Psychiatric emergency services and their relationships with the mental health network in Brazil

Serviços de emergência psiquiátrica e suas relações com a rede de saúde mental brasileira

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Abstract

Objective: To review the literature concerning the role and the inclusion of psychiatric emergency services in mental health networks. **Method:** We performed a search in online databases (PubMed and SciELO) for empirical articles and reviews about psychiatric emergency services and networks of mental health services. **Results:** Psychiatric emergency services are a crucial part of well-structured mental health networks, both due to their role in the management of emergencies proper and to their function in the regulation of the network they belong to. Emergency psychiatric services are related to all inpatient and outpatient services, which enables them to organize the flow of admissions and to prevent the overload of the mental health network. The functions of emergency psychiatric services are broad and go beyond the simple referral for hospitalization, encompassing the clinical stabilization of acute cases and the provision of psychosocial support. In Brazil, these functions were expanded after the mental health reform and the overload of the mental health network resulting from the difficulties and limitations of inpatient and outpatient services. **Conclusion:** Emergency psychiatric services must be valued and expanded; especially those located in general hospitals. It is suggested that investment in psychiatric emergency services be a priority in Brazilian public health policies to improve mental health care.

Descriptors: Emergency services, psychiatric; Mental health services; Community psychiatry; Psychiatric department, hospital

Resumo

Objetivo: *Revisão de dados da literatura relativos ao papel e à inserção de serviços de emergências psiquiátricas em redes de saúde mental.* ***Método:*** *Foi realizada uma busca em banco de dados (PubMed e SciELO) de artigos empíricos e revisões sobre serviços de emergências psiquiátricas e rede de serviços de saúde mental.* ***Resultados:*** *Serviços de emergências psiquiátricas constituem unidade central para o funcionamento adequado de redes de saúde mental, tanto pelo manejo de situações de emergências, como pela regulação da rede em que se insere. Os serviços de emergências psiquiátricas relacionam-se com todos os serviços hospitalares e extra-hospitalares, possibilitando a organização do fluxo das internações e evitando sobrecarga da rede de saúde mental. As funções dos serviços de emergências psiquiátricas são amplas e extrapolam o simples encaminhamento para internação integral, pois estabilização clínica e suporte psicossocial podem ser alcançados em serviços de emergências psiquiátricas bem estruturados. No Brasil, estas funções foram ampliadas após a Reforma da Assistência à Saúde Mental e a sobrecarga das redes de saúde mental provocadas pelas dificuldades e limitações dos serviços hospitalares e extra-hospitalares.* ***Conclusão:*** *Serviços de emergências psiquiátricas devem ser valorizados e ampliados, principalmente aqueles localizados em hospitais gerais. Recomenda-se que o investimento em emergências psiquiátricas seja prioridade das políticas de saúde pública brasileiras para o aprimoramento da atenção na saúde mental*

Descritores: *Serviços de emergência psiquiátrica; Serviços de saúde mental; Psiquiatria comunitária; Unidade hospitalar de psiquiatria*

Introduction

Over the last decades, the psychiatric practice has undergone profound changes aimed at providing treatment alternatives in mental health which are able to prevent long-term hospitalizations in psychiatric institutions. Consonant with the objective of the mental health assistance reform, a service network has been organized to provide outpatient care to psychiatric patients,

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including psychosocial attention centers, specialized outpatient clinics, and primary attention services. Additional strategies in this sense include the implementation of partial hospitalization services such as day-hospitals, the creation of psychiatric beds in general hospitals, and the expansion of the functions of psychiatric emergency services (PESs) for the management of patients in acute episodes.[1]

In the United States, specialized PESs appeared in the 1960s as one among the five services considered essential by local policies for community mental health assistance. This assistance network should also encompass outpatient services, full-time and partial hospitalization, and consultation liaison. In the subsequent decade, seven additional assistance programs were included in this list of essential services.[2]

In Brazil, patients in acute episodes rarely had priority in public health policies. Until the reform in the mental health assistance, which began in the 1980s, most of these patients were assisted at the entrance door of mental health institutions, in an improvised manner at the several non-psychiatric health services, or using non-medical approaches like those provided in law enforcement and religious settings. Some PESs came forth as isolated initiatives of university centers or public hospitals, especially in larger urban centers. There was no concern about integrating the few specialized PESs with the other units that were part of the mental health network. Even today, data related to the attention in psychiatric emergency are scarce and, to the best of our knowledge, there is no information concerning the distribution of PESs in the Brazilin territory.

The definition of the essential aspects that characterize those psychiatric interventions that could be termed as emergency, as well as of the specificities of services aimed at providing this type of assistance, is not a simple task, with poor agreement between the different conceptualizations and the difficulty to establish accurate definitions. Furthermore, the distinction between urgency and emergency used in the general medicine seems to be of little use for the psychiatric practice.[3]

Psychiatric emergencies can be defined as conditions in which disturbances in thought, emotions or behavior require immediate medical assistance aimed at avoiding greater impairments to one's mental, physical, and social health or at eliminating possible risks to one's life and to the life of others.[4] This group includes both patients with a history of chronic psychiatric disorders in relapse and people with no previous psychiatric history in an acute episode.

Psychiatric emergencies can also be defined as any behavioral disturbance that cannot be quickly and adequately managed by the health, social, and law enforcement services existing in the community.[2] This definition suggests that psychiatric emergencies are not the exclusive result of any given psychopathological alteration, but include the characteristics of the services offered by a certain region in which the person is inserted.

The promptness in the management of cases – crucial for the proper functioning of an emergency service – may imply some limitations, related both to the treatment of the patient and to the training of the healthcare staff to act in this type of service. In general, PESs have few beds available for a better observation and follow-up of cases, which often leads to an early decision for full-time hospitalization. Outpatient services do not always possess a structure offering the same promptness found in the emergency room. Difficulties in scheduling an initial follow-up consultation after release from psychiatric emergency hamper the effective integration of therapeutic programs, decreasing treatment adherence and increasing, thus, the risk of relapse of the clinical condition that motivated the admission at an emergency room. Additionally, the medical staff assisting the patient in an emergency situation is only able to perform a cross-sectional evaluation, missing the follow-up and, with it, the possibility to observe the evolution of the case and to assess the efficacy of the measures taken at the service. Alternatives to attenuate the impact of these limitations include the expansion of support services for emergency assistance, associated with an effective integration between the professional teams working in the different services that provide assistance to psychiatric patients.

This article describes a review of the relationships between PESs and the other services that constitute a mental health network, assessing possible changes brought about by the guidelines of the reform in mental health assistance.

Psychiatric emergency and the reform in mental health assistance

As mentioned previously, the reforms in the mental health assistance have redirected the model of attention based essentially on large asylums toward a diversified and articulated network of outpatient services, with hospitalizations reserved for acute episodes.[5] The changes in mental health policies, with an emphasis on outpatient treatment, led to an increase in the number of patients in the community who are subject to relapse, sometimes repeated, requiring the increasing use of PESs.[6]

As a consequence, PESs took over a new role in the design and functioning of the mental health services network, fostering a better relationship among these services.[2] PESs became central in the functioning of mental health services because, in addition to acting as the main entrance door to the system[7] and to organizing the flow of hospitalizations,[8] they contributed to the reduction of unnecessary hospital admissions[9] and enabled a better communication between the different units of the healthcare system.[10]

These changes in the assistance network led PESs to expand their functions as a result. Thus, in addition to performing the triage of cases for hospitalization, they also took over the role of stabilizing and implementing the treatment of acute cases, besides providing psychosocial support.[11] In this new framework, PESs would have quick and effective assistance as their goals, seeking to characterize the diagnostic, etiologic, and psychosocial aspects of the patients' conditions, enabling their treatment in the short term and defining the type of treatment that would best fit the patient in the medium and long terms.

Table 1 – Main changes in the Brazilian mental health network between 2002 and 2009

	2002	2003	2004	2005	2006	2007	2008	2009
Estimated Brazilian population	176.303.919	178.741.412	181.105.601	183.383.216	185.564.212	187.641.714	189.612.814	191.480.630
Number of *CAPS*	424	500	605	738	1010	1155	1326	1467
Number of psychiatric beds	51.393	48.303	45.814	42.076	39.567	37.988	36.797	35.426
Outpatient expenses*	153.31	226.00	287.35	406.13	541.99	760.47	871.18	1012.35
Inpatient expenses*	465.98	452.93	465.51	453.68	427.32	439.90	458.06	482.83
% outpatient expenses/total expenses	24.76	33.29	38.17	47.23	55.92	63.35	65.54	67.71

CAPS: Centros de Atenção Psicossocial (Psychosocial Attention Centers); * *in millions of Brazilian Reais*

PESs are extremely sensitive to the dynamics of the mental health service network they belong to. The low availability of beds for psychiatric hospitalizations and the inexistence or ineffectiveness of outpatient services may increase the demand in PESs because of the access facilities offered by these units.[12] The excessive demand might lead to a greater rotation of patients at PESs, resulting in inaccurate diagnoses, excessive referral for full-time hospitalization,[13] and increased re-hospitalization rates.[14]

Mental health policies in Brazil have been based on a modification of the structure and communication between services.[15] In the mid 1980s, the movement known as "Psychiatric Reform" had a significant growth.[16] Consonant with world guidelines, a central aspect of the Brazilian movement was the closure and progressive disengagement of psychiatric beds.[17] There was a gradual decrease in the number of beds in psychiatric hospitals, which were no longer the core of the assistance system, now fundamentally based on a network of increasingly complex outpatient services.[18] Table 1 describes the main changes in the Brazilian mental health network over the last years.[19]

With these changes in the policies of assistance, PESs also began to perform a new function within the mental health network. Initially, they started to act as the main entrance door to the mental health network.[20] Afterwards, they became responsible for the regulation of this network, preventing the use of unnecessary hospitalizations and significantly reducing the overload of psychiatric beds.[21]

In many countries, including Brazil, most first psychotic episodes are initially managed by PESs.[22] Therefore, PESs can play a pivotal role in the management of acute cases of psychotic disorders, mood disorders, disorders related to the use of psychoactive substances, and personality disorders.[21]

Psychiatric emergency services and psychiatric hospitalization units

The first Brazilian psychiatric hospitalization units appeared with the purpose of providing social and humanitarian care to the so called "lunatics". This function was undertaken mainly by the religious order *Irmandade de Misericórdia* (Fraternity of Mercy) through the Holy Houses, which had a prominent role in the appearance of the earliest Brazilian asylums.[23] Until the beginning of the decade of 1990, the psychiatric treatment was mostly centered in psychiatric hospitals and outpatient options were limited.[24] Most of the specialized assistance in psychiatric emergency was restricted to the admission sectors of the asylums and, therefore, virtually all the patients in an emergency situation were treated in the asylum environment.[25] In this period, PESs had a secondary role in the mental health network, performing at best the restricted function of referring patients for full-time hospitalization.[26] Since many admissions in psychiatric hospitals required no referrals to specialized care and could be decided upon by the hospital services themselves ("door admissions"), PESs received no investments or incentives to expand their functions.[27]

The relationship between PESs and traditional psychiatric hospitalization units has changed as a result of deinstitutionalization policies. The deleterious effects of macro-hospitals, the scandals involving mentally ill patients, the recognition of the necessity to improve their freedom and quality of life, as well as the search for more humane treatment options justified the dismantling of the asylum model[28,29] and highlighted the value of PESs as units qualified to manage patients in acute episodes.[30]

Such management is not limited to the control of the behavioral problems that motivated the admission at an emergency service and to the decision on the need for hospitalization. The assistance at PESs includes an accurate diagnostic evaluation and the institution of the proper treatment for the management of the clinical condition underlying those psychopathological and behavioral manifestations.[31] The systematic use of essentially technical criteria to decide on the need for hospitalization in a psychiatric hospital may significantly contribute for the reduction of unnecessary psychiatric admissions.[20] Additionally, brief hospitalization at PESs can be enough for the management of a significant portion of patients in acute episodes,[21] restricting the use of beds in psychiatric hospitals to those patients that would really benefit from longer hospitalization periods.

Psychiatric emergency services and general hospitals

The need for a broader and more humane therapeutic proposal has stimulated the appearance of psychiatric hospitalization units in general hospitals (PHUGH).[32] This proposal brought about a reduction in the stigma and prejudice associated with mental illness,[33] as well as a closer relationship with other medical specialties, resulting in the provision of a more universal care for patients.[34] Despite the advantages that psychiatric hospitalizations in general hospitals might offer in terms of diagnostic evaluation and clinical management of patients in relation to traditional hospitalizations,[35] some obstacles remain for the implementation of PHUGH.[36] In Brazil, the resistance against the implementation of PHUGH was noticeable in the public administration itself, as well as among the managers and medical staffs of hospitals. As a consequence, few PHUGH exist today and most of them are found in the most economically developed Brazilian regions.[37]

PESs linked to general hospitals incorporate this expanded treatment proposal,[38] maintaining an evidence-based approach for healthcare, since they assess and seek to manage clinical comorbidities in addition to the primary psychiatric disorders.[39] PESs in general hospitals are the first choice for the referral of cases requiring better clinical and surgical support, such as alcohol abstinence syndromes,[40] suicide attempts,[41] and acute confusional states, in addition to psychiatric patients suffering from clinical and surgical conditions that require the support of intensive or semi-intensive care units.[42]

Ideally, a properly structured mental health network should have PESs combined with PHUGH, preferentially within the same hospital unit. This relationship can provide individually tailored assistance to patients;[43] for example, by prioritizing the prompt management of first psychotic episodes, avoiding the adverse effects of long hospitalization periods between the onset of the episode and the beginning of the treatment.[44] The shortage of beds in psychiatric hospitals and the resulting lack of vacancies for psychiatric hospitalization[45] cause PESs that support PHUGH to be overloaded by cases with comorbid clinical conditions, which demand longer hospitalization periods.[46] In larger metropolitan areas, following the increasing demand of emergencies in other clinical and surgical specialties, PESs end up functioning as hospital units as they maintain patients hospitalized for longer periods.[47]

Psychiatric emergency and outpatient services

The functioning of outpatient services has a direct influence on the dynamics of PESs.[48] Well-organized and efficient outpatient networks capable to quickly manage acute episodes may significantly decrease the referrals made by PESs for full-time hospitalization.[49] On the other hand, PESs are the reference units where non-hospital services are insufficient or inexistent,[50] with a significant association existing between problems in the functioning of the outpatient mental health network and the increased number of hospitalizations and re-hospitalizations[51] and the number of visits to PESs.[52] Since PESs work 24 hours a day and usually offer free access, it is natural that unassisted patients and their relatives overload these facilities, which in turn have to deal with the exceeding demand of inefficient outpatient services.[53]

Factors that are intrinsically related to the functioning of outpatient services, such as restricted multiprofessional assistance,[54] limited therapeutic proposals,[55] vacancy shortage,[56] medication availability issues, and overload due to demands related to the justice system[57] imply difficulties for the stabilization of patients in acute episodes. As a result, PESs counterbalance these issues with an operational profile that goes beyond the conventional assistance provided in psychiatric emergency, assuming the functions of stabilizing acute cases and referring patients to the primary and secondary care networks.[58]

Among the alternative units proposed within the reform of the Brazilian mental health assistance,[59] a prominent role is occupied by the psychosocial attention centers (*CAPS*, in the Portuguese acronym).[60] There are few studies assessing the relationship of this service with the mental health network in general[61] and the impact of such centers on PESs is little understood. Notwithstanding, the *CAPS* III deserves special attention in the context of psychiatric emergency, performing the broader function of managing emergency situations 24 hours a day. The advantages and the risks involved in this type of outpatient assistance, however, have not been well described in the national literature. Due to their complexity and to the high costs incurred in the implementation of this type of health care service, few *CAPS* III are currently at work, even in bigger cities. The difficulties in the implementation and functioning of the *CAPS* III became clear in the city of São Paulo, where there were no such units working in accordance with the guidelines of the Ministry of Health as of the beginning of 2009.[62] These data suggest that the *CAPS* III may not be a solution to address the needs of acute psychiatric patients, and that planned alternatives for the provision of emergency assistance to these patients are still required.

Psychiatric emergency and primary care

In spite of the increasing investments in specialized mental health services, a significant portion of psychiatric patients still attend primary care units.[63]

The effective participation of primary care in the mental health network decreases the overload of the network and allows for a severity grading of cases in the services involved.[64] An efficient network with strong primary care assistance relieves PESs[65] to attend only to actually necessary cases, which leads to a better management of emergency cases.[66] Primary care instruments have direct implications on PESs, avoiding the worsening of mild cases, permitting the access of more severe cases to secondary care and, thus, resulting in a decrease in the number of unnecessary hospitalizations.[67,68]

The organization of the mental health network is likely to be strengthened in primary care with the work of small teams that are able to perform individual and group consultations (one psychiatrist, one psychologist, and one social worker) at basic health care facilities, in addition to the matrix policy.[69] Matrix support refers to specialized technical support provided to an interdisciplinary health care team in order to expand their practice and qualify their actions. With conjoint discussions with the teams or even with concrete conjoint interventions (consultations, home visits, and family interviews) mental health professionals can contribute to increase the teams' capacity for resolution, qualifying them to provide a broader attention, especially in mental health-related issues.[70]

Conclusion

PESs are related to all the services forming the mental health network, in addition to playing an important role in the organization of the patient flow within this network. Therefore, the functions of PESs go beyond the simple necessity to stabilize acute psychiatric cases or to refer patients for full-time hospitalization.

PESs are a core feature in the design of mental health networks and may act as a thermometer of the adequate functioning of primary and secondary attention, besides working as a provisional solution to deal with the exceeding demands associated with deficient outpatient services. Because they are one of the main entrance doors to the mental health network, especially in the case of first psychotic episodes, PESs are key points in programs of prevention and therapeutic improvement of new psychiatric cases.

The best insertion of psychiatric emergency services is in the context of PHUGH, integrating the network formed by the *CAPS*, specialized outpatient clinics, and primary attention within a regionalized and hierarchized model of mental health assistance. The *CAPS* III proposal requires deeper investigation in regard to its efficiency, its cost-benefit profile, and its capacity to actually work as an adequate structure to manage the demand of acute psychiatric cases, especially in great metropolitan areas.

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** Modest*
*** Significant*
**** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.*
Note: FMRP-USP = Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo; USP = Universidade de São Paulo; UNIFESP = Universidade Federal de São Paulo; FAPESP = Fundação de Amparo à Pesquisa do Estado de São Paulo; CNPq = Conselho Nacional de Desenvolvimento Científico e Tecnológico.
For more information, see Instructions for Authors.

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