

Psychosocial Care Circuit: the systematization of intervention in psychic crisis in mobile pre-hospital care

Circuito dos Cuidados Psicossociais: sistematização de intervenção na crise psíquica no atendimento pré-hospitalar móvel (resumo: p. 14)

Circuito de los Cuidados Psicossociales: sistematización de intervención en la crisis psíquica en la atención pre-hospitalaria móvil (resumen: p. 14)

Renata de Almeida Cavalcante^(a)

<renatacavalcante100@gmail.com> 

Samita Batista Vieira Vaz^(b)

<samitavaz@gmail.com> 

Tiago Silva Vaz^(c)

<vaz.enf@gmail.com> 

Gustavo Carvalho de Oliveira^(d)

<psiquiatragustavo@gmail.com> 

Dais Gonçalves Rocha^(e)

<daisrocha.dr@gmail.com> 

^(a) Programa em Pós-Graduação em Saúde Coletiva (Mestrado Profissional), Faculdade de Ciências da Saúde, Universidade de Brasília (UnB). Campos Universitário Darcy Ribeiro, s/n, Asa Norte. Brasília, DF, Brasil. 70910-900.

^(b, c, d) Serviço de Atendimento Móvel de Urgência (Samu), Secretaria de Estado de Saúde do Distrito Federal. Brasília, DF, Brasil.

^(e) Departamento de Saúde Coletiva, Faculdade de Ciências da Saúde, UnB. Brasília, DF, Brasil.

An experience report that aims to present the systematization of care for the management of psychic crises developed by the SAMU-DF Mental Health Center. The methodology, based on the steps of the Maguerez's Arch, allowed both the identification of professionals' difficulties regarding psychic crises management and the construction of the system called "Psychosocial Care Circuit" to guide the assistance of the mobile pre-hospital care. The Circuit has as mnemonic AEIOU, and each letter corresponds to an element evaluated as necessary for the psychic crisis intervention. Therefore, it is possible to affirm that the permanent education in health enables the transformative action of professionals, in addition to transforming the reality in which they are inserted, and that the systematization has accelerated the consolidation of the necessary skills for psychic crises care.

Keywords: Mental health care. Crisis intervention. Pre-hospital care. Permanent health education.

Introduction

In the mental health field, the expression “crisis” is polysemic, and the practical-theoretical conceptions around the phenomenon determines the approach in caregiving, as well as the types of service available¹. Dias *et al.*¹ argue that not every crisis is a psychiatric urgency or emergency, therefore, the interventions cannot be conducted indiscriminately.

Almeida *et al.*² argue that the urgent and emergency care network is based predominantly in the biomedical frame and that mental health crises are understood as psychiatric emergencies due to its harm to the health and emotional and behavioral instability of the patients.

Moura *et al.*³ consider that the notion of psychiatric crisis is historically hegemonic in the mental health field, but the psychosocial paradigm proposes a severance from that simplification, as it understands the crisis as a complex and multifaceted phenomenon, which includes the life context as well the network of people in psychic distress.

The Pan American Health Organization⁴ understands that the intervention work in crisis situations, which aids individuals that lived through situations of extreme anguish, includes both psychological and social support. Therefore, based on the references of the psychosocial model, the term “psychic crisis” is used in place of “psychiatric crisis” to refer to the process of aggravated mental distress.

The post-pandemic context of covid-19 is causing a devastating impact in the mental health of peoples, a growing number of people have been experiencing episodes of psychic crises and severe mental disorders. In light of this, several studies have highlighted how important it is for countries to strengthen their responses to the demands of the people’s mental health, demanding more coordination from the health services to guarantee resolution in caregiving^{5,6}.

Knowledge of the critical points, for the implementation of a line of care in mental health, is necessary, as well as the shared responsibility of actions and services within the Health Care Network (RAS). The ordinance No.4.279, of December 30, 2010⁷, establishes the guidelines for the organization of RAS in the scope of the Brazilian National Health System (SUS), and recognizes the need to overcome the fragmentation of the care, seeking to assure the user of the completeness of the care. Thus, this ordinance highlights the importance for building horizontal relationships between the lines of care, from primary to urgent and emergency care.

Once it was understood that the current model of healthcare showed itself insufficient to answer the sanitary challenges, that there were weaknesses in the Psychosocial Health Care Network (RAPS), and the need to widen the care to situations of crisis and urgency in mental health, the *Portaria de Consolidação* No.3, of September 28, 2017⁸, which redefines the guidelines for the implementation of Mobile Emergency Care Service (SAMU), states that the care to “psychiatric crises” are also SAMU’s responsibility⁹.

In Brazil, however, several ordinances that built the country's mental health policy with the conception of an open, community-based model, were revoked in the last four years¹⁰. The new project stimulates psychiatric hospitalization, funding of therapeutic communities and reinforcement of a punishable and prohibitionist approach to issues from alcohol use as well as other drugs. These changes represent a dismantling to the Mental Health National Policy and a regression of the achievements from the psychosocial care field and the consolidation of RAPS.

Almeida *et al.*¹¹ explain that episodes of crisis demand immediate professional care, which must be guided by practical-theoretical knowledge, "coherent with the transformative processes that impact professional interdisciplinary practice and aligned with current public policies on mental health policies" (p. 709). Therefore, it is possible to affirm that hospitalization in psych crisis situations requires from health professionals technical skills and rational competences, such as careful listening, accurate assessment of protective factors and effective search for solutions aimed at self-efficacy, among others¹².

Rosa *et al.*¹³ mention that the pre-hospital mobile care often is one of the first health staff to reach the person that needs immediate service, and that this care can influence the prognosis of the patient in crisis.

Mental health service is often in the daily work of SAMU professionals. Several studies highlight the importance of ongoing education processes when it comes to this service, for several professionals recognize their own fragility and doubt that they have enough knowledge and skills for the task^{2,11,14-19}.

In the Federal District (DF), given the expressive number of consultations to patients with mental distress by SAMU-DF, the Mental Health Centre (NUSAM), was implemented, composed by two forms of consultation: stationary (teleconsultation) and mobile (consultation *in loco*)⁹. NUSAM is a crisis intervention service within the pre-hospital service and is considered a pioneer in Brazil due to its interdisciplinary work, with a team composed of social workers, psychologists, psychiatrists, nurses and emergency drivers^{9,20}.

The stationary form is a base located at the Medical Regulation Centre of SAMU, where a social worker or psychologist from the mental care staff welcomes and listens to demands, followed by guidance, referrals and other conduct assessed as pertinent in psychosocial care. These actions are discussed with a regulatory physician; a health authority responsible for recognizing emergencies and managing the available resources⁹.

The mobile form is a vehicle driven by a multidisciplinary staff that hospitalizes the patient in crisis in private or public places and ensures the first psychosocial care. This intervention aims to help patients and their networks with strategies for overcoming the crisis and the search for services and social support^{9,20}.

Furthermore, NUSAM took over the ongoing mental health education processes as a work front and developed a systematization of care for the management of psych crises. Since 2016, the center has been developing training for psych crisis intervention to health professionals and other sector policies from DF and other states, as well as students from several fields^{9,21}.

Since acknowledging the demand of emergencies in mental health and the expertise of SAMU-DF in the psychic crisis care, the Brazilian Ministry of Health (MS) promoted in 2021 together with the SAMU-DF Emergency Education Center (NUEDU), the first training for emergencies in mental health called *I Curso de Formação de Multiplicadores em Urgências e Emergências em Saúde Mental*, seeking to qualify SAMU professionals from every Brazilian state to handle psychic crises, based in the systematization of care created by NUSAM. In 2022, the second edition of the training was made. In both editions, more than 500 professionals were qualified.

In this sense, this study seeks to introduce the systematization of care for the management of psychic crises created by NUSAM, called Psychosocial Care Circuit.

Methodology and systematization context

This is an experience report based on the steps of the active methodology with Maguerez's Arch, along the lines proposed by Colombo and Berbel²² (Figure 1). This report describes the creation process of the systematization of care for the management of psychic crises, which took place in the development of the training sessions held by NUEDU in collaboration with NUSAM between 2016 and 2022 and involved approximately 50 editions of training and more than 4 thousand participating professionals, from which around 47% were SAMU professionals.

The training of intervention in psychic crisis was made and operated by SAMU-DF employees to guide the staff of mobile pre-hospital emergency care. Furthermore, due to frequent external requests for professional training in mental health emergencies, these trainings were extended to workers from other health services, as well as to professionals from other sector policies.

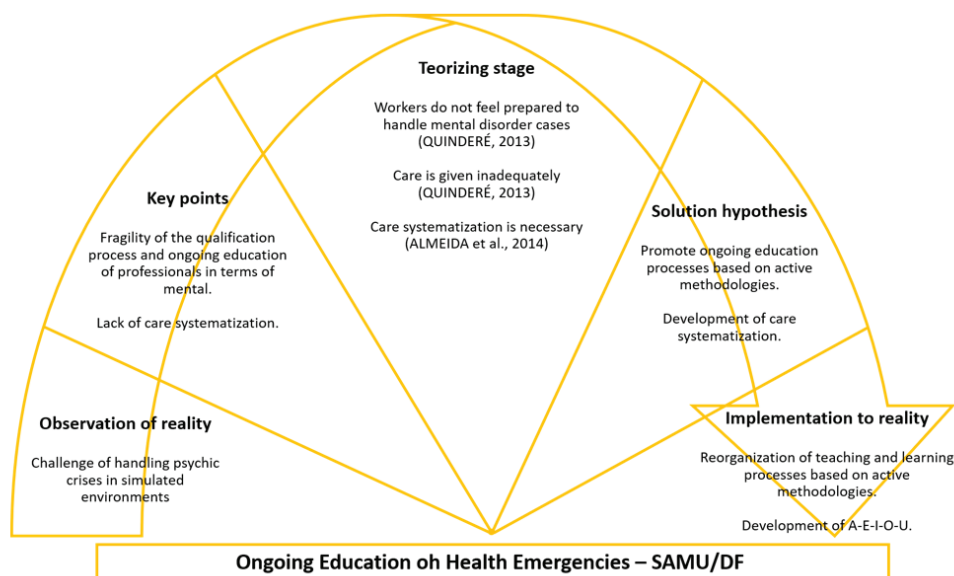


Figure 1. Context of systematization in Maguerez's Arch.



The Magueréz's Arch method has five stages: observation of reality, key points, theorizing, solution hypotheses and application to reality²².

Observation of reality is the stage which observes a portion of the reality which is being lived to identify a problem and seek a response to it²³. NUSAM has implemented training to SAMU-DF professionals considering the growing demand of emergencies in mental health in SAMU 192's context as well as the struggle professionals have shown in dealing with the management of this care. Then the training was amplified to professionals of different health services: primary health care, psychosocial care centers, hospital care, as well as to professionals from other public policies: education, social assistance, public safety, children and youth. This broadening of the audience was due to the frequent calling on SAMU by professionals from other services and policies.

The strategic audience for the courses included doctors, nurses, social workers, psychologists, occupational therapists, among other health professional categories, without defining the proportion in each category. Participation required a registration process based on spontaneous demand, with priority given to SAMU workers and limited vacancies. In order to include the greatest number of services as possible, no rigid selection criteria were adopted. The activities took place on an interprofessional basis, with the aim to ensure an interactive process capable of reflecting on collaborative health care and, consequently, improving the quality of care provided.

The courses were given in-person, in theoretical-practical nature, with 16 hours focused on dialogical explanations and case studies and 4 hours intended for monitored practical activities. The following topics were addressed: Therapeutic communication and psychosocial first aid; Mental disorders and disorders associated to drugs and alcohol use; Suicidal behavior; Communicating bad news; Psychotic crisis and psychomotor agitation; Violence and mental disorders. In the monitored practice, therapeutic containment techniques were discussed and applied.

After several editions of the course, it became noticeable that the professionals, even after theoretical explanations, kept having difficulties with the management of psychic crises and elements considered fundamental in the staff's practical intervention were not recalled during service. Noticing this was possible through observation of realistic simulation scenarios for intervention in psychic crises and through reports made in evaluation rounds at the end of the training sessions. Therefore, some strategies needed to be revised to improve the process of health education. The reports were registered in writing by the participants, anonymously, by the end of each training and later categorized by the course instructors into facilitating aspects, hindering factors and suggestions. Moreover, several reports were secured within a field diary.

Seeking to comprehend the complexity of the problem, some key points were brought up that related to possible factors that influenced it. The empiric observation, the dialogue with the training participants and the discussion of these aspects with the instructors led to the identification of these key points: at first, the fragility within the qualification process and ongoing education of SAMU



professionals in regard to mental health topics, which led several professionals to recognize their own insecurity and to doubt they have the necessary knowledge to intervene in psychic crisis cases; secondly, the lack of a systematization to perform the psychic crises care, as the care process of emergency services, especially in clinical and trauma occurrences, commonly develop the technical formalization of their practices in the form of protocols²⁴.

In the theorizing stage, more elaborated responses to the problem were sought based on exploratory studies in scientific literature. Thus, a literature review of journals indexed in the scientific databases SciELO and BVS was made. This search found several studies that highlight the need for processes of ongoing education. In a study carried by professionals of pre-hospital care, Almeida *et al.*¹¹ came up with two results:

[...] first, that the difficulties in caring for people in crisis in mental health are linked to the staff's lack of knowledge about how to provide care; and the second is the suggestions made by participants in the search for a service that is closer to desired, such as training and the need to systematize care¹¹. (p. 713).

At this point, supported by a dialogue with international literature from journals indexed in PubMed, the possibilities as “solution hypotheses” were reflected on to satisfactorily answer the problem and to plan resolute strategies so that they could be applied to reality.

In a Swedish pilot project, with a psychiatric emergency response team formed by nurses, knowledge and specialized skills in mental disorders and initial service options were identified as fundamental to specialized care²⁵.

Other authors mention that education programs for approaches in psychic crises cannot be focused solely on controlling the “scene” and that dialogue and the patient's experience must be taken into account in order to guarantee good care²⁶. Finally, the multi-professional mental health team that regularly attends ongoing education processes have increased levels of confidence and knowledge, especially in high-risk situations for the patient²⁷.

Then, the importance of promoting processes of ongoing education through active teaching-learning methodologies, such as realistic simulation and problematization, and the need to build up a systematization of care was settled. Villela *et al.*²⁸ note that “adoption of active methodologies seems to be a viable way to achieve the pedagogical proposal of mental health teaching and training of competent professionals” (p. 397).

In light of that, in the year of 2020, a new methodological proposal of the psychic crises intervention course was made by NUEDU, to qualify even SAMU professionals from every state of Brazil. The syllabus was taught partly through distance learning, using the inverted classroom methodology through synchronous classes, and part in a face-to-face module, at the center's headquarters, where the simulated stations and monitored practices²¹ occurred. In regard to the workload of

the content and activities related to the themes of emergencies in mental health, 30 hours were focused on the study of the teaching material, which was made available previously, and on the synchronous classes and 10 hours were intended for the simulated stations and monitored activities. A version of this course, its updating mode, happens monthly at NUEDU, with a workload of 10 hours, aimed at the SAMU-DF professionals.

Finally, in the implementation to reality, which consists of practical intervention, the first author of this study, a social worker of NUSAM, built up a systematization of care to psychic crises, called “Psychosocial Care Circuit”, to guide professionals in pre-hospital emergency care and reorganize the teaching and learning processes based on active methodologies. Colombo and Babel²² show the transformative role of this stage as a moment that allows the fixation of the produced solutions, in addition to contemplating the participants’ engagement to return to the same reality.

Results and discussion

The Circuit of Psychosocial Care was based on the reference of psychosocial care and scientific evidence from the field of intervention in crisis^{29,30}, psychosocial first aid⁴, therapeutic communication³¹ and the National Humanization Policy (PNH)^{32,33}, as well as on the experience of NUSAM professionals in the care of psychic crisis.

It is worth noting that these understandings and contents were part of the crisis intervention training, but were not presented in a systematic way or in the form of a protocol.

Regarding the choice of elements of analysis of systematization, the reception of patients is based on the guidelines of the PNH³², since it is part of all health services. The PNH places listening and guidance as central elements of reception, as it understands the reception as a response to the demands of individuals seeking health services³⁴.

The element “identification of risk and protection factors” is widely discussed in the literature of the field of intervention in crisis³⁵ and psychosocial first aid⁴ because understanding the conditions that involve the subject is fundamental to ensure a more assertive service, so that the process of completion of this intervention (“ultimation”) may bring a perspective of resolution to the subjects involved in the problem⁴.

Consequently, the authors arrived at the following elements: *Acolhimento* (Reception); *Escuta ativa* (Active listening); *Identificação de fatores de risco e proteção* (Identification of risk and protection factors); *Orientações* (Guidance); and *Ultimação* (Ultimation). Each element, represented by the initial letters “AEIOU” (Figure 2), has a concept and an objective, and is evaluated by the authors as necessary while approaching people in psychic crisis.

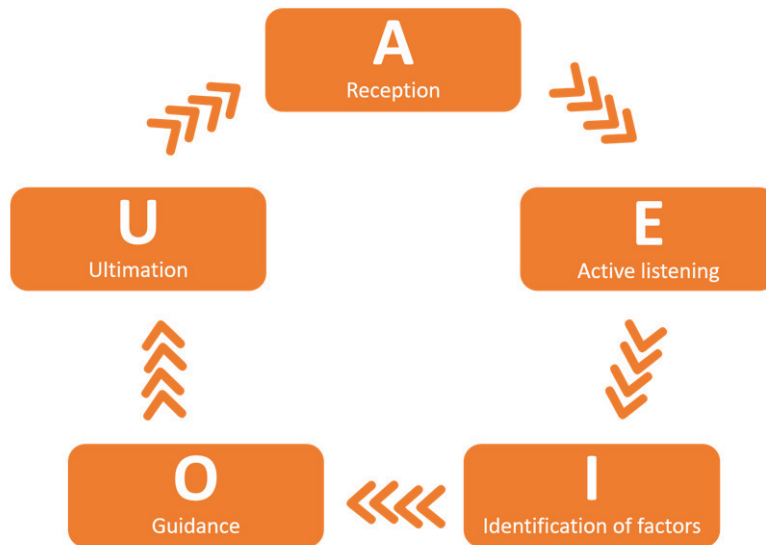


Figure 2. Psychosocial Care Circuit

The reception (A) refers to the moment of arrival of the user to the health service, it also concerns the construction of a relationship of trust between the health teams, the individual and his social and family network, in a humanized approach, characterized by the recognition of the user as an active subject in the health production process³⁴.

The focus of the reception is to offer support and practical care and help people feel safer, respected and cared for appropriately, considering the uniqueness of each person⁴. Therefore, as pre-hospital care is fast, directional and punctual, professionals use the techniques of therapeutic communication to facilitate the process of reception: introduce themselves, address the patient and call them by name, look into their eyes, use a calm tone of voice, provide support, check vital signs, among other possibilities.

Active listening (E) aims to understand people's needs and help them feel calmer⁴, and should be free from moralizing judgements¹². Maynard *et al.*³⁶ point to listening as a light technology, which enables the understanding of psychic suffering based on the discourse of the subjects; therefore, it values the individuals' experiences, being considered synonymous with trust and respect for uniqueness.

In emergency care, the professional's task is to "listen to how people visualize the situation and how they communicate"³⁰. Thus, it is believed that the professional should adopt a posture of support, listening and validating the discourse of pain experienced by each individual, ensuring comprehension, interacting with open/closed questions, assisting people in the search for options and perspectives of life^{4,31,36}.



The identification of risk factors (I) is related to the analysis of the problem from three moments: immediate past, present and immediate future. It is necessary to understand the events that triggered the crisis; then, to question the present situation: “who is involved, what happened, how, where, when”; and, finally, to focus on the difficulties established in the people and the family³⁰. There are several risk factors (psychological, social, mental disorder, etc.) that can influence the development of a crisis, and the interaction between them is more relevant for risk assessment than considering each factor alone. Moreno *et al.*³⁰ say the goal is to identify conflicts that need immediate management and those that can be left for later intervention.

Regarding the identification of protective factors (I), there should be an evaluation of which resources (individual and environmental) support the individual in coping with adverse life events³⁵. Cardoso *et al.*³⁵ highlight several factors considered important for young people and adolescents, for example: being close to trusted people and having social support.

In the context of pre-hospital care, it was identified that social and family support is among the most powerful protective factors for the individual, regardless of their life cycle, given that a quality network can help them face this moment of rupture more assertively.

The guidance (O) aims to assist people in the search for information and social services available, and should be addressed to individuals in crisis and to their support network⁴. It is understood that these are conducts that face the possibilities of crisis management, care transition and possible referrals.

In order to do this, the professional must know the network of health services and other sector policies. Even if they do not have all the information sometimes, it is necessary that the professional know how to learn it and keep up to date, in order to ensure that people know about these services and how to access them⁴.

Oftentimes, the patient, the family and the health team will not be in agreement over the concept of the crisis nor over a certain intervention¹³. People who are distressed about a problem may perceive that their expectations of support have not been met. In these moments, the professional’s role is also psychoeducational. Lemes and Ondere Neto³⁷ approach psychoeducation as a work of health awareness, which aims to teach and offer information to the subject and their trusted social network about their current state of health, the procedures to be adopted, the perspectives of treatment, among others.

The ultimatum (U) refers to the immediate outcome of the service and the agreements established. The way the care will be finalized, like the time required for the proper management of the crisis, will depend on the context of the crisis, people’s demands and the action of the professional⁴. Moreno *et al.*³⁰ report that the person responsible for conducting the intervention should have a facilitating and directive attitude to achieve effective actions.



At this stage, the professional should convey an optimistic but realistic perspective of improvement. It is important to summarize the facts and resolutions found, recall agreements made and, if possible, request that the patient or his support network repeat the orientations³¹. When indicating that they seek some specialized service, the professional should reinforce that this is a fundamental conduct to obtain improvements, since the people who receive adequate follow-up tend to lessen their distress and get well⁴.

Finally, procedures are established that allow a brief follow-up to verify the individual's personal progress and their insertion in the network of referenced services. The follow-up is performed through telephone contact within 72 hours after the service. Bertolote *et al.*³⁸ point out that, in a study conducted in Campinas with people who attended emergency services after an attempt at suicide, a follow-up made through periodic phone calls decreased suicides tenfold compared to the group that did not receive this follow-up. Moreno *et al.*³⁰ cite that this procedure aims to "complete the feedback circuit, or determine whether or not they achieved the goals established when the intervention began".

Final considerations

Given the understanding that problematizing practices in health education enable a transformative action of professionals and the reality in which they are inserted, it is possible to infer that, from these constructions of knowledge, the components of the proposed systematization have the potential to overcome critical factors of the intervention and to favor new human and technical skills in the professionals who work in the mobile pre-hospital service, allowing them to perform humanized care alternatively to exclusionary practices historically performed on people in mental distress.

It is necessary to highlight that the Circuit of Psychosocial Care does not consist of a standardization of care and should not be used in a rigid way, given the understanding that each approach is unique and will take into account the individual and the context in which they are inserted.

Without any intention of ending this discussion, we understand that, because this study is an experience report, a type of production built in a similar way to observational researches, its limitations come from the lack of an in-depth analysis and the production of evidence of the effectiveness of the courses from the systematization of their evaluations.

Therefore, the evaluation of the effectiveness of the ongoing educational process at the national level will be the subject of another research. However, the preliminary results show that the systematization has facilitated and accelerated the consolidation of the skills necessary to deal with psychic crises, from the point of view of both the instructors and the reports of the participants of the ongoing educational process. The authors' next steps go in the direction of validating this systematization of care.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Um relato de experiência que visa apresentar a sistematização de atendimento para o manejo de crises psíquicas desenvolvida pelo Núcleo de Saúde Mental do Samu-DF. A metodologia, fundamentada nos passos do arco de Maguerez, permitiu desde a identificação das dificuldades dos profissionais no manejo das crises psíquicas até a construção da sistematização denominada “Circuito de Cuidados Psicossociais” para orientar a assistência no serviço pré-hospitalar móvel. O circuito tem como mnemônico “AEIOU”, e cada letra corresponde a um elemento avaliado como necessário na intervenção de crise psíquica. Assim, é possível afirmar que a Educação Permanente em Saúde possibilita uma ação transformadora dos profissionais e da realidade na qual estão inseridos, e a sistematização tem acelerado a consolidação das habilidades necessárias ao atendimento das crises psíquicas.

Palavras-chave: Atenção à saúde mental. Intervenção na crise. Atendimento pré-hospitalar. Educação permanente em saúde.

Un relato de experiencia cuyo objetivo es presentar la sistematización de atención para el manejo de crisis psíquicas desarrollada por el Núcleo de Salud Mental del SAMU-DF. La metodología, fundamentada en los pasos del arco de Maguerez, permitió desde la identificación de las dificultades de los profesionales en el manejo de las crisis psíquicas hasta la construcción de la sistematización denominada “Circuito de Cuidados Psicossociales” para orientar la asistencia en el servicio pre-hospitalario móvil. El circuito tiene como iniciales mnemónicas “AEIOU” y cada letra corresponde a un elemento evaluado como necesario en la intervención de crisis psíquica. De tal forma, es posible afirmar que la educación permanente en salud possibilita una acción transformadora de los profesionales y de la realidad en la cual están inseridos y que la sistematización ha acelerado la consolidación de las habilidades necesarias para la atención de las crisis psíquicas.

Palabras clave: Atención a la salud mental. Intervención en la crisis. Atención pre-hospitalaria. Educación permanente en salud.