








# Psychiatric emergency units in Brazil: a cross-sectional study

Cintia de Azevedo-Marques Périco<sup>1,2</sup> , Roberto Mendes dos Santos<sup>3</sup> , Leonardo Rodrigo Baldaçara<sup>4</sup> ,  
Camila Santos Símaro<sup>1,2</sup> , Renata Costa Junqueira<sup>1,2</sup> , Maria Olivia Pozzolo Pedro<sup>1,2\*</sup> ,  
João Mauricio Castaldelli-Maia<sup>1,2,5</sup> 

## SUMMARY

**OBJECTIVES:** This study aimed to identify the infrastructure (e.g., availability, resources, and staff), basic metrics, and problems (e.g., network, overcrowding, resources, and infrastructure) of the psychiatric emergency services in Brazil.

**METHODS:** This is a cross-sectional study assessing psychiatric services (n=29) listed by the Brazilian Psychiatric Association in 2019.

**RESULTS:** Almost all the units reported 24 h/7-day availability having psychiatrists, nurses, and social workers, with 8.8 (SE=2.2) and 2.8 (SE=0.3) consultations and hospitalizations per day, respectively. Separated room for contention was reported by the minority of the services (38%). The most commonly reported problems were insufficient structure for child/adolescent care (83%), increasing patient demand (72%), housing referral for homeless (72%), excessive prescription demand (69%), short-term room overcrowding (59%), court orders for inpatient treatment (59%), lack of vacancies for inpatients hospitalization (59%), and referral to primary care (56%).

**CONCLUSIONS:** Similar to the United States, the Brazilian psychiatric emergency units are decreasing and encompass the shortcomings of the Brazilian mental health care network.

**KEYWORDS:** Health services research. Medical emergency services. Psychiatric emergency services.

## INTRODUCTION

Emergency situations can be defined as those that involve essential life or social risk, requiring immediate and unavoidable interventions. In comparison, urgent situations deal with less risk, requiring short-term intervention<sup>1</sup>. Psychiatry emergencies (PEs) are all behavioral changes that result in real and significant risk and require immediate and essential therapeutic intervention to prevent harmful evolution for the patient and third parties<sup>2</sup>.

In the past decades, the psychiatric practice has undergone profound changes in Brazil, aiming to elaborate therapeutic plans to prevent long-term hospitalization. A proposal of reformulating mental health care had been organized to introduce a network of services that seeks to manage the patient in psychosocial care units (*Centros de Atenção Psicossocial*), with greater integration of the patient with the community. Beyond the supply of outpatient care and the approximation of the psychiatric services with general hospitals, there was also the need to amplify the services and functions of PE services (PES) to deal with patients in crises<sup>3,4</sup>. Until the creation of the first PES, the Psychiatric Emergency Room of the Psychiatric Institute of the National Center at Rio de Janeiro, cases of PE were characterized as

“police cases”<sup>5</sup>. Before these proposals for restructuring mental health care, patients in an acute crisis had, at best, low-quality assistance. Most of the time, they were managed in nonpsychiatric health services or in asylum hospitals existing at the time<sup>6</sup>. Several PES have been created in all Brazilian regions in the following decades. Even though it is considered an important service for the organization of mental health network, Brazilian data of PES are scarce, with little information regarding the distribution of these centers in the territory. Consequently, less is known about the organization of emergency teams and the problems they face on a daily basis<sup>7,8</sup>.

The objective of this research was to collect information about the infrastructural characteristics and basic metrics of the Brazilian PES, as well as the main difficulties faced to provide proper acute psychiatric care to the Brazilians.

## METHODS

### Study design

This was a quantitative cross-sectional study. We invited the heads of all the PES listed by the Brazilian Psychiatric Association to

<sup>1</sup>Centro Universitário de Saúde FMABC, Medical School, Department of Neuroscience – Santo André (SP), Brazil.

<sup>2</sup>Centro ABC de Estudos de Saúde Mental – Santo André (SP), Brazil.

<sup>3</sup>Hospital Universitário Lauro Wanderley – João Pessoa (PB), Brazil.

<sup>4</sup>Universidade Federal do Tocantins – Palmas (TO), Brazil.

<sup>5</sup>Universidade de São Paulo, Medical School, Department of Psychiatry – São Paulo (SP), Brazil.

\*Corresponding author: maria.oliviapozzolo@gmail.com

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participate in a survey (one per PES). The study included all PES over the national territory that accepted and signed the consent term to participate. We have considered PES a mental health care unit designed to provide immediate care for acute cases of psychiatric symptoms.

### Sample

The respondents were directors, coordinators, or technical leaders who had extensive experience in the routine of the PES and voluntarily agreed to participate in the research. For each PES, only one professional, who was familiar with the practice and had a great knowledge of the service and structures, was offered a questionnaire developed by the authors of the study.

### Procedures

Because the study involves humans, all the requirements proposed by the National Health Council/Ministry of Health were attended through Resolution #466/2012<sup>9</sup>. Therefore, the data collection started after the appreciation of the Research Ethics Committee of the Fundação do ABC. The research team informed the respondents about the objectives and procedures of the study before the latter had signed the Informed Consent Term, guaranteeing them anonymity, confidentiality, and informing them of the ethical procedures.

### Measures/Analysis

The questionnaire was developed by members of the PE section of the Brazilian Psychiatric Association composed of specific questions about the profile of the health care professionals (e.g., psychiatrists, nurses, and nursing technicians), the PES physical structure, and the main problems faced by the health team of the emergency care. Data were collected through self-administered questionnaires answered by health professionals who had a working relationship with the PES in analysis at the time of the response. The results collected were tabulated, and we carried out a descriptive analysis by categories and subcategories, as follows:

- Infrastructure: availability, resources, and staff
- Metrics
- Problems: network, overcrowding, resources, infrastructure, and other

## RESULTS

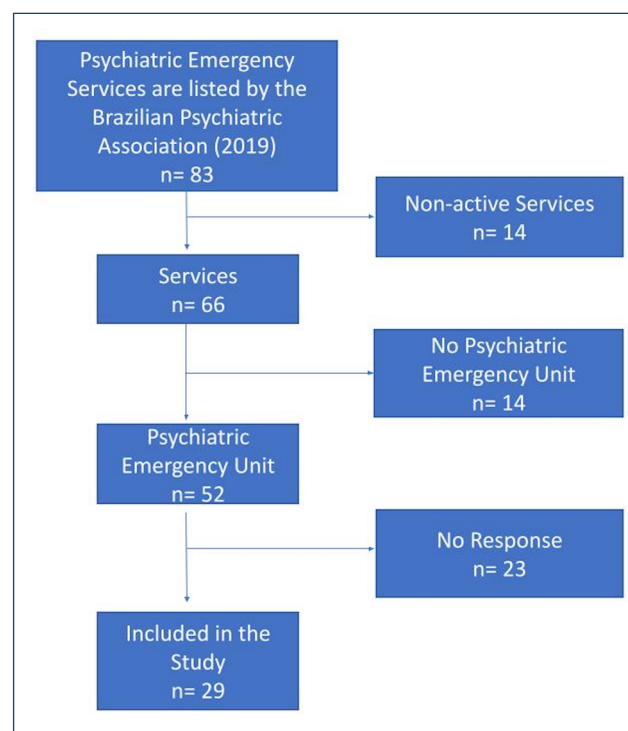
Figure 1 presents the flowchart of PES invited to participate in this study. The Brazilian Psychiatric Association listed 83 possible PES. Among these, 66 were found to be still active. Only 52 services were considered PES; the other 14 units were excluded from the study for not meeting the criteria of PES.

From these 52 locations, 29 accepted to participate and answered the questionnaire. Most of them were academic training sites.

Table 1 presents infrastructure, metrics, and problems of Brazilian PES. Regarding availability, 93% of these services work 24 h/day, evaluate children and adolescents, and accept patients from other municipalities. Responses on resources showed that almost 66% apply a screening protocol for risk classification and have a procedures protocol and a clinical analysis laboratory. In addition, 79% have adequate material for mechanical containment, but only 38% have a separate room for physical restriction. Almost all (97%) have an observation room for the patients. Concerning the staff, all teams are composed of psychiatrists, nursing technicians, and social workers, and almost all have nurses and administrative employees (97%). Psychologists (69%) and occupational therapists (48%) are less present. In addition, we found that 86% of the PES have guards.

There was an average of 8.8 and 2.8 consultations and hospitalizations per day, respectively. The team is formed by an average of 9.2 psychiatrists, 5.4 internal medicine physicians, and 1.5 psychiatrists per 12-h period. The mean number of beds per service was 6.8. In addition, we found an average of two consultancy rooms per service.

Among the problems previously selected by the survey, the item “insufficient/absent structure for childhood and/or adolescence” was reported by 83% of services. Furthermore,



**Figure 1.** Flowchart of psychiatric emergency services invited to participate in this cross-sectional study, Brazil, 2019.

**Table 1.** Infrastructure, metrics, and problems of psychiatric emergency units in Brazil, 2019.

Infrastructure	n	%	Problems	n	%
Availability			Network		
Open 24 h/7 days	27	93.1	Related to primary care	16	55.17
Any restriction in consultations	13	44.8	Related to specialized health system	14	48.28
Serves children and adolescents	27	93.1	Related to substance use care units	10	34.48
Accept patients from other municipalities	27	93.1	Related to mental health care units	11	37.93
Resources			Related to housing (homeless)	21	72.41
Performs risk rating	19	65.5	Related to therapeutic communities	4	13.79
Uses service protocols	19	65.5	Inpatient removal for hospitalization	7	24.14
Uses medical records	29	100.0	Overcrowding		
Separated room for contention	11	37.9	Increasing patient demand	21	72.41
Containment equipment	23	79.3	Excessive prescription demand	20	68.97
Short-term inpatient room	28	96.6	Short-term room overcrowding	17	58.62
Laboratorial tests available	19	65.5	Court orders for inpatient treatment	17	58.62
Staff			Resources		
Psychiatrists	29	100.0	Lack of vacancies for inpatients hospitalization	17	58.62
Psychologists	20	69.0	Lack of medicines at the emergency service	13	44.83
Nurses	28	96.6	Lack of medicines in public health system	15	51.72
Nurse technicians	29	100.0	Lack of internal medicine support	9	31.03
Social workers	29	100.0	Lack of employees (other than psychiatrists)	15	51.72
Security staff	25	86.2	Replacement of psychiatrists by nonspecialized physicians	2	6.90
Occupational therapist	14	48.3	Insufficient training	11	37.93
Administrative officer	28	96.6	Infrastructure/other		
Other professionals	5	17.2	Inadequate physical structure	14	48.28
<b>Metrics</b>			Inadequate physical containment	12	41.38
	<b>Mean</b>	<b>SE</b>	Insufficient structure for child and adolescence care	24	82.76
Number of consultations per day	8.8	2.2	Aggression	11	37.93
Number of hospitalizations per day	2.8	0.3	Others	2	6.90
Psychiatrists in the team	9.2	1.2			
Internal medicine physicians in the team	5.4	1.4			
Psychiatrists per 12-h period	1.5	0.1			
Beds	6.8	1.1			
Consultancy room	2.0	0.2			

72% had the following problems: “increased patients demand” and “homeless people.” In addition, 69% declared “excessive demand for recipes,” and 59% declared “lack of hospital beds,” “patients presenting court orders for hospitalization,” and “overcrowding of the observation room.” Moreover, 55% pointed as a problem “contact with the basic service network,” and 52% pointed to “lack of employees (nonpsychiatrists)” and “lack of medication in the health network.” Other items were less identified as problems, such as contact with the specialized service network (48%), contact with CAPS AD (34%),

contact with the CAPS (38%), insufficient team training (38%), contact with therapeutic communities (14%), transfer to hospital (24%), lack of medication in the emergency unit (45%), inadequate physical structure (48%), lack of support of internal medicine physicians (31%), problems due to inadequate physical restraint (41%), deaths during psychiatric hospitalization while the patient was still in the psychiatric emergency department (17%), agitated patients (38%), exchange of psychiatrists for physicians from another specialty (7%), and other problems (7%).

## DISCUSSION

This study identified major flaws for proper PE care. In spite of the majority of the Brazilian PES providing 24 h/7 days care, a lack of adequate infrastructure to children and adolescents and overcrowding related to the shortcomings of the mental health care network were largely reported. The lack of medications was also reported by most of the services. However, we also found some strength. All the PES had a social worker as part of the team, making it possible to obtain a better collection of social and family data and act on social and economic issues. Almost all the PES were also available for patients from other cities. This is important because of the absence of PES in most of the regions of the country.

In Brazil, there is no consolidated information regarding the distribution of PES in our territory or also the difficulties that they encounter on a daily basis<sup>6,9</sup>. There are insufficient official data on such locations, and most states do not have information available in official media. Thus, despite being a fundamental and essential service<sup>10</sup>, PES are still incipient and insufficient to serve a population of more than 212 million inhabitants, an alarming data found in this study.

The decrease in the number of Brazilian active PES has also been noted in the United States. A very recent study showed that the availability of U.S. psychiatric “walk-in” services has been declining by 15.8% from 2014 to 2018<sup>11</sup>. There was also a decrease of 7.5% in crisis services during the same period<sup>11</sup>. The problems related to the shortcoming of the mental health care network found in this study are also found in the United States<sup>12</sup>. Interestingly, some of our findings were similar to those of a survey with the U.S. PES in 1998<sup>13</sup>. The majority of the U.S. PES were academic training sites. Almost all the PES were open 24 h/7 days and had a psychiatrist present at some point of the day. Nearly 70% of respondents reported inadequate referral options for patients with substance abuse<sup>13</sup>.

These findings support the importance of updating the PES data and, based on that, understanding the flaws and the problems faced. But, conversely, it is crucial to identify the

positive aspects of each service that could serve as a model for other regions with similar demands.

## CONCLUSION

Similar to the United States, the Brazilian PES are decreasing in number and encompassing the shortcomings of the Brazilian mental health care network. Data collection enables the better organization and updating of services in the national territory, facilitating new research in the area. Given the importance of the PES, it is necessary to accelerate improvements in services and the construction of public policies to care in a qualified and preestablished form for acute cases. In addition, through this study, it is feasible to talk about the possibility of making the distribution of these services more homogeneous in our regions, thus resulting in better access to services and adherence to treatment of our patients.

## AUTHORS' CONTRIBUTIONS

**CA-MP:** Conceptualization, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. **RMS:** Conceptualization, Data curation, Methodology, Project administration, Resources, Supervision, Writing – original draft, Writing – review & editing. **LRB:** Conceptualization, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. **CSS:** Data curation, Formal Analysis, Investigation, Resources, Validation, Visualization, Writing – original draft. **RCJ:** Data curation, Formal Analysis, Investigation, Resources, Validation, Visualization, Writing – original draft. **MOPP:** Data curation, Formal Analysis, Investigation, Resources, Validation, Visualization, Writing – original draft, Writing – review & editing. **JMC-M:** Conceptualization, Formal Analysis, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

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