Original Article

Understanding the assistance dynamic of the psychiatric emergency service using the fourth generation assessment*

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ABSTRACT

A study to comprehend the requests, concerns, and questions of professionals about the assistance dynamic of a psychiatric emergency service. We conducted a case study, using the Fourth Generation assessment method, with 15 participants. We collected data using documental analysis, semi-structured interview and observation and, we used the constant comparative method for analysis. Therefore, two thematic axes arose: a) Comprehending the assistance dynamic of the Psychiatric emergency service and, b) The disarticulation of the psychosocial attention network as a barrier to satisfaction with the assistance in the psychiatric emergency. We considered that the assistance dynamic in the Psychiatric Emergency extrapolated the simple, unique character of stabilizing patients with acute mental disorders, once it directs the user's flow to the adequate treatment in the psychosocial attention network.

Descriptors: Emergency Services, Psychiatric; Mental Health Assistance; Psychiatric Nursing; Health Evaluation.

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INTRODUCTION

The National Mental Health Policy regulates mental healthcare in Brazil, through the Law 10.216/2001, addressing humanized and resolutive psychiatric care, using the Psychiatric Reform movement built in 1970's decade by Franco Basaglia in Italy, as pillars to build its assumptions, while at the same time, mental health workers' movement and social moviments were happening in Brazil[1-2].

The Psychiatric Reform aims implementation and consolidation of a Psychosocial Attention Network, a substitute to the manicomial and asylum admittion. It is composed by Psychosocial Attention Centers

(CAPS), Children's Psychosocial Attention Centers (CAPSi), Mental Health Ambulatories; Conviviality Centers; Day Hospital; Psychiatric Emergency Services in General Hospitals and, Psychiatric Attention beds, as care units, inside general hospitals[3].

The Psychiatric Emergency units suffer to install care articulated with the Psychosocial Network, especially in cases related to the risk of suicide. Thus, the Psychiatric Emergency Service constitutes an important tool to direct the demand for mental health care and disease acceptance, in the social and family environments[4]. In this context, we highlight the importance of studies assessing fragilities and potentialities of emergency units[5].

According to imposed challenges by the new mental health attention model, grounded on the deinstitutionalization, the importance of investigations about assistance dynamic are noted, instituted in the psychiatric emergency environment, especially from the nursing perspective, once these can contribute to the decrease of stigmas and prejudice, intermediated by humanized care[6]. At the moment, there is a need to know the global context where care for the mental disorder patient is established, in a way to comprehend the assistance dynamic as a whole and, its relationship with the Psychiatric Attention Network and primary health services [7].

As a knowledge gap, there is a lack of studies assessing the assistance dynamics of new health services contemplated in the Psychosocial Attention Network (RAPS). Therefore, our study is justified by the need of comprehending how health professionals perceive the offered care in a psychiatric emergency service inside a general hospital. Data from this study could subsidize actions to improve the quality of mental health assistance.

Based on the exposed, we question: considering the Psychiatric Reform as Mental Health Attention model, how does the person with the mental disorder is attended in the Psychiatric Emergency unit? Therefore, our study aimed to comprehend the requests, concerns and, questions of professionals about assistance dynamics in a psychiatric emergency service.

METHODS

A case study, conducted in a Psychiatric Emergency unit in a General Hospital, from February to June of 2014, using the Fourth General Assessment as a theoretical-methodological reference, with a hermeutic-dialetic approach, of constructivist and responsive characteristics. It is hermeutic because it has an interpretative character, dialectic because it proposes debate of opinions about the assessment object; it is constructivist, because it allows the (re)interpretation of facts and, at last; it is responsive because it has requests, concerns and, questions of interested groups (Stakeholder) as important aspects the assessment process[8].

As groups of interest, we chose 15 professionals from the health staff of the Psychiatric Emergency. As initial respondent (R1) of the professionals' circle, we elect the person worked at the Service for the longest time. We established the inclusion criteria: to work in the Service for more than six months and to directly

care for people with mental disorder and/or the patient's family. We excluded those professionals who were temporarily allocated in the service.

The assessment process using the Fourth Generation started by the *Contact with the field* (meeting with the Service staff to explain the study objectives and methods); *Identification of members who would compose the group of interest* (who would be indicated by professionals); *Development and expansion of conjunct constructions* (perceptions recognition of members composing the group of interest, as well as, the analysis of documents pertaining to the Service); *Data presentation to the group of interest* (starting from the negotiation process, constituted in the group building organization, information validation and, consensuses verification). At last, *Construction of final results of the assessment process* (definition of thematic axes, according to speeches qualified after negotiation).

We collected the data using Non-Participative Observation techniques (previous etnography); Participative Observation and; Individual Interview, guided by the assumptions of the hemeutic-dialletic circle.

The Non-Participative Observation was performed in February of 2014, with 61 hours of total duration, aimed to recognize aspects of assistance dynamic of the Service.

The step corresponding to the Participative Observation was developed between March to June of 2014, totallizing 152 hours. It aimed to analyze, in a systematic manner, the Service dynamic, once the participative observation allows the researcher to be immersed in the assistance dynamic, offering an inductive analysis and it comprehends the facts built in the investigated reality[9]. During the study period, the researcher actively participated in the assistance dynamic established in the Service.

The material produced in the participative and non-participative observation processes was not used in this article as an analysis product to create analytical categories, but as a support for the inferential construction about the speeches, as well as, it was important to approximate researchers and the study objective, because it allowed the experience in the real service context and, experiences which allowed to know the developed activities.

The hermeutic-dialetic circle started in May with the respondent 1 (R1). At the end of the interview, we asked the respondent to indicate another one (R2). But before the next interview, we analyzed themes, concepts, ideas, values, concerns and central questions, resulting in the construction 1 (C1), which, served as an information source for the R2 interview with the initial questions, and so on.

We used a semi-structured script as an instrument to guide interviews, and initially, it had the following guiding question: "How is the Psychiatric Emergency Service where you work?" ; "What are the fragilities and potentialities of this Service?". As constructions arising after the R1 interview, we included the following questions in the subsequent interviews: "How do you perceive the health attention in the Psychiatric Emergency Service?" and "What is the influence of the mental health attention network in the dynamic of this Service?" Interviews were conducted in a private environment, and we used a digital recorder.

Initially, we analyzed the interview content using the Constant Comparative Method[8]. We listened to

recorded speeches right after its collection to identify the constructions of each respondent and, to be able to present the content of preceeding interviews, in the posterior interviews. Thus, conducting new formulations about questions identified in previous testimonials.

After the end of the hermeneutic-dialetic circle that occurred with the repetition of subjects' indications, we fully transcribed the data, therefore, initiating the organization and analysis phase. We extracted elements from speeches that were thematically similar and, after that, we transcribed the same through extractions, presented in thematic axes and, we discussed them in negotiation meetings, based on the Mental Health National Policy.

The negotiation meetings were previously scheduled, and most interviewed individuals participated. We produced a printed material for this moment, containing the data synthesis from interviews and we gave them to each member. After, we explained the interviews' results by oral presentation and using Power Point, to discuss, validate and negotiate data as priority axis for assessment.

This study followed all ethical and legal requirements of the Decree 466/12[9] and its project is registered in the Ethics in Research with Human Beings Committee of the signatory institution, registry CAAE: 25786714.0.0000.0104. All participants signed two copies of the Free and Informed Consent Term, and the extracts from their testimonials are identified by the letter P (professional) to guarantee anonymity; followed by the number indicating the sequence of conducted interviews and a short characterization.

RESULTS

Comprehending the Assistance Dynamic of the Psychiatric Emergency Service

When analyzing the speeches refering to the (dis)articulation of the Psychiatric Emergency in the general hospital with services composing the Psychosocial Attention Network, we were able to identify the potentialities and fragilities to build a resolutive care.

During the observation, it was possible to identify that the unit frequently received people coming from the Basic Health Units with light mental disorders, requesting psychotropics prescription. On average, this event happened every 10 consultations.

The service is attenting more than it was planned and this ends up imparing our action. If people knew how many consultations we have to do a prescription, and how many patients we put inside, only to medicate and to ask for a spot in the network, these managers would value more our work and resolve the lack of services in the network. (P3 – nurse, 37 years, working for one year and six months in the Service)

The testimonials also pointed to the incipience of substitute services. This fact can be considered as one of the facilitators for the Emergency Service overload.

When we attend a patient that does not have an admission indication, we give the first attention and after we make a referral to other services, like the CAPS, what happens is that the patient always comes back to the emergency and tell us that the place where we referred them to does not attend well [...] (P15 – 29 years, physician, works for two years

and one month in the Service)

We also observed people with issues related to chronic abuse of psychoactive substances searching for the Psychiatric Emergency, although these people did not present any psychiatric intercurrence.

What tumults here are the drug users, they come here many times to run away from crimes, and it gets messy, these days they did a riot because they wanted to be discharged and the physician did not allow [...]. few are the ones who come here to get treated [...] (P13 – 33 years, nursing assistant, works for four years in the Service)

Another detail compromising the assistance dynamic efficacy is the constant attention to children, conducted due to judicial orders for compulsory admission. The constraint of the team when facing this situation can be seen as follows:

One thing that we have a weakness is the attention to children referred by judicial order. Our difficulty is imense because we do not have an adequate physical structure for this type of attention. (P1 – physician, 36 years, works for three years in the Service)

About the staff, the Psychiatric Emergency Service works as a multi-professional team. However, this team is very fragile, once the nursing workers are rearranged daily to help in other hospital sectors. This situation can be seen as follows:

Here we make a miracle with the nursing because see, I am here at the emergency and at the same time I am in the clinic, annd then tell me "how can I do nursing correctly in two places at the same time?" [...] (P12 – 37 years, nurse, works for four years in the Service)

Even with the reduced staff, we verified that during the observation period, even with an inadequate number of professionals, the multi-disciplinary team is diligent to offer a welcoming care.

The disarticulation of the psychosocial attention network as a barrier to satisfaction with the assistance in the psychiatric emergency

Regarding the assistance dynamic established in the Psychiatry Emergency, what called more attention was the disarticulation of the Psychosocial Attention Network with the Service. This proposition can be seen in the following speeches:

People from other services send all psychiatric patients to the Emergency because it is that basic thing of not having service that cares for it in the Network. With this, we are not able to care for all with resolutivity and, it makes us get troubled (P1 – physician, 36 years, works for three years in the Service)

The frequent admission of children in the Emergency is a factor that also aggregates dissatisfaction in the professional work, and this aspect is worsened by the long permanence time of these cases in the Service, associated to the structural fragility for the infant-juvenile attention.

What complicates a lot the care routine here is the admission of children because the Network does not have a structure

for that. So, the way is to admit in the Emergency [...] But it is needed to consider that here is not the adequate place, it is a closed place, of only one corridor, full of adults. [...] it ends up disturbing our way of caring, making us sad to see these kids locked in here (P8 – physician, 31 years, works for three years in the Service)

The RAPS disarticulation with the Psychiatric Emergency Service was previously pointed as the precursor of great disatisfaction among professionals, specially due to de-assistance in health units composing the RAPS, associated to care overload in Emergency units.

DISCUSSION

The precariousness of the mental health care Network results in attention overload in emergency units[10-11]. Another relevant aspect is that although the Psychiatric Emergency Service does not have writing prescriptions as a priority, it fills its role articulating mental healthcare when *"they bring it inside"*, people to be medicated, denoting the compromise with the resolutiveness of cases and consequent bond with the user.

From the professional's conception, users during attention report the assistance in the Psychiatic Emergency as being better, and for this reason, they search for this service instead of being accompanied in other points of the psychosocial attention network.

About the services composing the Psychosocial Network, a study conducted in the west of São Paulo state, aiming to identify actions develped in the Family Health Strategy with mental disorder patients and their families, we concluded that people in need of mental healthcare in the primary attention suffer from de-assistance[12], therefore, denoting the emerging situation of actions for the better practice of mental healthcare in the community.

The RAPS fragility is also present in the treatment context for chemical dependency. In our study, the search for the Psychiatric Emergency care unit, by people in need of care related to chemical dependence happens because of public services' incipence that provide specific care to this population, making the Psychiatric Emergency Service as "The Entrance Door" for attention in the Mental Healthcare Network, which by the described context, is fragile in what concerns the offer of spots.

The fragility of the chemical dependence attention is also a reality in other regions. For example, a study perfirmed a retrospective analysis of the emergency attention demand in the central region of Rio Grande do Sul, and they identified a significant number of consultations, mainly determined by the use/abuse of psychoactive substances, with a higher prevalence of alcohol use[13].

Another problem presented in this study refers to the indignation on the testimonials of P1 and P7 when mentioned that children were "living" in an Emergency Service, with it not having an adequate structure for this type of attention. This aspect denotes the severity of the mental healthcare situation for children. The long term permanence, associated to the lack of adequate structure for child assistance creates the need of discussions about the child's rights, as a way to keep their psychic integrity as a Being who is growing and becoming.

Studies point the de-assistance to children with mental disorders when finding an increase in the demand for occurrences in health units, that, in most cases, are fragilized to assist children and adolescents[14-15].

Therefore, there is a need for managers to attend needs for infant healthcare, established by current ethical norms in public health policies, requiring new ways to structure and transit between Services, aiming to consolidate the welcoming attention, in a way to not reproduce the centric-hospital and segregative model, preconized in asylum psychiatric institutions, therefore keeping bioethical principles as precursors of the humanized healthcare[16].

In some moments, we observe that the emergency units gets fragilized in what concerns specialized mental healthcare, leading to decrease in health actions' quality, associated with worker's overload.

According to fragilities and potentialities pointed by participants, it is possible to affirm that even with many difficulties in building a qualified assistance dynamic, the Psychiatric Emergency Service, inside the general hospital tries to become stronger by acting as a place of humanized care, building health actions according to possibilities offered by this environment.

However, it is possible to assert the lack of services that comprehends the RAPS being a complicator for the quality of Emergency attention[11]. This fact is proven when the professional 1 expresses not to be able to propitiate more resolutive health actions, therefore feeling disatisfied with the quality of the offered care, as well as, with the disappointment of the family member for not having other care options.

The high demand of psychiatric attention in one unique service can fragilize the quality of it; once punctual health actions are conducted, therefore emerging the need of greater intervention by Public Health Policies, to build services including mental health as care object for humanized assistance[17].

The testimonials also made evident the existing discompass in conducting children's treatment with adults in a Psychiatry unit. In the context of children's mental health attention in Psychiatric Emergency, there is the duty to identify the initial clinical case, the risks caused by the presence of a mental disorder, the factors leading to acute clinical case or worsening it, as well as, the presence of family and social support, and of extra-hospital health services to continue the treatment of these children and their families[15].

The health team's concerns considering the judicial admission of youngers were also evident in moments when professionals tried to convince the hospital management about the fragility of the physical structure and of human resources, to get on board with this type of attention. However, there was no success in these negotiation moments, making the team responsible for the disciplinary care of youngers admitted in the Emergency.

In the psychiatric care context, the new way to do mental health requires the construction of health services allowing the consolidation of actions favoring the dynamic care flow in RAPS, for adults, as well as, for children[17]. It aims at a humanizing healthcare transforming the excludent model[18]. Therefore, it is important to broaden the offer of extra-hospital spots for the continuity of the treatment initiated in Emergency units.

In summary, it is possible to infer that the assistance dynamic built in Emergency units constantly fights to articulate with other RAPS services. However, the physical and emotional wear, associated with the professional dissatisfaction, seem to be complicators for the building of more resolutive health actions.

FINAL CONSIDERATIONS

Through this study, it was possible to infer that the assistance dynamic established in the Psychiatric Emergency tries to direct the flow of users to adequate treatments, taking in consideration that the Service constantly fights to relate to the Psychosocial Attention Network, aiming to improve the articulation between care units. Considering all experienced challenges, it is believed that the assistance dynamic of this Service extrapolates the unit character of stabilizing patients with acute mental disorders.

It was also possible to find that professionals were unsatisfied with issues imposed by the de-articulation of the Network with the Psychiatric Emergency, and the greatest challenge is to continue the mental healthcare, as well as, to consolidate the Mental Health National Policy, and, the Humanization National Policy.

According to described fragilities, it is possible to aprehend that the quality of the care offered in the Psychiatric Emergency Service is compromised by the existing decompass between specific aspects of the assistance dynamic, as inadequate physical space for children's attention, high number of consultations, quantitative loss of professionals and, nurses overloaded with activities.

As potentiality, about the use of the Fourth Generation Assessment method, it is possible to affirm that this theoretical-methodological referential which addresses the constructivist research with a formative and responsive focus, make the empowering of groups of interest emerge as protagonists of the needed transformations to improve the Service, once, through negotiation, foreseen in the study methods, it was possible to establish proposals to adequate aspects to be re-structured.

Regarding chidren's attention, we established a construction of a report, by the whole professional team, requesting the execution of an existing project in a medium-term, to build a unit of infant attention, to extinguish mixed attention of children and adults in Psychiatric Emergency Services.

As a limitation of this study, we point to the fact that data reflects the information obtained in a certain moment and in a specific place. Thus, data are subject to temporal and sociocultural influences. Therefore, the process of systematized research in this study does not intend to make generalizations beyond the limits of the study place and, in any moment, it has the intention to exhaust the theme.

To establish plans to improve health units still is a challenge to be surpassed. In this context, the Fourth Generation assessment study allowed to bring out the actual theme and of great relevance for public health, which is the de-institutionalization of the person with a mental disorder in a way to guarantee a resolutive health attention and with quality.

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