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Possibilities and Limits of Multiprofessional Attention in the Care of Psychiatric Emergencies: Analytical Study

REVIEW

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Abstract

Goal: To analyze the possibilities and limits of *multiprofessional* care in the attention to psychiatric emergencies.

Method: It is an analytical study of the type integrative review of the comprehensive literature. Searches were conducted in the Latin American and Caribbean Literature (LILACS) and Nursing Database (BDENF) databases and in the ScieLo Virtual Library, with the use of Descriptors in Health Sciences (DECs): "Emergency Services, Psychiatric", "Forensic Psychiatry", "Psychiatric Rehabilitation", in the period from 2007 to 2017.

Results: After data analysis, two thematic categories emerged: "Possibilities and limits in *multiprofessional* care for patients in crisis" and "The continuity of care to the patient in crisis by the *multiprofessional* team". The studies point out fragility in the management of the *multiprofessional* team of care to the patients in psychiatric crisis. Therefore, in the substitutive services to the psychiatric hospital, it is necessary

to strengthen the care and bonding tools for continuity of treatment after the cases of psychiatric emergency of these patients.

Conclusion: This research provided a deepening of the knowledge regarding the challenges of the *multiprofessional* team in the care of analytical psychiatric emergencies and in relation to the patient in crisis, considering the main *multiprofessional* actions, understanding how this approach is done and patient follow-up.

Keywords
Emergency Services; Psychiatric; Forensic Psychiatry; Psychiatric Rehabilitation.

Introduction

Emergency mental health situations refer to any disturbance of thinking, feelings or actions that require immediate intervention to protect the person or third parties from the risk of death. Among the most frequently encountered emergencies are suicidal behavior, aggressive behavior and disturbances in thinking and perception, with 20% of those assisted in emergency mental health services having suicide problems and 10% violent behavior [1].

The violent and aggressive behavior expressed by the client denotes fear, anxiety and insecurity in those around him, including professionals. However, the culturally constructed fear of society towards all people in the psychiatric setting is disproportionate to the few that, in fact, constitute a risk to the social environment. Excessive fear in professionals may impair clinical judgment and lead to premature and large-scale use of sedative medications and physical restraints, such as bed restraints [1].

Mental health emergencies are related to the various evolutionary and accidental crises related to human experience. But what specifies an emergency in mental health is the manifestation of behavior as a consequence of a situation in which the person is and for which his general performance is seriously impaired and the individual becomes incapable of assuming personal responsibilities [2].

Emergency mental health refers to a situation of altered thinking (delirium) or actions (aggressive acts) that demand rapid care. These changes are associated with the risk of death, such as in suicide or in patients with violent behavior, or the situation of mental alterations resulting from the use of psychoactive substances or physical diseases, which must provide interventions for the reduction of sequelae. Thus, emergency is a set of contrasting emotional and practical interests, in which the patient and his/her crisis are only part and not the whole, and the health team must take into account all these possibilities at the time of evaluation [2].

The approach to the person with mental disorder in an emergency situation is very important, because if carried out with safety, agility and quality it allows a greater adherence of that person to the treatment. The care actions should be articulated with the other services in the system, allowing the appropriate referral of users to other competent services. This way of developing health work promotes the reception and collaborates in establishing a relationship of trust of the user with the service and with the team [3].

Psychiatric care in Brazil until the 1970s was marked by the poor quality of care for subjects who coexist with diseases of the mind, psychiatric institutions, making the commerce of madness and the chronification of the patient of mental health, having as main aspect the medical and hospital-centric model for such practice [4].

Agility in the care of a person is essential for the proper functioning of a psychiatric emergency service composed of a multiprofessional team, can cause some limitations, both with regard to the treatment of the subject and the training of health professionals to work in this type of service.

Therefore, the question that guided the study was: what are the possibilities and limits for multiprofessional care in psychiatric emergencies? Therefore, this research had as objective: to analyze the possibilities and limits of *multiprofessional* care in the attention to psychiatric emergencies.

Method

Study of the analytical type of integrative review that includes the analysis of significant research that supports decision making and improvement of clinical practice. This type of study enables the synthesis of the knowledge state of a given subject, also points out the lack of knowledge that needs to be filled with the practice of new studies. It is a very important method for the health sciences, since professionals often do not have the time to read all the available scientific knowledge due to the high volume, besides the difficulty to carry out the critical analysis of the studies [5].

The following five steps were followed: establishment of the criteria for inclusion and exclusion of studies and search in the literature, categorization of the studies found, evaluation of the included studies, interpretation of the studies, and finally, synthesis and presentation of the findings [5].

Searches were conducted in the Latin American and Caribbean Literature (LILACS) and Nursing Database (BDENF) databases and in the ScieLo Virtual Library, with the use of Descriptors in Health Sciences (DECs): "Emergency Services, Psychiatric", "Forensic Psychiatry", "Psychiatric Rehabilitation", in the period from 2007 to 2017.

Articles that did not meet the objectives of this research, articles repeated in the databases and were not available in full were excluded from the study.

An instrument was developed to facilitate the collection of data. **(Figure 1)**

Figure 1. Instrument.

Title	Newspaper	Author	Year	Source	Method	Database

Results

During the data collection, 30 scientific publications were found. Of these, 15 are not available electronically, six articles were selected, since they include the inclusion criteria of the research and the remaining nine studies were excluded because they did not meet the study objectives and because they were repeated in the databases. With regard to the time period, it was observed that the publications occurred in the years 2007 to 2017, which met the prerogatives of this research. **(Table 1)**

Table 1. Distribution of the domains and facets of QoL. João Pessoa, PB, 2015.

Nº	Title	Newspaper	Author	Year	Source	Method	Database
01	Risk and crisis: thiking about psychiatric urgency	Psicologia em Revista	Jardim K	2007	Minas Gerais	Review	SciELo
02	Emergency psychiatric service in general hospitals: a retrospective study	Rev Esc Enferm USP	Sousa FSP	2010	Ceará	Field Research	BDENF
03	Conceptions of mobile emergency service health professionals concerning psychiatric emergency	RENE	Bonfada D	2012	Rio Grande do Norte	Field Research	LILACS
04	The compliance to prescribed drug treatment and referral in a psychiatric emergency service: a follow-up study	Rev Bras Psiqut.	Calfat ELB	2012	São Paulo	Field Research	LILACS

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Nº	Title	Newspaper	Author	Year	Source	Method	Database
05	Brazilian psychiatric reform: knowledges of health professional of mobile service of urgency	Rev Esc. Anna Nery	Bonfada D	2013	Rio Grande do Norte	Field Research	LILACS
06	A hospice in crisis: images of an experience of deinstitutionalization	Interface	Kinker FS	2017	São Paulo	Experience Report	LILACS

Discussion

In order to facilitate the understanding of the analysis of the explored scientific material, the discussion of the present study was divided into two thematic categories: *Fragility of the multiprofessional team in psychiatric emergency care*; *Continued customer care in crisis from the perspective of the multiprofessional team*.

Fragility of the multiprofessional team in psychiatric emergency care

The approach to the customer in an emergency situation is of such importance that, being made with self-confidence, agility and quality will facilitate the acceptance of this client to the treatment. It can be developed as an important advance in an emergency service, by this means, the professional can listen to the client offering him security in its particularity and adequate answers.

The care of this client must be planned with the other services in the system, allowing the referral of the clients to other competent services. In this way the way to improve health work simplifies the reception and contributes to the trust of the client with the multiprofessional team and with the service [6].

Therapeutic communication is shown to be a powerful tool in intervention in crisis, in addition to the use of psychotropic injectables. This type of communication between the multiprofessional team for clients is essential for the establishment of a good relationship and for the care of clients in a psychiatric emergency situation [7].

Therapeutic communication is a basic tool for the care of the multiprofessional team. It is present in all actions taken with the patient, whether to guide, inform, support, comfort or meet their basic needs. As an instrument, communication is one of the tools that the multiprofessional team uses to develop and perfect professional know-how [7].

The fear and insecurity of the multiprofessional team are caused by the violent and aggressive behavior of the client in crisis. In spite of this, it is disproportionate to the fear that exists to all psychiatric clients, since few in fact constitute a risk to others. Consequently, hindering clinical data, leading the client to use sedatives or even clothes to tie him to the bed [8].

In the use of therapeutic communication, in cases of psychiatric urgency, the knowledge and management of the "human communication" of the professional must be significantly relevant, since the client, needs help finding a sense of autonomy, recognizing their limitations, accepting what can not be changed and facing the challenges [8].

Even in cases of psychiatric emergency, the relationship between the multiprofessional team and the client is important to obtain the necessary information. Thus, it is necessary to have a planning, using the knowledge of "therapeutic communication" to help the client to have confidence and self-esteem, through the support and assistance of the professional [8].

There are some difficulties on the part of the professionals, for the lack of understanding of the psychological suffering that the client is going through, especially when there is a picture with the behavior of agitation. This behavior that the client presents is one of several ways of expressing their suffering. Professionals report that there is a shortage of skills to deal with specifications in the area of mental health and that they arouse negative

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feelings, such as: fear, distrust, anger, guilt, pity, and insecurity. There are also reports related to how some professionals treat the client with mental disorder, neglect, leaving the subject for hours under evacuation and urine, do not undo contention for fear of aggression, this generates a dissatisfaction among co-workers [6, 7].

The greatest deficiency in the mental health sector is the lack of preparation and lack of training to receive the client with mental disorder, especially professionals with less experience. This lack of empowerment causes fear and insecurity to act in the emergence of mental health [6, 8].

There is no emotional structure to serve psychiatric clients, as there is no knowledge of approaching a client with a psychiatric urgency demand. Even with the lack of capacity to care for people with mental disorders, the multiprofessional team has an obligation to provide care, since, in a certain way, are charged for being subjected to a hierarchy of supervisors and directors. Being that, in addition to the lack of preparation to deal with clients in crisis, the little time available to elaborate various activities makes it difficult to have this greater contact with the person in mental suffering [7].

It can be affirmed that there is a lack of preparation of the multiprofessional team to execute the approach to the client in crisis, especially those that arrive more agitated to the services. The fear and insecurity of these professionals makes work difficult, rendering care unsatisfactory, which is a new challenge in the psychiatric emergency.

Continued customer care in crisis from the perspective of the multiprofessional team

Assistance to psychotic clients in outpatient care is extremely important, leading and caring for treatment after discharge. Many of these clients go to the outpatient clinic only to receive the administration of the Prolonged Neuroleptic (NAP) and have the medical care, which is periodic, being excluded from some therapeutic activities, making it easier to abandon treatment [9].

The continuity of the client at home after hospital discharge is very important, despite being the best, the family is not always available to receive it at home, becoming vulnerable to hospitalization. The multiprofessional team of psychiatric care should help the client by developing activities that can improve their readaptation to the social environment and reduce the number of hospitalizations [9].

In the context of basic care, specifically in the health unit, the reception is important because it is a strategy that seeks to offer some type of response to all clients who seek the health service. The promotion of integral actions would be an alternative to avoid the crisis of the client, considering their living conditions, organizing various forms of care, avoiding relapses and making intervention [10, 3, 4].

Group care, carried out with clients and family members in the therapeutic process, is an alternative of care, in view of the change in the outpatient structure, to complement the traditional medical care through a collective space of listening and welcoming. The NAP group was created with the purpose to have a better care, thinking about the well being of the client, that are limited only to consultations, medication and hospitalization, that prevents this client from having a better life, due to the illness and the limitations that exist. With the help of the team of professionals can generate better results through new therapeutic proposals [11].

In the Ribeira mental health outpatient clinic in Natal - RN, the actions developed are: psychiatric consultations, therapeutic and family groups, therapeutic workshops and social reintegration activities. Although the dynamics of the service are similar to that of the CAPS, there are still deficiencies, because the institution only works on the morning shift and on Mondays only has internal work, unlike the CAPS that works both shifts, every day of the week. The proposal at Ribeira's outpatient clinic is to prioritize group visits, through therapeutic groups and workshops, as it is a larger clientele [8, 10].

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The characteristic of agility in the management of the patient - essential for the proper functioning of an emergency service - may imply in some limitations, regarding both the treatment of the patient and the training of health professionals to work in this type of service. In general, psychiatric emergency services have little availability of beds for better observation and follow-up of the evolution of the clinical picture, which often leads to an early decision on the patient's complete hospitalization. Not always the extra-hospital services have a structure that offers the same agility found in the emergency room [12, 13, 14].

Difficulties in scheduling an initial consultation after discharge from the psychiatric emergency prevent an effective integration into the therapeutic programs, reducing adherence to treatment and, consequently, increasing the risk of relapse of the clinical condition that justified emergency room care [15, 16, 17].

In addition, the multiprofessional team that cares for the patient in an emergency situation has the possibility to perform only a cross-sectional evaluation, losing the follow-up of the patient and, therefore, the possibility of observing the evolution of the condition and evaluating the effectiveness of the measures taken in the After discharge from care continuity [18, 19, 20].

Conclusion

This research provided the deepening of the knowledge regarding the challenges of the multiprofessional team to the client in crisis, considering the main actions of the professionals, understanding how this approach is done and the follow up to the client. Therapeutic communication should be practiced by the multiprofessional team in order to strengthen client trust and bonding.

This study presents itself as a strong tool guiding the role of the multiprofessional team in the psychiatric emergency, because it points out the challenges and importance of the continuity of care in mental health after the crisis situation has completed its process.

Ambulatory follow-up and basic care for these clients should be permeated by individual and group visits, in order to enable and share experiences that are gradually being readapted into life and social life. It is observed that many clients go to the outpatient clinic to get the medication and to be seen by the doctor monthly. The need to establish groups in the services would collaborate in breaking the paradigm of the biomedical model, the medication.

The main limiting relevance to this article was the scarce electronically available material for scientific society regarding the possibilities and limits of multiprofessional care to psychiatric emergencies. There is little knowledge production related to the multiprofessional team approach in psychiatric emergencies. It is hoped that new studies will denote such care and that systematizations of experiences may contribute to the deepening of this study.

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