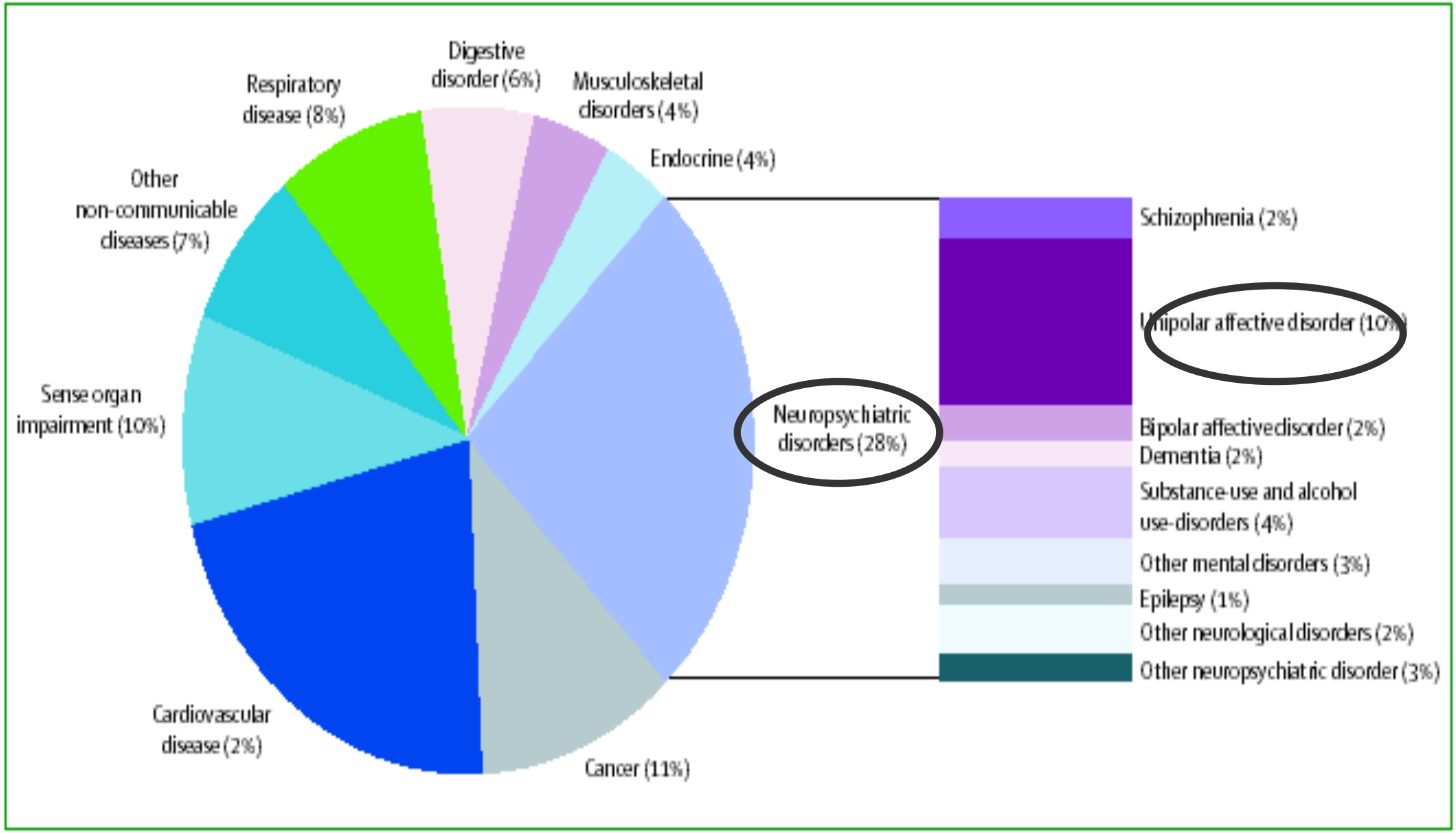


Figure 1: Contribution by different non-communicable diseases to disability-adjusted life-years worldwide in 2005
Data adapted from WHO, with permission.[1]

Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort[1] (n=9282)

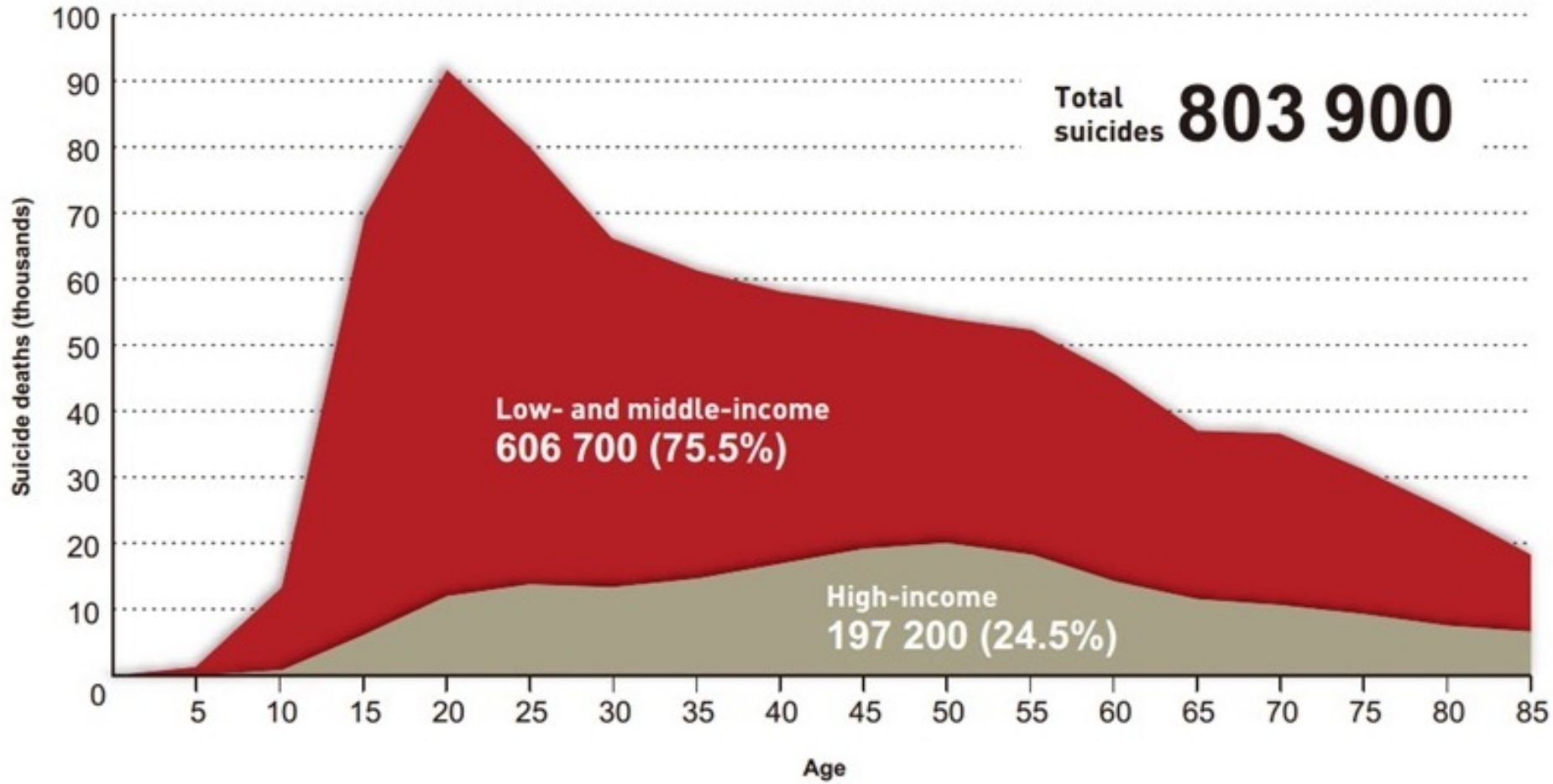
12-month	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	2.7	(0.2)	3.8	(0.3)	1.6	(0.2)	2.8	(0.4)	3.7	(0.5)	3.1	(0.4)	0.8	(0.2)
Agoraphobia without panic	0.9	(0.1)	0.9	(0.2)	0.8	(0.2)	1.0	(0.2)	0.8	(0.2)	1.2	(0.3)	0.4	(0.1)
Specific phobia	9.1	(0.4)	12.2	(0.5)	5.8	(0.5)	10.3	(0.8)	9.7	(0.6)	10.3	(0.9)	5.6	(0.5)
Social phobia	7.1	(0.3)	8.0	(0.5)	6.1	(0.5)	9.1	(0.7)	8.7	(0.7)	6.8	(0.6)	3.1	(0.3)
Generalized anxiety disorder	2.7	(0.2)	3.4	(0.2)	1.9	(0.3)	2.0	(0.3)	3.5	(0.3)	3.4	(0.3)	1.5	(0.3)
Post-traumatic stress disorder[2]	3.6	(0.3)	5.2	(0.4)	1.8	(0.3)	4.0	(0.5)	3.5	(0.5)	5.3	(0.6)	1.0	(0.2)
Obsessive-compulsive disorder[3]	1.2	(0.3)	1.8	(0.5)	0.5	(0.2)	1.5	(0.4)	1.4	(0.6)	1.1	(0.6)	0.5	(0.3)
Adult separation anxiety disorder[2]	1.9	(0.2)	2.1	(0.2)	1.7	(0.3)	4.0	(0.5)	2.2	(0.3)	1.3	(0.3)	0.1	(0.1)
Any anxiety disorder[5]	19.1	(0.7)	23.4	(0.8)	14.3	(0.8)	22.3	(1.0)	22.7	(1.0)	20.6	(1.3)	9.0	(0.8)
II. Mood Disorders														
Major depressive disorder	6.8	(0.3)	8.6	(0.4)	4.9	(0.4)	8.3	(0.4)	8.4	(0.5)	7.0	(0.7)	2.9	(0.4)
Dysthymia	1.5	(0.1)	1.9	(0.2)	1.0	(0.1)	1.1	(0.2)	1.7	(0.3)	2.3	(0.5)	0.5	(0.2)
Bipolar I-II-sub disorders	2.8	(0.2)	2.8	(0.2)	2.9	(0.3)	4.7	(0.6)	3.5	(0.4)	2.2	(0.3)	0.7	(0.2)
Any mood disorder	9.7	(0.4)	11.6	(0.5)	7.7	(0.6)	12.9	(0.7)	11.9	(0.7)	9.4	(0.7)	3.6	(0.4)
III. Impulse-control Disorders														
Oppositional-defiant disorder[4]	1.0	(0.2)	1.1	(0.2)	0.9	(0.3)	1.2	(0.3)	0.8	(0.2)	--	--	--	--
Conduct disorder[4]	1.0	(0.2)	0.4	(0.1)	1.7	(0.5)	1.4	(0.3)	0.8	(0.3)	--	--	--	--
Attention-deficit/hyperactivity disorder[4]	4.1	(0.3)	3.9	(0.6)	4.3	(0.5)	3.9	(0.4)	4.2	(0.6)	--	--	--	--
Intermittent explosive disorder	4.1	(0.3)	3.4	(0.4)	4.8	(0.4)	8.3	(0.9)	4.6	(0.4)	2.1	(0.3)	0.9	(0.3)
Any impulse control disorder[4,6]	10.5	(0.7)	9.3	(1.0)	11.7	(0.8)	11.9	(1.1)	9.2	(0.7)	--	--	--	--
IV. Substance Disorders														
Alcohol abuse with/without dependence[2]	3.1	(0.3)	1.8	(0.3)	4.5	(0.4)	7.1	(0.7)	3.3	(0.5)	1.6	(0.3)	0.3	(0.2)
Drug abuse with/without dependence[2]	1.4	(0.2)	0.7	(0.1)	2.2	(0.3)	3.9	(0.5)	1.2	(0.3)	0.4	(0.1)	0.0	(0.0)
Nicotine dependence[2]	11.0	(0.6)	10.5	(0.8)	11.6	(0.7)	16.7	(1.4)	11.2	(1.0)	10.0	(1.1)	5.6	(0.7)
Any substance disorder[2]	13.4	(0.6)	11.6	(0.8)	15.4	(0.9)	22.0	(1.6)	13.8	(1.1)	11.2	(1.2)	5.9	(0.7)
V. Any Disorder														
Any[5]	32.4	(1.1)	34.7	(1.1)	29.9	(1.3)	43.8	(1.8)	36.9	(1.3)	31.1	(2.0)	15.5	(1.0)

[1]This table includes updated data as of July 19, 2007. Updates reflect the latest diagnostic, demographic and raw variable information.

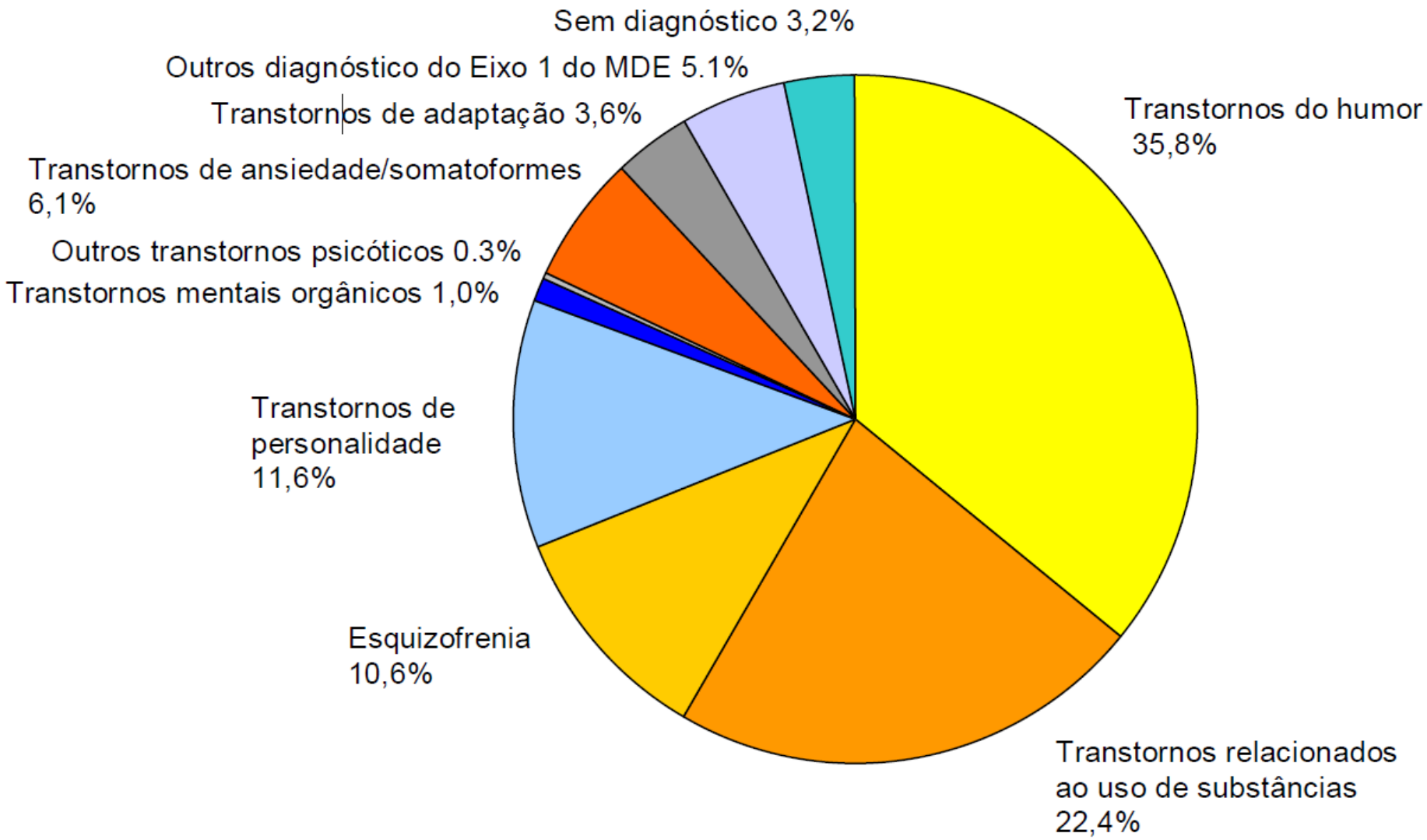
[2]Assessed in the Part II sample (n = 5692).

[3]Assessed in a random one-third of the Part II sample (n = 2073).

Figure 2. **Global suicides by age and income level of country, 2012**



Suicídio e transtornos mentais



Fonte: BERTOLOTE, J. M. *2002*

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Major Article

The burden of suicide in Brazil: findings from the Global Burden of Disease Study 2019

***Cecília Silva Costa Bonadiman*[1], *Mohsen Naghavi*[2] *and Ana Paula Souto Melo*[1],[3]**

[1]. Universidade Federal de Minas Gerais, Faculdade de Medicina, Programa de Pós-Graduação em Saúde Pública, Belo Horizonte, MG, Brasil.
[2]. Institute for Health Metrics and Evaluation, Seattle, WA, USA.
[3]. Universidade Federal de São João Del Rei, Faculdade de Medicina, Divinópolis, MG, Brasil.

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https://doi.org/10.1007/s00127-021-02060-6

ORIGINAL PAPER

Trends in method-specific suicide in Brazil from 2000 to 2017

Keltie McDonald[1] · Daiane Borges Machado[2,3] · Luís F. S. Castro-de-Araujo[2,4] · Lígia Kiss[5] · Alexis Palfreyman[5] · Maurício L. Barreto[2,6] · Delanjathan Devakumar[5] · Glyn Lewis[1]

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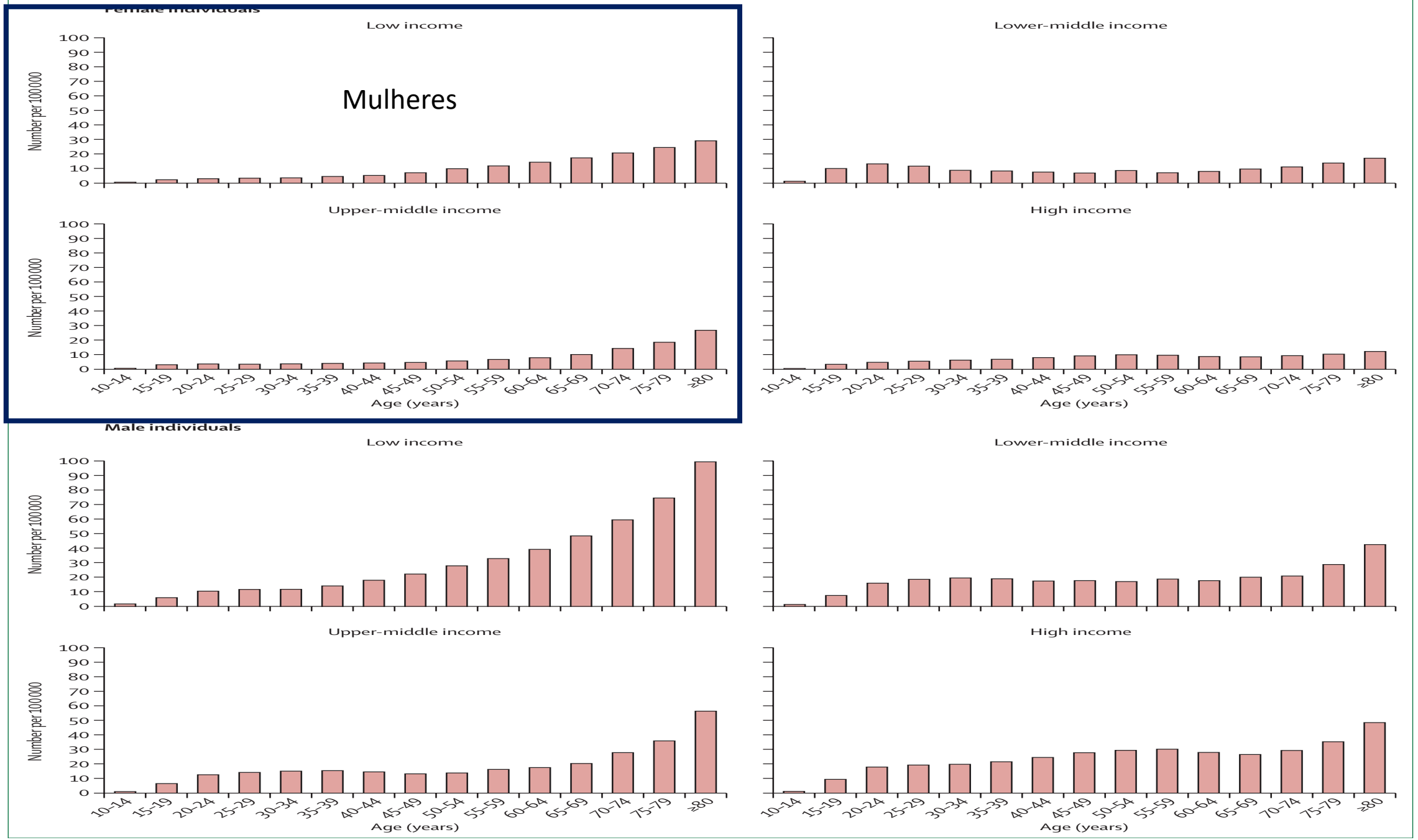

Figure 2: **Age and sex distribution of suicide (per 100 000 population) by World Bank income groups**
Data are based on the 2019 release of the Global Burden of Disease Study.[2]

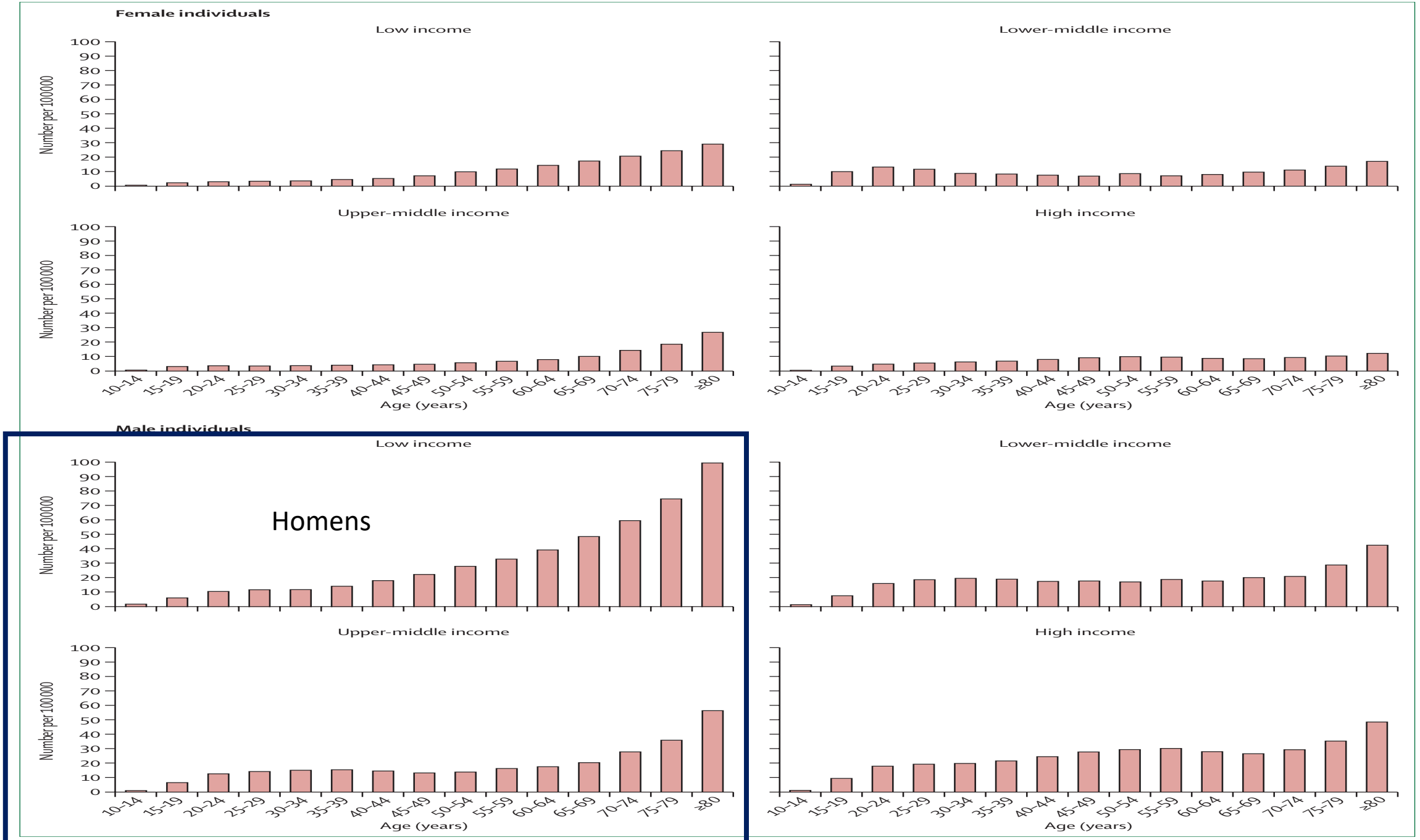

Figure 2: **Age and sex distribution of suicide (per 100 000 population) by World Bank income groups**
Data are based on the 2019 release of the Global Burden of Disease Study.[2]

Epidemiologia

- 01 pessoa morre por suicídio a cada 40 segundos
- 60 a 135 pessoas são afetadas por cada suicídio
- Taxa Global 9.4/100.000 (homens 13.3/100.000 e mulheres 5.7/100.000)
- Principal causa de morte em pessoas de 15 a 34 anos
- Autolesão: estima-se que para cada suicídio ocorram 20

McDonald et al., 2021

Epidemiologia

- Brasil: 10.2/100.000
- Mulheres: entre 2000 e 2017 aumento de 50% (atual 2.8/100000)
- Homens: aumento de 39% (atual 10.4/100000)

McDonald et al., 2021

O que propomos?

Focar em prevenção primária, secundária e terciária.

O que propomos?

- Proteção em prédios, pontes, viadutos
- Proibição e fiscalização de comércio de produtos que possam ser usados em tentativas de suicídio (ex. chumbinho)
- Restrição ao uso de outros métodos letais (armas de fogo)
- Receitas azuis devem ser extintas

O que propomos?

- Prontuário único – possibilita controle das prescrições e do que é dispensado pelas farmácias
- Aumento do número de ambulatórios especializados em saúde mental
- Aumento de leitos de saúde mental em hospitais gerais
- Disponibilidade de tratamentos que reduzam o risco de suicídio como eletroconvulsoterapia e cetamina
- Disponibilidade de atendimento psicoterápico

VIEWPOINT

Increase in US Suicide Rates and the Critical Decline in Psychiatric Beds

Tarun Bastiampillai, FRANZCP
Mind and Brain, South Australian Health and Medical Research Institute, Adelaide, Australia; and Discipline of Psychiatry, School of Medicine, Flinders University, Adelaide, Australia.

Steven S. Sharfstein, MD
Shepherd Pratt Health System, Baltimore, Maryland.

Stephen Allison, FRANZCP
Discipline of Psychiatry, School of Medicine, Flinders University, Adelaide, Australia.

The closure of most US public mental hospital beds and the reduction in acute general psychiatric beds over recent decades have led to a crisis, as overall inpatient capacity has not kept pace with the needs of patients with psychiatric disorders.[1] Currently, state-funded psychiatric beds are almost entirely forensic (ie, allocated to people within the criminal justice system who have been charged or convicted). Very limited access to nonforensic psychiatric inpatient care is contributing to the risks of violence, incarceration, homelessness, premature mortality, and suicide among patients with psychiatric disorders. In particular, a safe minimum number of psychiatric beds is required to respond to suicide risk given the well-established and unchanging prevalence of mental illness, relapse rates, treatment resistance, nonadherence with treatment, and presentations after acute social crisis. Very limited access to inpatient care is likely a contributing factor for the increasing US suicide rate. In 2014, suicide was the second-leading cause of death for people aged between 10 and 34 years and the tenth-leading cause of death for all age groups, with firearm trauma being the leading method.[2,3]

Currently, the United States has a relatively low 22 psychiatric beds per 100 000 population compared with the Organisation for Economic Cooperation and Development (OECD) average of 71 beds per 100 000 population. Only 4 of the 35 OECD countries (Italy, Chile, Turkey, and Mexico) have fewer psychiatric beds per 100 000 population than the United States. Although European health systems are very different from the US health system, they provide a useful comparison. For instance, Germany, Switzerland, and France have 127, 91, and 87 psychiatric beds per 100 000 population, respectively.[4]

Furthermore, between 1998 and 2013, the total number of psychiatric beds in the United States decreased from 34 to 22 beds per 100 000 population, a 11.4 suicides per 100 000 population per year.[5] The increasing suicide rate contrasts with the improving health outcomes and life expectancy that US residents have generally experienced.[3] Many explanations have been suggested for the US increase in suicides, mostly related to economic and social factors like unemployment. However, US unemployment rates have steadily decreased from a recent peak of 10% in October 2009 in the aftermath of the global financial crisis to 5.6% in December 2014. Yet suicide rates have continued to increase during this period of declining unemployment levels and gradually improving economic conditions.

A crucial aspect is missing in the analysis of the increasing suicide rate: the possible role of the reductions in psychiatric beds. Is it possible that a key explanation for the increase in suicide rates could be the corresponding decline in the number of psychiatric beds in the United States? It is complicated to determine whether the reduction in psychiatric beds is directly related to increased suicide rates given the multiple variables associated with suicide and the relative rarity of the event.

In a study examining suicide rates in relation to psychiatric bed availability and community mental health spending by US states, Yoon and Bruckner[6] found that reductions in publicly funded psychiatric beds were associated with increasing suicide rates between 1982 and 1998, which was only partially compensated for by increased community mental health spending. These authors specifically cautioned US policy makers that further reductions in publicly funded psychiatric beds could increase suicide rates in all states of the United States. However, this prescient warning was not heeded by leaders of the US health care system. It is particularly concerning that the number of psychiatric beds continued to decline during and immediately after the global financial crisis in 2008, when US unemployment levels increased rapidly from 5%

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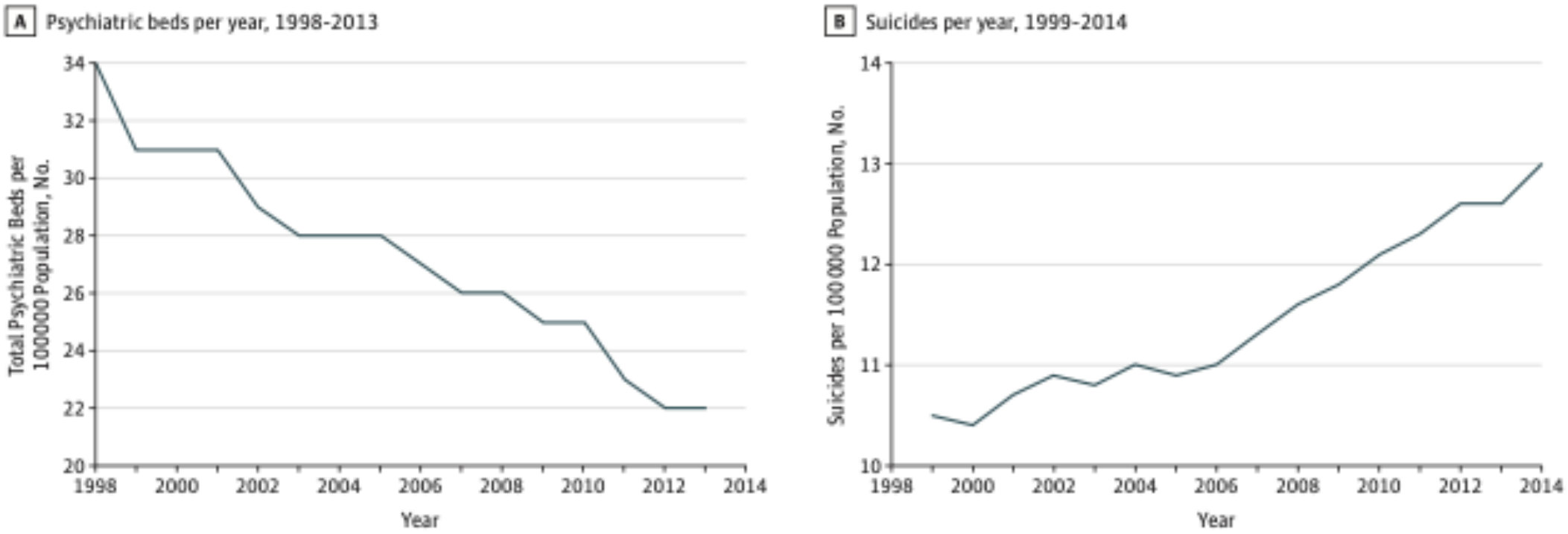
Figure. Numbers of Psychiatric Beds and Age-Adjusted Suicides per 100 000 Population in the United States From 1998 to 2014



Data are from Curtin et al[3] and the Organisation for Economic Cooperation and Development.[4]

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The quantification of the psychiatric revolution: a quasi-natural experiment of the suicide impact of the Basaglia Law

Caterina Ronchetti[1], Veronica Toffolutti [2,3], Martin McKee [3], David Stuckler[1,2]

1 Department of Social and Political Science, Bocconi University, Milano, Italy
2 "Carlo F. Dondena" Centre for Research on Social Dynamics and Public Policies, Bocconi University, Milano, Italy
3 Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

Correspondence: Veronica Toffolutti, "Carlo F. Dondena" Centre for Research on Social Dynamics and Public Policies, Bocconi University, Via G. Roentgen, 1, 20136 Milano, Italy, Tel: +39 02 5836 5077, Fax: +39 02 5836 2798, e-mail: veronica.toffolutti@unibocconi.it

Background: The Italian 180/1978 reform abolishing asylums is one of the most contested mental health programs ever implemented. It aimed to shift care of mental illness into the community improving outcomes and reducing expenditure. It was a model for successive deinstitutionalization initiatives across Europe and North America. However, there were longstanding concerns that, without expansion of community care, it may have deprived patients with mental illness access to support, placing them at increased risk of suicide. **Methods:** Regression discontinuity models were used to quantify the association between the number of suicides and the introduction of the Basaglia Law, disaggregated by age-group and gender, covering 20 Italian regions during the period 1975–84. Models were adjusted for potential socio-demographic confounding factors, region-specific fixed effects and pre-existing time-trends. **Results:** Italian regions implemented the Basaglia Law to varying degrees over time. We observed that, after adjusting for pre-existing time trends, the implementation was associated with a consistent increase in the number of suicides for all the age-groups [incidence rate ratio, age 15–44: 1.29, 95% confidence interval (CI) 1.18–1.41; age 45–74: 1.45, 95% CI 1.37–1.54] and for both genders (males: 1.47, 95% CI 1.41–1.53; females: 1.36, 95% CI 1.25–1.47). Hospital closure appeared to be an important mediating mechanism. **Conclusions:** The Basaglia Law was associated with a significant increase in the number of suicides, with evidence of an association with closures of facilities, leaving those with mental illness with nowhere to go, as the envisioned community care structures failed to be developed as originally planned.

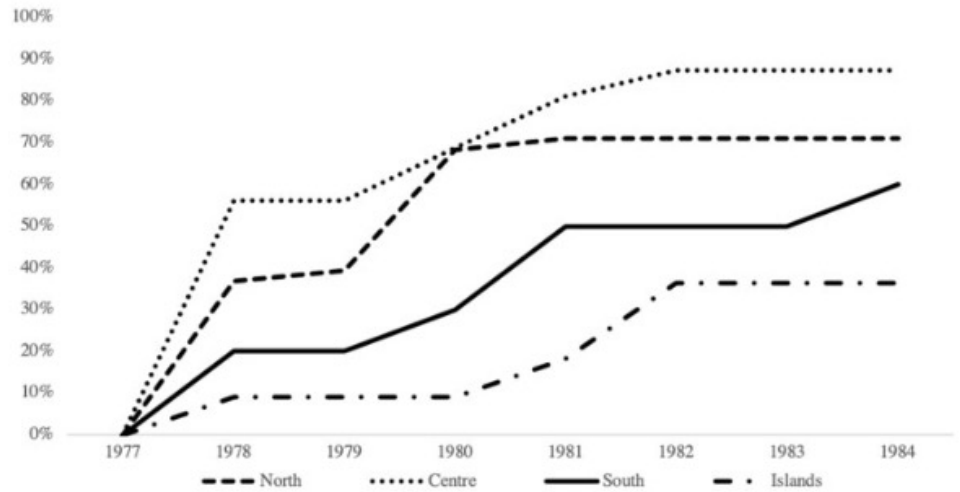

Figure 1 Time-trend in the cumulative percentage of asylums closures, by region
Source: Author's calculations using data from the Italian Ministry of Cultural Heritage and Activities

Table 1 Change in the number of suicides associated with the Basaglia Law implementation, results separately by age-group and gender—Poisson model

	Ages 15–44	Ages 45–74	Males	Females
Implementation of Basaglia Law	1.29	1.45	1.47	1.36
95% CI	[1.18–1.41]	[1.37–1.54]	[1.41–1.53]	[1.25–1.47]
Regional dummies	Yes	Yes	Yes	Yes
Year dummies	Yes	Yes	Yes	Yes

Note: Coefficients represents Incidence Rate Ratios.
Source: Data from ISTAT—Statistical Sanitary Yearbooks (1975–1984) and ISTAT—Italian Statistical Yearbooks (1976–1985). Number of regions = 20, number of region-years = 200. 95% confidence intervals calculated with Robust Standard Errors are presented in brackets. The dependent variable represents the number of suicides. This has been regressed through an Poisson model on a dummy variable equal to 1 after 1978 (implementation of Basaglia Law), regional fixed-effect, year linear trend.

Psychological Medicine

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Original Article

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Key words:
Deinstitutionalization; global health; health care reform; mental health services; prisoners

Author for correspondence:
Adrian P. Mundt,
E-mail: adrian.mundt@mail.udp.cl

Psychiatric beds and prison populations in 17 Latin American countries between 1991 and 2017: rates, trends and an inverse relationship between the two indicators

Mathias Siebenförcher[1,2], Francesco D. Fritz[1,2], Matías Irarrázaval[2,3], Andrés Benavides Salcedo[4], Corinne Dedik[5], Ana Fresán Orellana[6], Alejandro Herrera Ramos[7], J. Nicolás Ivan Martínez-López[6], Carla Molina[8], Fany Alejandra Rivas Gomez[7], Guillermo Rivera[9], Ignacio Sandia Saldivia[10], Julio Torales[11], Natalia Trujillo Orrego[12], Andreas Heinz[1] and Adrian P. Mundt[13,14]

[1]Department of Psychiatry, Medical Faculty Charité – Universitätsmedizin, Berlin, Germany; [2]Department of Psychiatry and Mental Health, Medical Faculty, Universidad de Chile, Santiago, Chile; [3]Millennium Institute for Research in Depression and Personality, Santiago, Chile; [4]Ministry of Public Health, Quito, Ecuador; [5]Centro de Investigaciones Económicas Nacionales, City of Guatemala, Guatemala; [6]Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Mexico City, Mexico; [7]Universidad Nacional Autónoma de Honduras, Tegucigalpa, Honduras; [8]Department of Psychiatry, Hospital Universitario de Los Andes, Mérida, Venezuela; [9]Department of Psychology, Universidad Privada de Santa Cruz de la Sierra, Santa Cruz de la Sierra, Bolivia; [10]Department of Psychiatry, Universidad de Los Andes, Mérida, Venezuela; [11]Department of Psychiatry, Universidad Nacional de Asunción, San Lorenzo, Paraguay; [12]Mental Health Group, National Faculty of Public Health, Universidad de Antioquia, Medellín, Colombia; [13]Medical Faculty, Universidad Diego Portales, Santiago, Chile and [14]Medical Faculty, Universidad San Sebastián, Puerto Montt, Chile

Abstract

Background. In 1990, Latin American countries committed to psychiatric reforms including psychiatric bed removals. Aim of the study was to quantify changes in psychiatric bed numbers and prison population rates after the initiation of psychiatric reforms in Latin America.
Methods. We searched primary sources to collect numbers of psychiatric beds and prison population rates across Latin America between the years 1991 and 2017. Changes of psychiatric bed numbers were compared against trends of incarceration rates and tested for associations using fixed-effects regression of panel data. Economic variables were used as covariates. Reliable data were obtained from 17 Latin American countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Honduras, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, El Salvador, Uruguay and Venezuela.
Results. The number of psychiatric beds decreased in 15 out of 17 Latin American countries (median −35%) since 1991. Our findings indicate the total removal of 69 415 psychiatric beds. The prison population increased in all countries (median +181%). Panel data regression analyses showed a significant inverse relationship −2.70 (95% CI −4.28 to −1.11; $p = 0.002$) indicating that prison populations increased more when and where more psychiatric beds were removed. This relationship held up when introducing per capita income and income inequality as covariates −2.37 (95% CI −3.95 to −0.8; $p = 0.006$).
Conclusions. Important numbers of psychiatric beds have been removed in Latin America. Removals of psychiatric beds were related to increasing incarceration rates. Minimum numbers of psychiatric beds need to be defined and addressed in national policies.

Table 1. Rates of psychiatric beds, rates of prison population and Gini Index with changes between first and last data points in 17 Latin American countries 1991–2017

	Numbers of psychiatric beds per 100 000 population				Numbers of prisoners per 100 000 population				Gini Index			
Country	First data point	Last data point	Percentage change	Period of observation	First data point	Last data point	Percentage change	Period of observation	First data point	Last data point	Change	Period of observation
Argentina	70	47.7	−32	1995–2017	62	174	181	1992–2016	46.8	42.4	−4.4	1991–2016
Bolivia	9.8	8.9	−9	1997–2017	69	142	106	1996–2016	58.2	44.6	−13.6	1997–2016
Brazil	58.3	10.2	−83	1992–2017	74	353	377	1992–2016	53.2	51.3	−1.9	1992–2015
Chile	24.6	10.5	−57	1992–2017	166	265	60	1991–2016	54.8	47.7	−7.1	1992–2015
Colombia	6.5	24.8	281	2001–2017	90	249	176	1991–2017	51.5	50.8	−0.7	1992–2016
Costa Rica	35	17.6	−50	1991–2017	118	395	235	1991–2017	46.6	48.7	2.1	1991–2016
Ecuador	13.7	3.9	−72	2000–2017	75	216	tel:166%20265%2060%2090%20249		53.4	45.0	−8.4	1994–2016
El Salvador	6.5	5.9	−10	2001–2017	125	616	393	1995–2017	54.0	40.0	−14.0	1991–2016
Guatemala	3.5	2.1	−41	2001–2017	62	137	120	1991–2017	54.2	48.3	−5.9	2000–2014
Honduras	6	3.6	−41	2001–2016	109	209	91	1992–2017	51.9	50.0	−1.9	1991–2016
Mexico	4.2	2.8	−33	1991–2016	48	62	28	1995–2016	49.6	43.4	−6.2	1992–2016
Nicaragua	3.2	3.3	3	2005–2017	98	276	182	1995–2017	57.4	46.2	−11.2	1993–2014
Panama	18.9	9.7	−49	2002–2017	237	397	68	1995–2017	58.2	50.4	−7.8	1991–2016
Paraguay	7.9	5.2	−35	1991–2017	62	196	214	1995–2017	58.2	47.9	−10.3	1995–2016
Peru	4.3	2.7	−36	2001–2017	87	252	190	1995–2016	53.7	43.8	−9.9	1997–2016
Uruguay	53	49.6	−6	1992–2017	90	319	255	1991–2017	45.9	39.7	−6.2	2006–2016
Venezuela	7.9	6.1	−24	2000–2017	152	163	7	1991–2015	42.5	46.9	4.4	1992–2006
Mean	19.6	12.6	−17		101	260	169		52.4	46.3	−6.1	
Median	7.9	6.1	−35		90	249	181		53.4	46.9	−6.2	
IQR	18.6	6.9	39		49	145	122		5.2	4.9	8.0	

IQR, interquartile range

Rede da Vida

- 100% das pessoas que cometeram suicídio tinham um transtorno mental, muitas vezes não diagnosticado e não tratado.
- De fato, dos que morrem por suicídio, cerca de 50% a 60% nunca consultaram com um profissional de saúde mental no período de seis meses que antecederam a morte.
- Falar de uma rede de saúde para prevenção do suicídio é reforçar a importância de ter uma rede bem integrada.
- A prevenção não deve iniciar apenas nos centros com foco em saúde mental, mas deve ser observada em todos os âmbitos do sistema de saúde.

Receitas fisicas devem acabar

Formação de profissionais de saúde

- A educação e a formação dos profissionais de saúde são necessárias para assegurar que o apoio psicossocial seja prestado aos necessitados e seja um passo fundamental na prevenção do suicídio. Um grande número de pessoas que morrem por suicídio tiveram contato com provedores de cuidados primários de saúde no mês anterior ao suicídio (OMS, 2014).

Group	Setting of research showing increased risk	Estimated magnitude of increased risk	% of total suicides in England and Wales	Reference numbers
Current or former psychiatric patients (inpatient or outpatients)	United Kingdom; United States	**x10**	**50**	13-16

13.Appleby L.Suicide in psychiatric patients: risk and prevention.Br J Psychiatry1992;161: 749–58.

16.Morgan HG.Suicide prevention: hazards in the fast lane of community care.Br J Psychiatry1992;160: 149–53.

Group	Setting of research showing increased risk	Estimated magnitude of increased risk	% of total suicides in England and Wales	Reference numbers
Patients in four weeks after discharge from psychiatric hospitals	United Kingdom	Men x 200 Women x 100	10-15	18

18.Goldacre M, Seagrott V, Hawton K.Suicide after discharge from psychiatric in-patient care.Lancet1993;342: 283–6.


SPECTRUM 5000Q
POWER
STIMULUS STATUS
STIMULUS CONTROL
STIMULUS OUTPUT
ECG1
ECG3
PULSE WIDTH
FREQUENCY
DURATION
CURRENT

Grupo	Setting of research showing increased risk	Estimated magnitude of increased risk	% of total suicides in England and Wales	Reference numbers
História Familiar de Suicídio	United Kingdom		**4**	14

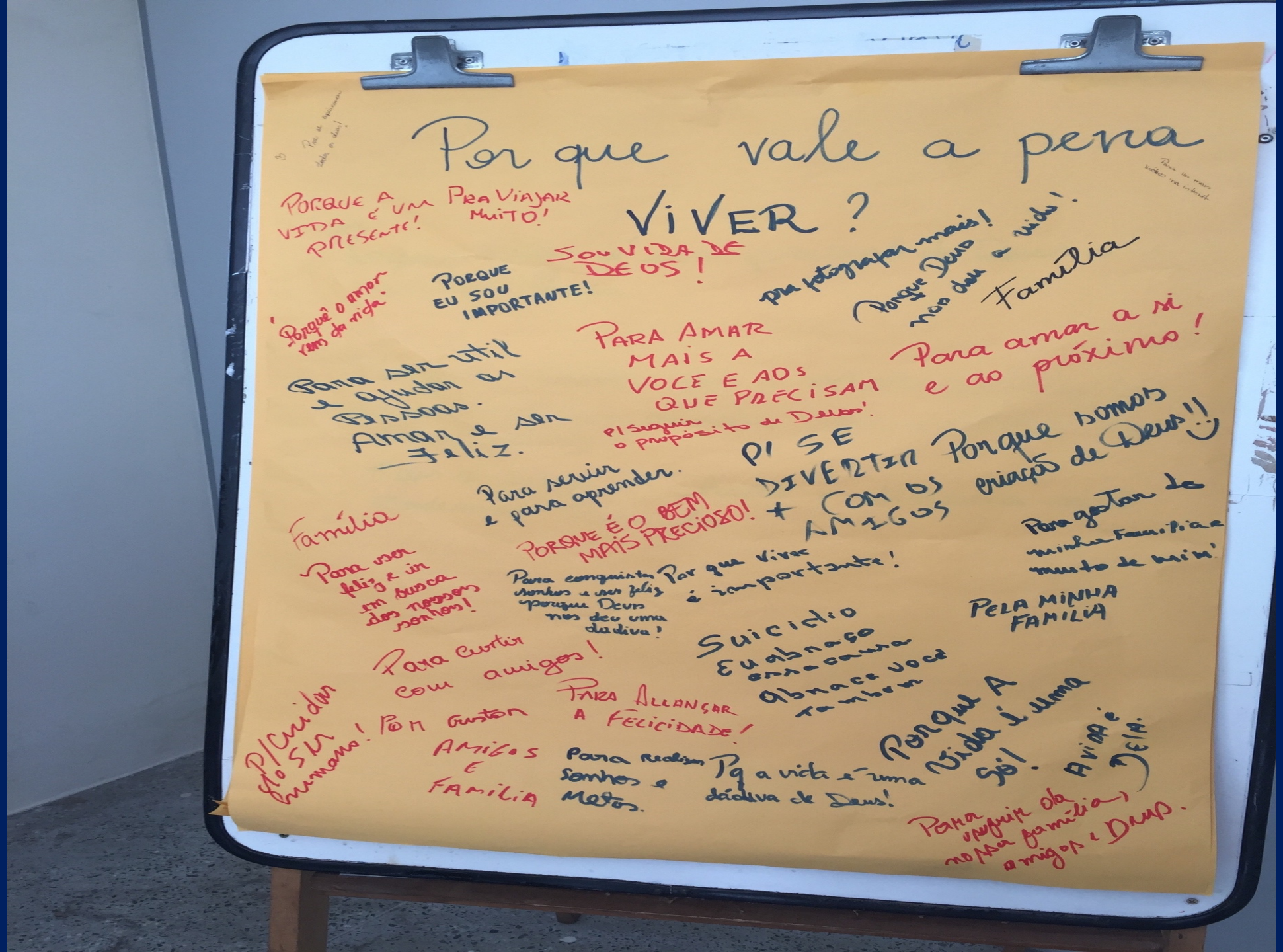
14.Barraclough B, Bunch J, Nelson B, Sainsbury P.A hundred cases of suicide: clinical aspects.Br J Psychiatry1974;125: 355–73.

Barreiras antisuicídio em viadutos e pontes

Fortaleza - Rua Nereu Ramos entre Godofredo Maciel e Osório de Paiva

Restringir o acesso aos meios

- O acesso direto ou a proximidade aos meios (incluindo pesticidas, armas de fogo, alturas, vias férreas, venenos, drogas lícitas e ilícitas, fontes de monóxido de carbono como escapamentos de automóveis ou carvão e outros gases tóxicos e venenosos) é um importante fator de risco para o suicídio.
- A disponibilidade e preferência por meios específicos de suicídio também dependem de contextos geográficos e culturais (Mann et al. 2006; Ajdacic-Gross et al. 2008).


Por que vale a pena
VIVER ?
PORQUE A VIDA É UM PRESENTE!
PRA VIAJAR MUITO!
SOU VIDA DE DEUS!
PORQUE EU SOU IMPORTANTE!
Porque o amor vem da vida!
Para ser útil e ajudar as pessoas.
Amar e ser feliz.
PARA AMAR MAIS A VOCÊ E AOS QUE PRECISAM
P/ seguir o propósito de Deus!
pra fotografar mais!
Porque Deus nos deu a vida!
Família
Para amar a si e ao próximo!
Para ser e para aprender.
PORQUE É O BEM MAIS PRECIOSO!
P/ SE DIVERTIR + COM OS AMIGOS
Porque somos crianças de Deus!! ☺
Para gostar da minha Família e muito de mim!
Família
Para ser feliz e ir em busca dos nossos sonhos!
Para conquistar sonhos e ser feliz porque Deus nos deu uma dádiva!
Por que viver é importante!
PELA MINHA FAMÍLIA
Para curtir com amigos!
Suicídio
Eu abraço essa causa
Abrace você também
P/ Cuidar dos Humanos! Pois gostam
PARA ALCANÇAR A FELICIDADE!
AMIGOS E FAMÍLIA
Para realizar sonhos e metas.
Pq a vida é uma dádiva de Deus!
Porque A vida é uma só!
Para cuidar da minha família, amigos e DEUS.

Em estudantes de 14 a 15 anos de idade, as intervenções escolares são eficazes na redução de tentativas de suicídio e mortes por suicídio em comparação com os cuidados habituais?

PORTARIA Nº 1.271, DE 6 DE JUNHO DE 2014 - 2

- CAPÍTULO I
- DAS DISPOSIÇÕES INICIAIS
- Art. 1º Esta Portaria define a Lista Nacional de Notificação Compulsória de doenças, agravos e eventos de saúde pública nos serviços de saúde públicos e privados em todo o território nacional, nos termos do anexo.
- Art. 2º Para fins de notificação compulsória de importância nacional, serão considerados os seguintes conceitos:
- I - agravo: qualquer dano à integridade física ou mental do indivíduo, provocado por circunstâncias nocivas, tais como acidentes, intoxicações por substâncias químicas, abuso de drogas ou lesões decorrentes de violências interpessoais, como agressões e maus tratos, e **lesão autoprovocada**;

Quantos CPFs você tem??

Quem acha que Saúde Mental é Importante?

- Hoje em torno de 2% da dotação orçamentária da saúde

- Está na hora de sair do Verbo
- e entrar na Verba

SUIS

Sistema Único Integrado de Saúde

Municipalizado

Prontuário Único de Saúde


PRA VIDA
Projeto de apoio à vida

Obrigado!

fgmsouza@yahoo.com.br

Poder Judiciário

Conselho Nacional de Justiça

RESOLUÇÃO N. 487, DE 15 DE FEVEREIRO DE 2023.

Institui a Política Antimanicomial do Poder Judiciário e estabelece procedimentos e diretrizes para implementar a Convenção Internacional dos Direitos das Pessoas com Deficiência e a Lei n. 10.216/2001, no âmbito do processo penal e da execução das medidas de segurança.

A **PRESIDENTE DO CONSELHO NACIONAL DE JUSTIÇA (CNJ)**, no uso de suas atribuições legais e regimentais,

CONSIDERANDO os princípios da República Federativa do Brasil, fundada na dignidade da pessoa humana e, especialmente, os direitos fundamentais à saúde, ao devido processo legal e à individualização da pena (CF, arts. 1º, III; 5º, XLVI, LIV e 6º, *caput*);

Hipertensão
Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Infarto Agudo no Miocárdio
Onde deve ser tatado?

- Ambulatório
- Ou
- Hospital

Fratura no Braço
Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Politraumatismo craniano
Onde deve ser tratado?

- Ambulatório
- Ou
- Hospital

Crise de pânico
Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Fibromialgia
Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Anorexia Nervosa (1.50m com 22 Kg)
Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Paciente alcoolista em syndrome d abstinência com Delirium Tremens
Onde deve ser tratado?

- Ambulatório
- Ou
- Hospital

Paciente teve tentativa de suicídio em coma Onde deve ser tratada?

- Ambulatório
- Ou
- Hospital

Para que serve o Hospital?

- Para tirar das crises em internações breves

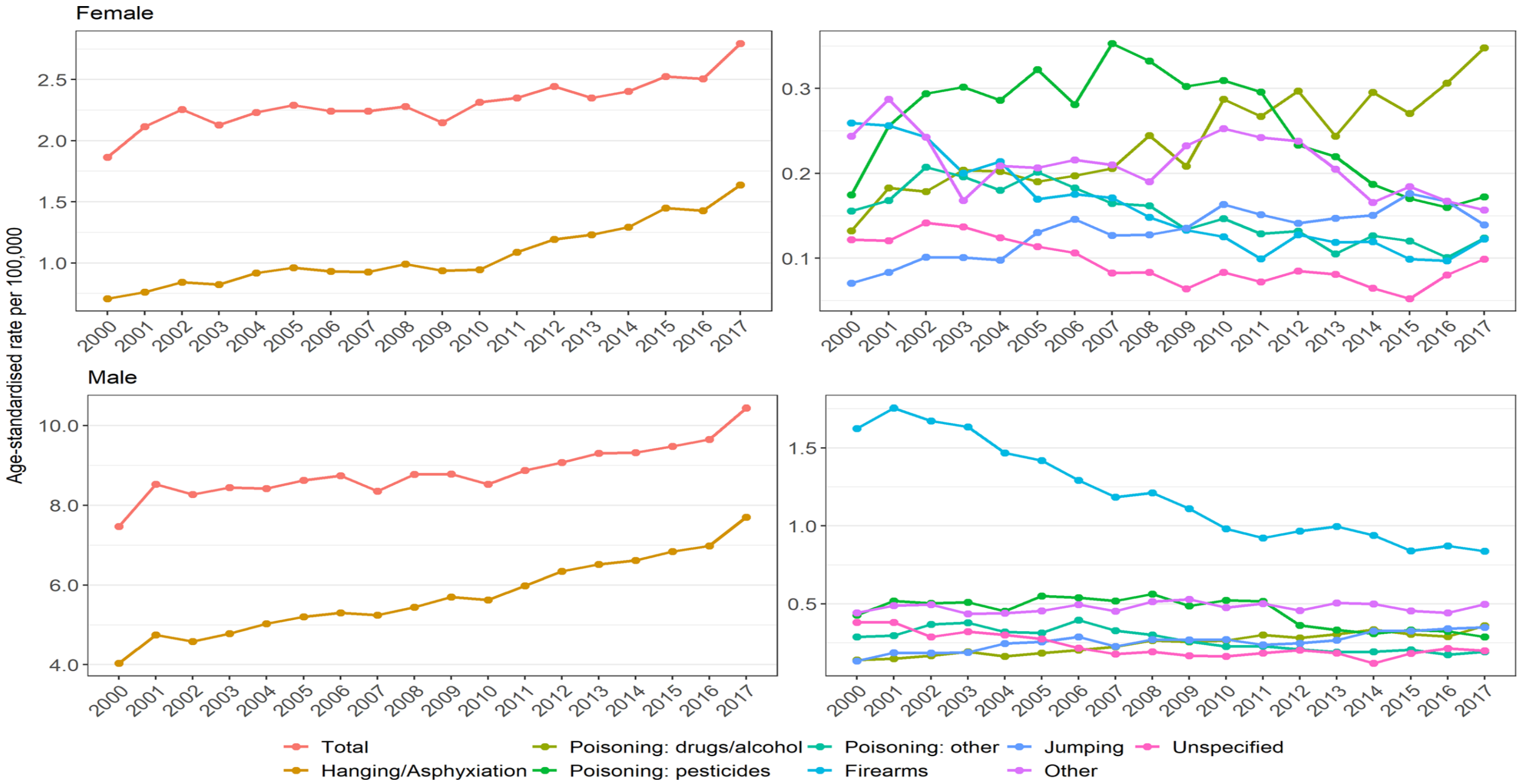


Fig. 1 Age-standardised suicide rates per 100,000 by sex and method, 2000–2017

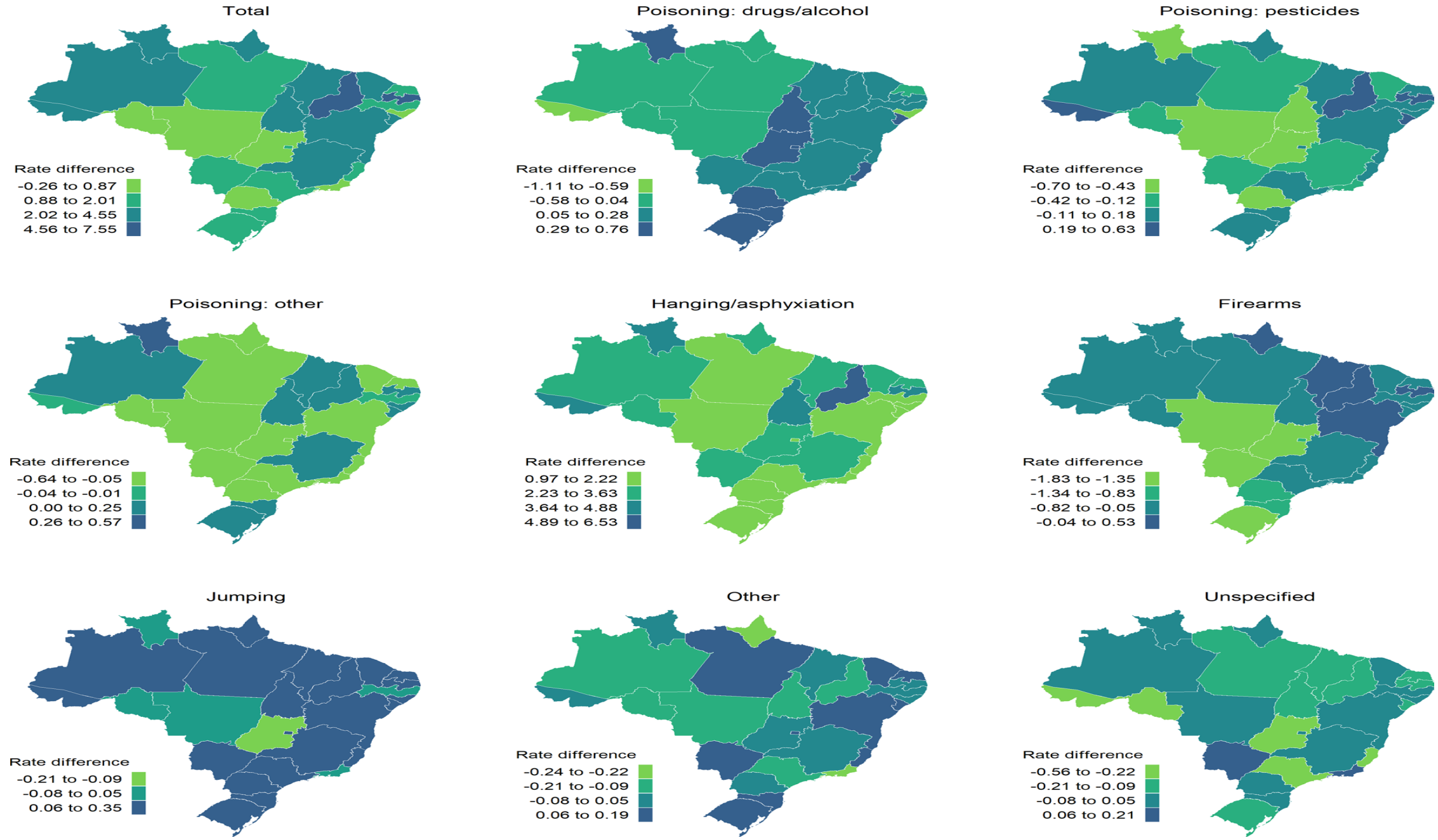


Fig. 2 Change in age and sex-standardised rates per 100,000 of suicide by method, 2000 to 2017 for each Brazilian state. Data are absolute change in rate of suicide per 100,000 (rate difference)

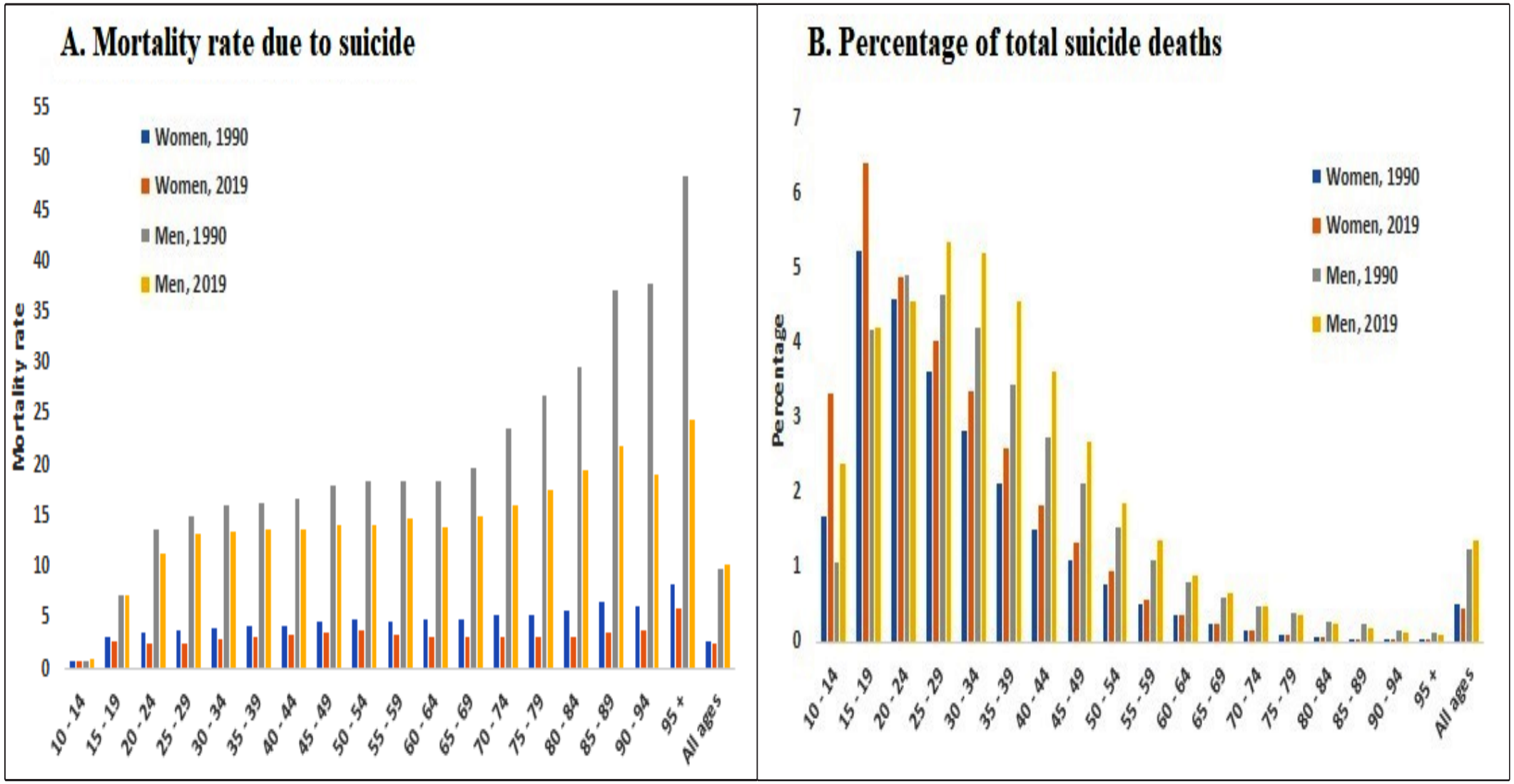


FIGURE 1: Mortality rate and percentage of total suicide deaths in males and females by age group in 1990 and 2019.

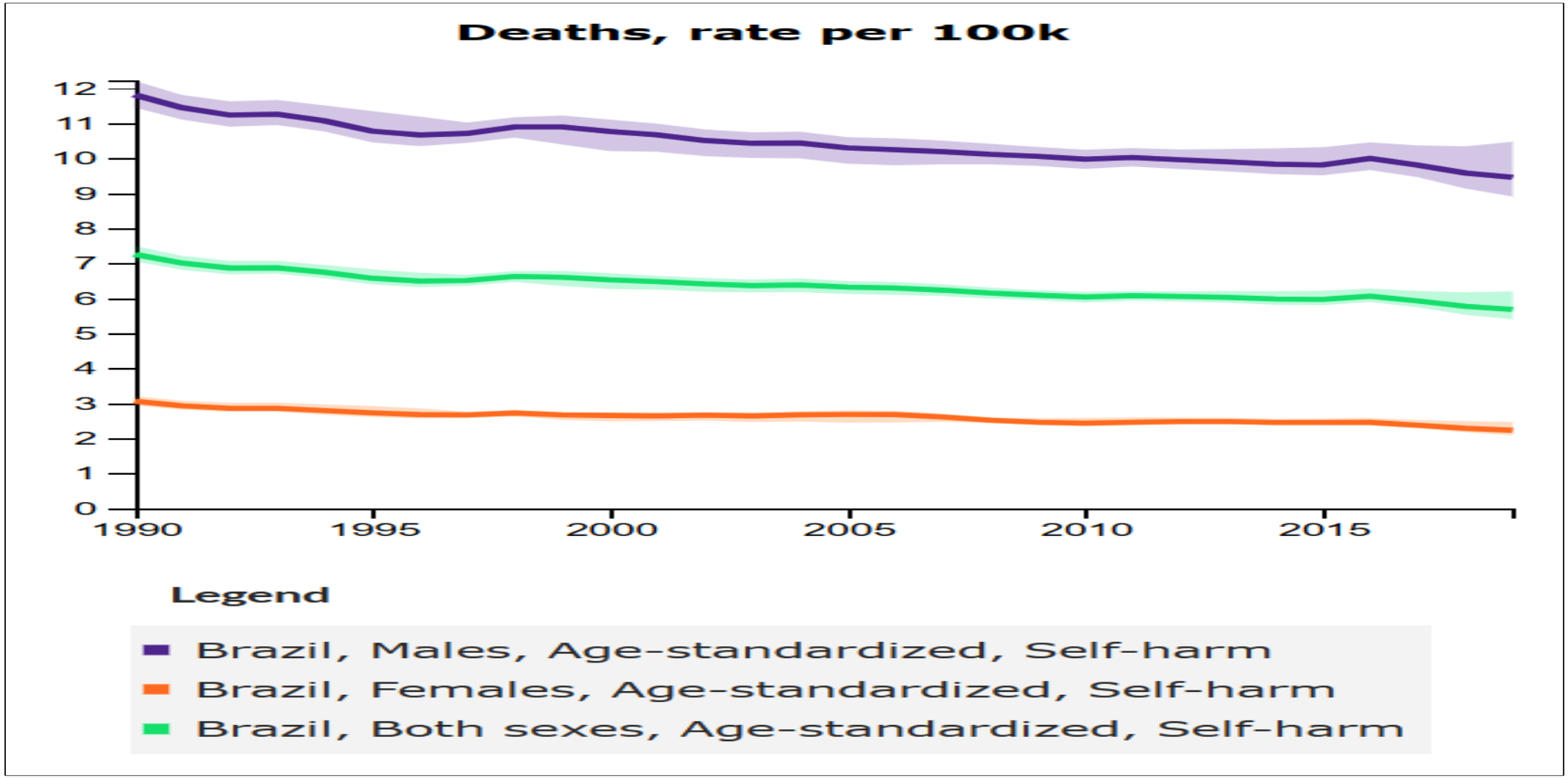


FIGURE 2: Annual estimates and uncertainty intervals of age-standardized mortality rate from suicide in Brazil, by sex, between 1990 and 2019.

Source: IHME, GBD Study Results Tool: http://ghdx.healthdata.org/gbd-results-tool

Suicide and self-harm

Duleeka Knipe, Prianka Padmanathan, Giles Newton-Howes, Lai Fong Chan, Nav Kapur

Suicide and self-harm are major health and societal issues worldwide, but the greatest burden of both behaviours occurs in low-income and middle-income countries. Although rates of suicide are higher in male than in female individuals, self-harm is more common in female individuals. Rather than having a single cause, suicide and self-harm are the result of a complex interplay of several factors that occur throughout the life course, and vary by gender, age, ethnicity, and geography. Several clinical and public health interventions show promise, although our understanding of their effectiveness has largely originated from high-income countries. Attempting to predict suicide is unlikely to be helpful. Intervention and prevention must include both a clinical and community focus, and every health professional has a crucial part to play.

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Saúde Mental dos brasileiros, a Política Nacional de Prevenção da Automutilação e do Suicídio, as estratégias públicas de atenção à saúde mental e a capacidade do Sistema de Único de Saúde para atender ao aumento da demanda por atendimentos nessa área.

Table 1

Total number of forensic cases as in-patients in 2013 across countries participating in the survey

Country	Number of forensic psychiatric in patients	Population in 2013 (from National Statistical Offices)
Belgium	1,939	11,099,554
Germany[a]	5,752[a] (Baden-Württemberg and Bavaria not included)	57,531,941 (Baden-Württemberg and Bavaria not included)
Latvia[a]	83 (Riga district only)	643,615 (Riga district only)
Italy	1,015	60,782,668
Ireland	91	4,593,100
Poland	2,200	38,495,000
Portugal	251	10,427,301
Netherlands	4,016 (1,858 TBS)	16,779,575
England & Wales	6,680	56,948,229
Scotland	522	5,327,700
Slovenia	42	2,060,663
Spain	666	46,727,890
Finland[a]	551	5,451,270
Croatia[a]	266	4,279,256
Macedonia	163	2,065,769
Lithuania	104	2,971,905

Notes: Germany: point prevalence, end of the year. Data source: State Ministries of Health. Baden-Württemberg and Bavaria not included

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PMCID: PMC7847441
PMID: 32651594

Forensic mental health in Europe: some key figures

Jack Tomlin,[✉1] Ilaria Lega,[2] Peter Braun,[3] Harry G. Kennedy,[4,5] Vicente Tort Herrando,[6] Ricardo Barroso,[7] Luca Castelletti,[8] Fiorino Mirabella,[9] Franco Scarpa,[10] Birgit Völlm,[1] and the experts of COST Action IS1302

Author information Article notes Copyright and License information Disclaimer

Associated Data

Supplementary Materials

Abstract

Go to:

Purpose

While the number of forensic beds and the duration of psychiatric forensic psychiatric treatment have increased in several European Union (EU) states, this is not observed in others. Patient demographics, average lengths of stay and legal frameworks also differ substantially. The lack of basic epidemiological information on forensic patients and of shared indicators on forensic care within Europe is an obstacle to comparative research. The reasons for such variation are not well understood.

Methods

Experts from seventeen EU states submitted data on forensic bed prevalence rates, gender distributions and average length of stay in forensic in-patient facilities. Average length of stay and bed prevalence rates were examined for associations with country-level variables including Gross Domestic Product (GDP),