RESEARCH | PESQUISA

Health workers' perception on crisis care in the Psychosocial Care Network

Percepção dos trabalhadores da saúde sobre o cuidado às crises na Rede de Atenção Psicossocial

Percepción de los trabajadores de salud sobre la atención a la crisis en la Red de Atención Psicosocial

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Abstract

Objective: The aim of this study was to investigate the care provided to people in crisis situations in the mental health services in Brazil, according to reports of workers of these services. **Methods:** Qualitative research, which analyzed reflective portfolios of 156 workers taking the Urgency and Crisis in Mental Health Course. **Results:** The workers describe care as taking place, primarily, by means of drug containment, followed by mechanical restraint and hospitalization, actions that prioritize symptom reduction, devaluing suffering and putting those who suffer into the background. **Conclusion:** The study reveals the existence of a gap between the reality of the services and the criteria professed by the mental health policies in the country. It demonstrates implications for the mental health care practice and in the consolidation of care modalities established on psychosocial care based on the right to liberty and on respect for human dignity.

Keywords: Crisis Intervention; Medicalization; Mental Health; Hospitalization; Health Services Accessibility.

Resumo

Objetivo: O objetivo foi conhecer o cuidado prestado às pessoas em situação de crise em serviços de saúde mental do país, de acordo com relato dos trabalhadores desses serviços. **Métodos:** O estudo é uma pesquisa qualitativa, em que foram analisados portfólios reflexivos de 156 trabalhadores alunos do Curso Crise e Urgência em Saúde Mental. **Resultados:** Os trabalhadores descrevem o cuidado como sendo, prioritariamente, através da contenção medicamentosa, seguida da contenção mecânica e internação, ações que priorizam a redução dos sintomas, desvalorizando o sofrimento e colocando em segundo plano aquele que sofre. **Conclusão:** A conclusão do estudo revela a existência de uma distância entre a realidade dos serviços e o preconizado pela política de saúde mental do país. Demonstra implicações para a prática do cuidado em saúde mental e na consolidação de formas de cuidado baseadas na atenção psicossocial fundamentada no direito à liberdade e no respeito da dignidade humana.

Palavras-chave: Intervenção na Crise; Medicalização; Saúde Mental; Hospitalização; Acesso aos Serviços de Saúde.

Resumen

Objetivo: Conocer el cuidado dirigido a las personas en situación de crisis en servicios de salud mental del país, según el testimonio de los trabajadores de eses servicios. **Métodos:** Investigación cualitativa, en que fueron analizados portfolios reflexivos de 156 trabajadores alumnos del Curso Crisis y Urgencia en Salud Mental. **Resultados:** La atención es descrita cómo siendo, prioritariamente, a través de la contención medicamentosa, seguida por la contención mecánica e internación, acciones que priorizan la reducción de los síntomas, minimizando el sufrimiento y poniendo en el fondo quien sufre. **Conclusión:** El estudio reveló una distancia entre la realidad de los servicios y el ideal preconizado por la política de salud mental del país. Demuestra implicaciones para la práctica del cuidado en salud mental y en la consolidación de formas de cuidado basadas en la atención psicosocial fundamentada en el derecho a la libertad y en el respecto a la dignidad humana.

Palabras clave: Intervención en la Crisis; Medicalización; Salud Mental; Hospitalización; Acceso a los Servicios de Salud.

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INTRODUCTION

Mental health, for a long time, was established as an exclusion field. Therefore, discussions regarding the users' chronicity, biomedical model, violation of human rights and citizenship have raised political, scientific and social initiatives that come to surface a new form of thinking about the health-disease process by the valorization of care to the subject. One of these strategies was the implantation of the Psychosocial Care Network (PCN), which proposes a reorganization of mental health services in an integrated manner, expanding and diversifying health actions and equipment and, aiming to warrant the universal access and comprehensive quality care for people in psychological distress[1].

This network seeks to ensure that such care is not only thought by diagnoses or practices that restrict or limit the exercise of coming and going, nor to undergo the subject to a control and monitoring system of their actions. Care should be seen as a living space with stimulus, confrontation, opportunities, relationships that envisage cultural change and a policy that is more social than sanitarist[2]. From this perspective, it recognizes the other as a legitimate citizen with rights and, values the different subjects involved in health production[3].

Therefore, health care starts to be organized in light, light-hard and hard technologies. Light technologies compose interpersonal relationships, such as the creation of bonding, autonomy and embracement; soft-hard technologies relate to well-structured knowledge, such as clinical medicine, epidemiology and clinical psychoanalysis; and hard technologies consist of technological equipment like machines, organizational norms and structures[4].

Regarding mental health, light technologies are the most relevant. Embracement, bonding, co-responsibility and autonomy are devices of these technologies and represent possibilities to build a new practice in health. Thus, they allow to understand health actions as embracing and listening to the population, giving appropriate answers to every demand along the course of search, from the reception and individual or collective care, to the external referral, return, reschedule and discharge[5].

Mental health care, therefore, requires an active attitude from those who take care, recognizing the other in their freedom, dignity and uniqueness. It is an attitude of responsibility and involvement, which is evidenced by the strengthening of ties between the subject who seeks service, the service and the territory[6].

In this study, a broad concept of crisis was used, which includes not only its traditional sense of exacerbation of symptoms or disturbance of social order. The researchers decided to approach it as a unique and disruptive experience that, at the same time, produces painful experiences, marked by uncertainty, fear and estrangement, but that contains creative elements that express the particularity of the subject and their desire.

This concept, which should guide all mental health care in the country, is still in process of appropriation by health workers and, in some cases, far from the expected realization. In a recent study in a medium-sized city, it was found that the services simplify the care to the crisis by treating the symptom, eliminating people's responsibility for their suffering and life[7].

Services still have limitations in dealing with crises, with specific and hasty conducts, only operating the subjects' silencing, preventing bonding, and thus reproducing the same lunatic asylum logic inherited from nursing homes. Such behaviors facilitate the users return to psychiatric hospitalizations, proven by studies indicating that a large number of patients arriving in crisis to the services are referred to hospitals[8].

This approach was perceived, for example, in a health care study in a northeastern capital. Authors found, using focus groups conducted with users, that professionals are influenced by the biomedical model, configuring their work processes as something impersonal, focused on disease healing, hospitalization and subject fragmentation, removing people's autonomy as for their health-disease process[9].

If the services individually have this orientation, it does not seem to be different in the PCN. Users, by means of life narratives, denote that services use medicalized and hospital-centric strategies that lead to a false deinstitutionalization, because the values on which care is based remain the same and the asylum logic comes about, mainly in more delicate situations, as in a crisis outbreak[10].

In our country, there is still a lack of research unveiling the use of coercive measures, precisely in its elementary aspects of frequency and type, as viewed in comparative studies between countries[11].

Analysis of the scientific literature on the mental health care in Brazil shows that, in general, it consists of research located in specific services or municipalities. It is necessary to know the topic with a broader scope, revealing the care offered by different services that compose the Psychosocial Care Network in its various regional realities.

Therefore, the aim of this study was to describe the care provided by workers in mental health services to people in crisis situations.

METHODS

A descriptive exploratory study, with a qualitative approach, was conducted. The target audience was 429 students of the first edition of the Crisis and Urgency in Mental Health Course, graduate PCN workers, who act in mental health care at the Unified Health System (SUS, as per its acronym in Portuguese), coming from various regions of Brazil, selected by the Ministry of Health.

This course is offered in a partnership among the Ministry of Health, the Federal University of Santa Catarina (UFSC) and the SUS open university (UNASUS), through APIS - Technology and Innovation Laboratory in Education, Research and Extension in psychosocial care and drugs. It serves as a professional development course, comprising 100 hours, divided into four modules, all done at a distance, using interactive tools (profile,

chats, forums, evaluative exercises and portfolios), with the aim to provide new knowledge and produce reflections, transforming and (re) building the reality in the context of the student's performance. The challenge is to provide training, enabling a reflexive and contextualized practice, an appropriate pedagogical praxis to overcome the merely technical and traditional training, glimpsing the formation of ethical, critical, reflective, collaborative, historical, transformative, and humanized subjects, with social responsibility[12].

Participants' characterization was carried out by filling out the profile activity, including information on their sex, age, profession, origin and work place.

The inclusion criteria were: to be regularly enrolled at the course and have answered the four reflective questions that composed the portfolio. The exclusion criterion was: to have given up the course before its ending. Of 429 students who started the course, 56 gave up, 302 met the criteria and 156 students agreed to participate in the study, after reading the Free and Informed Consent Form.

Data were collected by means of a portfolio instrument, a learning activity in which students prepared a single document with reflections on their professional practice, considering alternatives to transform their reality. The portfolio of each student consisted of four reflective questions, one in each module of the course, and for this study we considered the answer for the following question, regarding the second module: "Describe situations of mental health crises and emergency that happen more often at your workplace and analyze how care is performed in these situations." This document was produced and posted by students in the Teaching-Learning Virtual Environment.

The documents were printed, constituting the database of this research. Researchers organized and collectively reviewed these data, according to the thematic content analysis suggested by Bardin[13], following three phases: pre-analysis, material exploration and data treatment. In the first step, the material was organized with the aim to make it operational, systematizing the initial ideas. The next step was data coding, classification and categorization. In the third and final stage, information was concentrated and highlighted, culminating in a reflective and critical analysis of the material.

Data collection began in January 2015, once the research proposal was approved by the Research Ethics Committee of the Federal University of Santa Catarina, under protocol number 924.432/2014, respecting research ethic precepts.

To ensure their anonymity, the study participants were identified as E1, once they were from the first edition of the course, and S1 (student 1) up to S156, followed by a reference to the type of mental health service they worked at.

RESULTS AND DISCUSSION

The profile of the studied workers is presented descriptively in Table 1 for contextualization and, findings regarding the participants' speech were grouped in the thematic category: workers voice on crisis care in mental health.

Table 1. PCN workers profile, students of the 1st edition of the course (n = 156)

Variable	n	%
Care sites		
PSCC II	70	44.9%
PSCC III	33	21.2%
General hospital	13	8.3%
Basic health unit	11	7.1%
PSCC I	10	6.4%
Profession		
Psychologists	60	38.5%
Nurses	44	28.2%
Social assistants	22	14.1%
Occupational therapists	13	8.3%
Physicians	8	5.2%
Country region		
Northeast	47	30.1%
Southeast	44	28.2%
Center-west	27	17.3%
South	19	12.2%
North	19	12.2%
Age in years		
22-31	46	29.5%
32-41	58	37.2%
42-51	37	23.7%
52-61	15	9.6%
Sex		
Female	126	80.8%
Male	30	19.2%

Study participants were mostly workers from Psychosocial Care Centers (PSCCs) at the I, II and III modalities. According to the ordinance that rules the structuring of these services, PSCCs constitute specialized components of the Psychosocial Care Network, being a reference to people with severe and persistent mental disorders in the National Health System. Psychosocial Care Centers vary in modalities I, II and III defined in ascending order of size, complexity and population coverage: PSCC I for municipalities with a population between 20,000 and 70,000; PSCC II for municipalities with 70,000 to 200,000 inhabitants; both with daily functioning, Monday to Friday, from 8 a.m. to 6 p.m.; and PSCC III for municipalities with a population over 200,000 people and working 24 hours, including on weekends[14]. The selection of students for the Crisis and Emergency Mental Health course was conducted by the technical mental health department of the Ministry of Health, which focused this first edition on workers in

these services. A large percentage of PCN specialized services offers credibility to the findings.

The professions of the respondents were diverse, with numeric prominence for psychologists and nurses. This distribution agrees with findings of other studies, even though in a regional scope[15,16].

The Northeast region stands out as regards the origin of the participants, with 30.1%. PSCC coverage multiplied between 2002 and 2010 in the Northeast, currently with a similar coverage to the South[17], which might have influenced a greater interest in participating in this course. The Southeast, which concentrates a large number of the country's health services, having the highest concentration of Psychosocial Care Centers for Alcohol and Drugs (PSCC AD) in the country, appears in second place in this study, with a significant number of participants, reducing the likelihood of the Northeast having influenced primarily the results of this study. In addition, the sum of the other regions is higher than in the Northeast, which indicates that the research represents all regions of the country.

With ages ranging between 32 and 41 years old, 37.2%, and 80.8% female; it can be concluded that the participants reaffirm the characteristics of age and gender distribution of the workforce in PCN and at the health field, as shown by other studies[18-20].

Care to people in crisis situation

Participants reported that measures such as drug and mechanical restraint and hospitalization are primarily carried out as the standard care procedure in crises. These actions are limited to reducing symptoms reduction, without offering space and time so that the subject can express their suffering, as described in the lines below:

> *When they reach the service, depending on how they are, they are contained in bed with retaining bands by monitors. Then they are seen by psychiatrists, who determine the drug containment and after administrating the medication, they are under observation. (E1 S124 - PSCCII)*
>
> *When we have a user in crisis and family calls for help from PSCC, we guide them to contact the SAMU, to take the patient to a hospital and, then the user is medicated. If the crisis is too strong, the person is referred to the capital, to be hospitalized. [...] (E1 S147 - PSCC II).*

Advances in mental health practices in recent decades are undeniable, but there are still many challenges to be overcome, mainly regarding the place of medications in healthcare practices, when the focus is on the care of crises. The primacy of pharmacological treatment[21] is clear in these situations and, in some cases, care and symptom management are limited to it.

Care has a disruptive potential, both being able to emancipate people and to tutor them[6]. In the observed reports, care is characterized as tutelary, placing the subject in place of the one who needs to be treated by another, who needs to receive medication, to be seen, to be oriented and not as someone who knows their disease and is able to make decisions.

It is necessary to differentiate the position of being responsible for someone from the attitude to support someone in their freedom in decision making, that is, it is essential to differentiate tutorship from care[22]. Various theoretical perspectives have pointed out that the purpose of mental health practices must be the expansion of the capacity of each one handle with themselves and with others, and not only the symptoms remission[23].

The indiscriminate use of drugs aims, mostly, at sedation and the rapid containment of the discomfort caused by the crisis. Services also guide their actions based on measures and strategies to frame the subject to rules, justifying the indiscriminate use of medication, mechanical restraint, confinement and all forms of symbolic and physical violence[24].

The reductionism and simplification of human suffering, which this excessive medicalization imposes on care, needs attention. Taking into account the individual who suffers and his life story, the possibilities of intervention[25] are extended. It is not intended to deny that the use of drugs is an excellent resource available to professionals, but it is known that their inappropriate use can be harmful. Medicalization can be at service of non-responsibility of the subject for their problem, because improvement relies on a magical and external solution.

New conceptions of care, madness and mental crisis must be apprehended. It is noteworthy that PSCC professionals, characterized as expert/strategic points of the Psychosocial Care Network, have difficulty in recognizing the responsibility for their role in the reception and management of crisis situations, since these are common and even expected, considering that they are the team responsible for the care of people with "severe and persistent mental disorders," as stated in the directive regulating these services[14]. The expectation is that other services concerned with crises and that the service in PSCC be established when the individual is "compensated":

> *The team has proven to be neglectful when witnessing a crisis moment and, instead of intervening, seek to refer and get rid of the problem (E1 S141 - PSCC II).*
>
> *The user with their tutor is referred to a general hospital for stabilizing, returning to the PSCC, as soon as they are compensated, for treatment continuation. (E1 S92 - PSCC II).*

It is known that, especially for young patients, in the first crisis episode, inpatient units are particularly dangerous. Either due to the contact with other patients, who are frightened, disorganized and aggressive, but also because they are at risk of using 10-30 times higher medication doses than would be necessary, according to British studies[26]. But, international experience also indicates that teams with appropriate training for the recognition and early intervention with people in crisis, present a decreased rate of psychiatric hospitalizations, expanding the possibilities for outpatient care[27].

In the studied reality, psychiatric hospitalization still plays a central role in care of crisis situations. By choosing for non-consensual actions, however, teams reveal to be unable to satisfactorily conduct them and one of the solutions found is the public security departments, as well as municipal guard or the police:

> *In urgencies the first conduct is drug intervention, which occurs by the ursing team, both at the unit and at home, in some cases with Municipal Guard support for physical restraint. As soon as possible the patient is evaluated by the physician, who almost always refers them to the hospital. (E1 S64 - PSCC II).*
>
> *Sometimes, crises are treated first by containment for urgent administration of injectable medication. We have already had outbreaks in which we needed police help to administrate urgent medication. In other cases, the SAMU was requested to support and transfer to the only hospital (regional) in the city.(E1 S97 - PSCC II).*

Care associated with serious psychic distress has generated frequent reflections, because the redirection of such assistance, in theory, advanced from a hospital-centered model to a model of psychosocial and community care, evidencing the need for a comprehensive view and care. Services and professionals, however, still find difficulty in offering this care based on light technologies, reception, bonding, co-responsibility and autonomy. This shift in the care model, however, has not been properly incorporated, although some participants report increased tension in this direction:

> *I find myself with so many questions about crises, how to identify them, what to do, what not to do, drug response seems easy and fast, however distresses me to have it as an answer, I would find other ways. (E1 S52 - PSCC II).*
>
> *The team has been struggling in "care", it has not been easy, because it requires maturing of it, trying not to be limited to drug therapy, in a physician-centered model, but to embrace not only the patient, but the family, seeking interaction with PCN partners. In our team meetings, we always discuss new cases. (E1 S66 - PSCC I).*

Another fundamental aspect is the evident fragility in the implementation of several PCN points. If the difficulties related to the development of shared actions between mental health services and primary health care are widely reported, even more serious is the disarticulation with emergency services and the insufficient expansion of the number of beds in general hospitals for care to people in severe and acute psychic distress[28]. This reality is perceived by the participants and identified as restrictive to carry out the recommended care:

> *We are still stuck in a biomedical model, because the user and the family in crisis are taken to a psychiatric hospital, and kept away from the PSCC for long periods. Without support from SAMU or firefighters, we make direct contact with the hospital. Despite the team not agreeing on it, this is the only solution found, as mental health network is still precarious. (E1 S100 - PSCC II).*
>
> *In some cases, families hospitalize users and only communicate the PSCC team later [...] We still not rely on the PSCCIII or with spare beds in general hospitals, making it difficult in some cases where the family is not able to cope with the crisis on weekends and end up admitting the user (E1 A150 - CAPS I).*

It is evident in the participants' speech that another challenge mentioned by them is the lack of professional training to deal with psychological distress, since it mobilizes issues in the professionals themselves, bringing out their beliefs, fears, personal and technical difficulties. Often, a rushed diagnosis, an extremely technical and inhuman conduct, the medicalization of all complaints and difficulties in contact, may obey the professional defense mechanisms. The opposite may also happen, when professionals fail to keep a distance that allows them insight into the other's suffering and feel invaded by this, thus losing power to intervene[29].

> *We still work focused on medical practice, almost in all episodes, medicalization occurs first. Especially with lack of training of the professionals involved. This action only strengthens dependence on mental hospitals. (E1 S53 - PSCC II).*
>
> *To aggravate the situation, the network is not able to give answers, because it is also not prepared for such situations. It happens that user courses a suffering and neglect path. (E1 S53 - PSCC II).*

Professionals formed by the biomedical paradigm, in the centralization of symptoms and in the therapeutic reductionism, present many difficulties in offering comprehensive care and qualified listening, needing a differentiated training for this. The lack of training compromises intervention outcomes and creates more suffering to both the patient and the professional. Mental health practices are still very much linked to the biomedical model; there is great difficulty in the implementation of what is recommended by public policies, bringing about a series of inadequate attitudes, such as medicalization, physical restraints, excessive hospitalizations, eliminating people's responsibility for their treatments, and discriminatory and prejudiced practices in the care of psychological distress.

FINAL CONSIDERATIONS

The view of professionals who participated in this study as regards how crisis and emergency situations in mental health are handled in their everyday work realities reaffirm a biomedical logic of psychic phenomena and poorly explore other main aspects of care, such as bonding, autonomy and co-responsibility. Such

understanding tends to exacerbate the crisis perception as an expression of a pathological trait, devaluing this suffering, using forms of asylum care, containment and symptoms remission, without a concern with the subjectivity of the one who seeks help and without giving voice and credit to him.

It is considered that one of the causal factors of care focused on medication is that professionals may not be able to provide assistance to such clients, due to low or no workload offered to mental health in their education. Thus, it is important to provide refresher courses for professionals working in the PCN, offering the possibility of expanding knowledge on these issues, coordinating it with the work reality, analyzing and reflecting on care modalities provided currently and care forms based on psychosocial care, in light technologies and in care with freedom.

It is necessary to increase care to crisis and emergency situations, producing services and networks to effectively respond to people's needs in their real life contexts, guaranteeing freedom, promoting rights, and providing new possibilities for life and new strategies to meet situations of intense suffering and fragility. This care must go beyond silencing symptoms and isolating subject, which directly impacts professionals and service capacity in being available to act in substitutive network, by reorganizing work processes and coordinating their practices, overcoming stigmas, prejudices and stereotypes linked to madness and the person's figure in psychological distress, in the direction of a look marked by human rights defense and citizenship recovery.

The process of change, though strongly encouraged by public policies, is produced in the day-by-day care, within the agreements and disagreements between professionals and users and based on the concept that each subject carries on psychological distress, health-disease, care, responsibility, crisis and mental health. A reflective and contextualized look on these concepts has not always been contemplated in institutional spaces, in health services.

It is worth noting, as a limitation of this study, that participants were mostly from specialized mental health services. Considering that the First Aid, Emergency Care Units and Emergency Mobile Care Services are strategic components of PCN for care to crisis situations, it was observed a need to access the view of the workers of these services on the theme, which reveals the need for further research in this area.

The psychiatric reform movement needs to be consolidated, expanding the implementation of diversified and committed services with care to crises at various levels and, investing strategically in the SUS workers' permanent education, not to be restricted to the field of theory and policies, without reaching practice and the everyday life reality.

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