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Psychiatric emergency service in Federal District: interdisciplinarity, pioneering spirit and innovation

Serviço de emergência psiquiátrica no Distrito Federal: interdisciplinaridade, pioneirismo e inovação

Servicio de emergencia psiquiátrica en Distrito Federal: interdisciplinariedad, espíritu pionero e innovación

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ABSTRACT

Objective: This study aims to discuss the care for people in psychic crises conducted by the team of the Mental Health Center of the Mobile Emergency Care Service of the Federal District - Brazil (NUSAM/SAMU/DF/BRAZIL), describing the dynamics of care, since the regulation from cases to follow-up. **Methods:** Qualitative, exploratory, descriptive study, with data collected through data collection in the information system of the Health Department of the Federal District (SES/DF), participant observation activities and interviews, over a period of three months, with professionals from NUSAM/SAMU/DF. The qualitative analysis consisted of Bardin's content analysis. **Results:** NUSAM/SAMU/DF showed its ability to offer care in a humanized and resolving way to urgencies and emergencies of a psychosocial nature, considering the resources it has. **Final considerations:** The service's pioneering spirit regarding the prehospital approach to people in psychic crises is highlighted, characterized by the singularized, humanized and resolutive service.

Descriptors: Nursing; Mental Health; Emergency Services, Psychiatric; Prehospital Care; Health Services.

RESUMO

Objetivo: Este estudo objetiva debater o atendimento a pessoas em crises psíquicas realizado pela equipe do Núcleo de Saúde Mental do Serviço de Atendimento Móvel de Urgência do Distrito Federal – Brasil (NUSAM/SAMU/DF/BRASIL), descrevendo a dinâmica de atendimento, desde a regulação dos casos até o *follow-up*. **Métodos:** Estudo qualitativo exploratório, descritivo, com dados coletados por meio do levantamento de dados no sistema de informações da Secretaria de Saúde do Distrito Federal (SES/DF), atividades de observação participante e entrevistas, no período de três meses, com profissionais do NUSAM/SAMU/DF. A análise qualitativa consistiu na análise de conteúdo de Bardin. **Resultados:** O NUSAM/SAMU/DF evidenciou sua capacidade de ofertar atendimento de forma humanizada e resolutiva às urgências e emergências de natureza psicossocial, considerando os recursos de que dispõe. **Considerações finais:** Destaca-se o pioneirismo do serviço no que se refere à abordagem pré-hospitalar a pessoas em crises psíquicas, caracterizada pelo atendimento singularizado, humanizado e resolutivo.

Descritores: Enfermagem; Saúde Mental; Serviços de Emergência Psiquiátrica; Assistência PréHospitalar; Serviços de Saúde.

RESUMEN

Objetivo: Debatir la atención a personas en crisis psíquicas realizado por equipo del Núcleo de Salud Mental del Servicio de Atención Móvil de Urgencia del Distrito Federal – Brasil (NUSAM/SAMU/DF/BRASIL), describiendo dinámica de atención, desde la regulación de los casos hasta el *follow-up*. **Métodos:** Estudio cualitativo exploratorio, descriptivo, con datos recogidos por medio del levantamiento de datos en sistema de informaciones de la Secretaría de Salud del Distrito Federal (SES/DF), actividades de observación participante y entrevistas, en el período de tres meses, con profesionales del NUSAM/SAMU/DF. Análisis cualitativo consistió en el análisis de contenido de Bardin. **Resultados:** El NUSAM/SAMU/DF evidenció su capacidad de ofertar atención de forma humanizada y resolutiva a las urgencias y emergencias de naturaleza psicosocial, considerando los recursos de que dispone. **Consideraciones finales:** Destaca el pionerismo del servicio en que se refiere al abordaje prehospitalario a personas en crisis psíquicas, caracterizada por la atención singularizada, humanizada y resolutiva.

Descriptores: Enfermería; Salud Mental; Servicios de Emergencia Psiquiátrica; Asistencia Prehospitalaria; Servicios de Salud.

INTRODUCTION

The number of people in a psychiatric emergency situation has increased exponentially in recent years, including an increasingly diverse range of situations, ranging from spontaneous disorders to those involving substance abuse; suicide; murder; rapes; in addition to social issues, such as aging, people on the street or affected by clinical disorders[1].

The World Health Organization (WHO) reveals a worrying epidemiological reality regarding mental disorders, which are already a serious public health problem, as shown by the data for 2015: depression affects 322 million (4.4%) people in the world and 11.5 million (5.8%) in Brazil, with an increase of 18.4% in the number of cases in the last 10 years. Anxiety affects 264 million (3.6%) people in the world and 18.6 million (9.3%) in Brazil. Suicide killed 788 thousand (1.5%) people in the world, with an average of 800 thousand new cases per year, being the second leading cause of death among young people aged 15 to 29 years in the world[2].

In order to deal with the complexity of the assistance directed to this public, public policies have been implemented, having as subsidy a vast set of regulatory frameworks, among which we highlight Law No. 10,216, of April 6, 2001, which provides for the protection and the rights of people with mental disorders and redirects the mental health care model[3]. This law boosted Psychiatric Reform in the country, seeking to ensure universal and equal access to mental health actions and services, in alignment with the principles of the Unified Health System (SUS)[4].

The National Policy on Mental Health, Alcohol and Other Drugs is another important regulatory framework for the area, advocating the model of Health Care Networks (RAS) for the construction of integrated systems that are articulated at all levels of care, in the states, municipalities and the Federal District (DF), ensuring health actions and services in a continuous, integral, responsible, humanized and quality manner[5].

From the logic of network care, thematic health care networks in Brazil were structured, aiming to improve the quality of care and user satisfaction, among which we highlight the Urgency and Emergency Care Network (RUE), established by Ordinance No. 1,600, of July 7, 2011[6-7].

The RUE includes its prehospital components, such as the Mobile Emergency Care Service (SAMU), the Emergency Care Units (UPA) and the emergency rooms of general hospitals. Primary Health Care devices, such as Family Clinics, are also included in this list, when they work with violence and accident prevention or provide mental health assistance until the articulation of patients with other units that follow up the case[8].

The SAMU, component of pre-hospital care of the RUE, aims to order the flow of assistance and provide early care and adequate, fast and resolving transport to the victims, and can be called by the number "192" throughout the country[4]. In the Federal District, the State Department of Health (SES) has, linked to SAMU, the Mental Health Center (NUSAM), a pioneering service in Brazil, instituted in 2011, which is responsible for assisting people in psychic crises, with specific training of its professionals[9-10]. The Program was recently improved by Ordinance No. 536, dated June 8, 2018, which updated service flows and standards[5,11].

Difficulties in assisting Psychiatric Urgencies and Emergencies are often associated with ignorance of crises as processes of mental imbalance, with social stigmas surrounding mental disorders and with the valuation of the biomedical model as the only one applicable to the management of these cases. Such factors limit the teams to therapeutic management in the care of psychic crises. Due to the significant growth in demands in psychiatric emergencies and the limitation of the care devices commonly available to the population, there is the importance and need for the implementation and strengthening of care strategies, directed to patients in acute psychological distress, by specialized teams for special needs contribute to meet such demands.

OBJETIVE

Discuss the care for people in psychic crises carried out by the NUSAM/SAMU/DF/BRASIL team, describing the dynamics of care from the regulation of cases to the follow-up.

METHODS

Ethical aspects

The research was approved by the Human Research Ethics Committee of the Health Sciences Teaching and Research Foundation, Distrito Federal (FEPECS/DF). It was developed based on Resolution No. 466/12 of the National Health Council, which provides for the rules on research with human beings. All participants signed the Free and Informed Consent Form. Confidentiality and anonymity were respected by replacing their names with the letter E (interviewee) followed by Arabic numbers indicating the order of the interviews (E1, E2…).

Study type

It was an exploratory study of the descriptive type, with an observational and qualitative approach guided by the Standards for Reporting Qualitative Research (SRQR) standard. The research was carried out from August to December 2017.

Methodological procedures

It was defined using participant observation methods and interviews, in addition to consulting the database of the subsecretariat of Planning, Regulation and monitoring of SES/DF. For the "participant observation" modality, the observation script was established to describe the sector's work environment and dynamics. The data obtained through participant observation were recorded in a logbook and digitized a posteriori. For the interviews, the authors developed a script with nine semi-structured questions about the perception of professionals about the work developed at NUSAM. Thirty interviews were carried out in the scenario, with an average duration of 30 minutes, all of them recorded and transcribed for analysis. All professionals who worked at NUSAM for at least 3 months, at the time of data collection, were invited to participate in the study and make up the sample of 30 respondents.

Study scenario

The setting for this study was the Mental Health Center/SAMU/DF, a service based at the SAMU Central, in the Industry and Supply Sector of the DF, where the 192 telephone center (Dial SAMU) and the vehicles for displacement and on-site service are located. In this location, the professionals who are on duty meet. In different shifts, the researchers accompanied the teams in an interview and observation action, exploring the points of view and practices directly in the chosen research scenario[11].

Data source

To the data collection in the SAMU information system, which covered all the consultations carried out by the service between January 2016 and October 2017, observational and interview data with doctors, psychologists, nurses, and social workers, who worked at the Center, were added. In an individualized approach to the participants, clarifications were made about the study and its objectives were reiterated. Then, the professionals who agreed to participate signed the Free and Informed Consent Form (ICF). The only inclusion criterion was that the professionals had worked at NUSAM for at least two months. Excluded from the study were those who worked overtime in the unit, with regular shifts lower than the weekly.

All professionals participated in specific qualifications to work at NUSAM, such as Basic Life Support (BLS) and Crisis Intervention courses. The training time of professionals varied between 6 and 33 years; and the length of experience within NUSAM/SAMU, between 4 months and 1 year and 2 months.

Data collection and organization

The participant observation activities were carried out by two of the authors of this study and consisted of 30 sessions to monitor the work of the NUSAM teams, in six-hour shifts in the environment where the regulation of mobile emergency care is developed, for the observation of the dynamics work in the sector or accompanying the rapid vehicle intervention teams[12]. In the area of regulation, by telephone, there were not only the first consultations, but also the follow-up of cases, which is called follow-up. This stage of the collection allowed the apprehension, in scenario and in real time, of the care provided to people in psychic crises[13]. Two semi-structured interviews were also carried out by two of the authors of this study, which were recorded and later transcribed, focusing on the mode of care and the challenges of NUSAM in the context of mental health care. Sociodemographic and epidemiological data were obtained in consultation with the SAMU Information System, as well as with the Directorate of Mental Health and the Secretariat for Planning Regulation and monitoring of the SES/DF, in addition to data provided by the same Secretariat[10]. The collection took place from August to December 2017.

Data analysis

The qualitative analysis consisted of Bardin's content analysis, involving exhaustive reading of the content, identification of the recurrence of key words and ideas, organization of them around similar and confluent units of meaning and definition of the analysis categories[13]. Two categories of analysis were defined: "Chama SAMU" and "Follow-up: meanings and practice in the context of the Mental Health Nucleus of SAMU".

RESULTS

The study participants belonged to the following professional categories: doctors, psychologists, nurses, and social workers. Of these professionals, 26 were female and 4 male, between 31 and 61 years of age, all with complete higher education and specializations in the mental health area.

Considering the reference framework used, the analysis of the data made it possible to define two categories of analysis: "Chama SAMU", which describes the flow of care for cases, from the call to SAMU until the outcome of the intervention; and "Follow-up: meanings and practice in the context of the Mental Health Nucleus of SAMU", which discusses the telephone service of the team in an active search for the cases attended to verify their follow-up.

Chart 1 – Health regions and number of inhabitants. Administrative Regions of each Health Region and number of cases attended by Health Region, considering the 951 cases attended by the Mental Health Center of the Mobile Emergency Service of the Federal District, Brazil, between January 2016 and October 2017

DF Health Regions and number of inhabitants (2017)	Administrative Regions of each Health Region of the Federal District	Number of cases attended by Health Region
South-West Number of inhabitants: 811,602	Taguatinga, Vicente Pires, Águas Claras, Recanto das Emas and Samambaia	293 (30.8%)
West Number of inhabitants: 539,623	Ceilandia and Brazlândia	167 (17.56%)
Center-North Number of inhabitants: 300,453	North Wing, North Lake, Varjão, Cruise, Southwest and Octagonal.	147 (15.4%)
Center-South Number of inhabitants: 465,614	Asa Sul, Lago Sul, Núcleo Bandeirante, Riacho Fundo I and II, Park Way, Candangolândia, Guará, Industry and Supply Sector (SIA), Complementary Industry and Supply Sector - SCIA (Structural)	134 (14.15%)
South Number of inhabitants: 296,933	Gama and Santa Maria	85 (8.94%)
North Number of inhabitants: 387,526	Planaltina, Sobradinho I, Sobradinho II and Fercal	78 (8.2%)
East Number of inhabitants: 237,696	Paranoá, Itapoã, Jardim Botânico and São Sebastião	47 (4.95%)
TOTAL Number of habitants: 3,039,447		951/100%

*Nota: * In the records of cases attended, there is no distinction between the locations Asa Sul and Asa Norte, so that all visits registered in Brasília were recorded in the Center North Region.*

Between January 2016 and October 2017, NUSAM attended 951 cases, of which 887 were strictly psychiatric and 64 in support of other SAMU general care demands (clinical, pediatric, obstetric and/or traumatic). Considering the 2016 financial year, between January and December, NUSAM attended 364 cases in total, of which 344 (94.5%) were for strictly psychiatric demands and 20 (5.5%) for other demands. Of the strictly psychiatric cases, in 2016, 188 (54.66%) of the visits were made by women and 156 (45.34%) by men. In 2017, the number of cases treated by NUSAM increased by 58%, totaling 587 cases, of which 543 (92.5%) cases were strictly psychiatric.

As for the age of patients treated by NUSAM, considering only strictly psychiatric cases, it is clear that, of the 887 cases treated between January 2016 and October 2017, 58 (6.5%) of them were under 20 years old; 336 (38%), between 20 and 39 years old; 347 (39%), between 40 and 59 years old; 146 (16.5%), 60 years old or more. It is evident that most of the people served by NUSAM (424; 47.4%) were between 30 and 49 years old.

As for the location of the visits, the data were organized by health regions, as described in Decree No. 38,982, of April 10, 2018, which defines 7 health regions for the DF, considering their territorialization, integrating its 31 administrative regions, as details in Chart 1.

Mobile Emergency Care Service (SAMU) Call

Respondents in this study recognize the growth of psychiatric emergencies worldwide when they report that, in recent years, there has been a significant increase in demands in psychiatric emergencies in the DF, and that, with the implementation of NUSAM, this demand started to be directed to the Core:

> *There was a need to create a specific nucleus where a team would be deployed to provide this type of assistance, because the number has been increasing every year.* (E5)

Refer as common demands to NUSAM:

> *We go to the occurrence of emergency situations, suicidal behavior, suicide attempt, consummated suicide, situations of sexual violence, accident with multiple victims, traumatic grief, psychotic outbreak, all urgent and emergency situations that are related to the issue of mental health , psychiatry and crisis intervention.* (E6)

The professionals explain that the creation of NUSAM occurred due to the identification of specific mental health demands to which the other services and SAMU itself did not dedicate a particular look and approach as the cases required.:

> *It was very common to enter calls through 192 patients with psychiatric and psychosocial demands, who were not served by the network and that no team knew how to approach* […] *in that sense, it was this idea of a specialized team, a team that could provide care most qualified for these patients.* (E24)

Such service, therefore, has been satisfactorily filling the gap in a psychosocial approach that overcomes the hospitalizing and medicalizing logic and advances towards the logic of humanization. In this sense, all demands for assistance to people in psychological crisis who arrive at the SAMU regulation center are received and forwarded to NUSAM professionals. Once the cases with psychic demands are identified, they are directed to the NUSAM professionals who make up the telephone service desks, and may, depending on the scale, be preferably a social worker or psychologist. Respondents report that two factors contribute to the singularized service offered by NUSAM to be more effective than the services provided by generalist teams.:

> *We do a more specialized screening due to the qualification you have, the time that is longer there in the regulation of mental health, you have a longer service time and more qualification.* (E12)

It is noteworthy that the professional working in the regulation by Telehealth already in the instance of NUSAM also acts from the perspective of matrix support to other Basic or Advanced Life Support Units, or professionals from other services with Basic Health Units and hospitals, when called by these units for the management of cases in mental health.

Following the service, it appears that if the demand is resolved by telephone, the case is closed, which will be resumed at a later time of active search (follow-up) to verify the follow-up in terms of linking patients with other network services, such as the Psychosocial Care Centers (CAPS).

If the case requires more than telephone communication and the need for on-site assistance is verified, a Rapid Intervention Vehicle (RIV), called a Mental Health Unit, will be moved and may be manned by a first aid driver, nurse, psychiatrist, social worker or psychologist, according to the daily scale.

When the vehicle arrives at the service location, the team assesses the environment and safety in general, establishing initial contact with the patient in psychic crisis, with a welcoming posture. Respondents describe this service, emphasizing flexibility and uniqueness in handling, as appropriate:

> *We approach it, analyze the case, and we will act according to the need of that case, if it has any comorbidity, if it is a clinical case of a general hospital, we do the medication on the spot, advise for follow-up or refer to the hospital… depends on the need.* (E26)

It is also possible to verify that the look and conduct are directed to comprehensive care and are not restricted to psychic issues. The approach involves qualified listening, physical and psychological examination, as well as interventions ranging from guidance, medication administration, mechanical restraint to referral to other services.

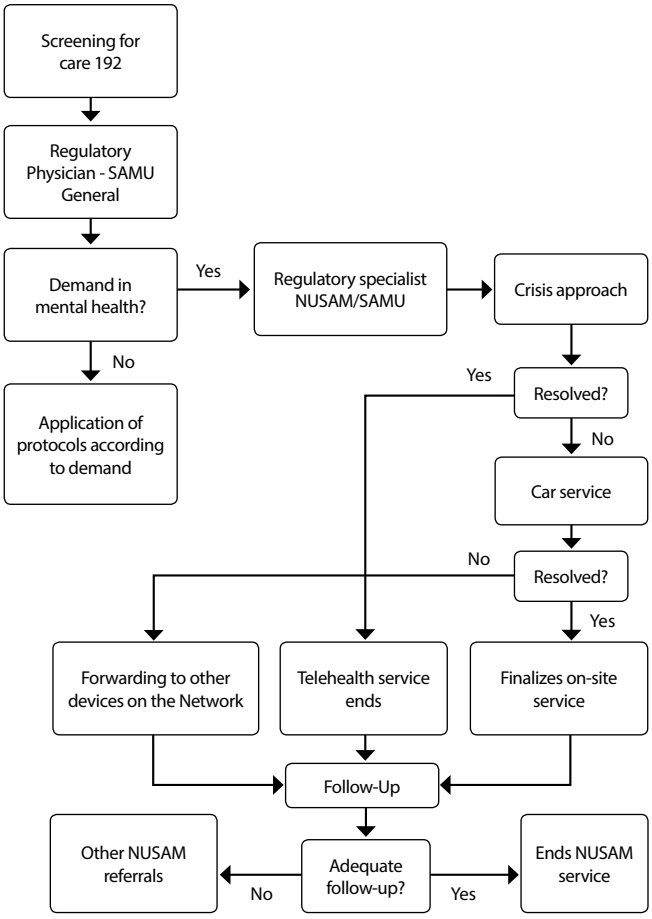
Networking is an important SUS guideline, however the panorama of mental health care in DF is delicate, since the Psychosocial Care Network (RAPS) does not have a sufficient number of CAPS to ensure coverage of the entire its population; and, with regard to the care of people in psychic crises, the situation is even more complex within the entire HCN.

During the service, specific forms are filled out with sociodemographic and epidemiological data, registering, at the end, as conducts attended:

> *Our work is as a team,* […] (E1)

> *It is a crisis intervention with a multidisciplinary team, with a social worker, psychologist, psychiatrist, nurse and first aid driver.* (E2)

After the end of the telephone or vehicular service, contact with the user and family will be resumed during the follow-up, an element that will be discussed in greater detail in the next topic of this article. Figure 1 presents a summary of the service flow chart of NUSAM/SAMU/DF. This flowchart was prepared by the authors based on the research carried out at the service.



Nota: SAMU - Mobile Emergency Care Service; NUSAM - Mental Health Center.
Figure 1 – Flowchart of care of the Mental Health Center of the Mobile Emergency Care Service of the Federal District, Brazil (2017)

A fundamental aspect for the success of the Nucleus' attendance concerns the actions of articulation with the other devices of the HCN, especially the RAPS. In the interviewees' perception, the service has been successful in interacting with CAPS, who often ensure the follow-up of the therapeutic process initiated by NUSAM:

> *I'll give you an example* […] *if it is a case that we evaluate, that needs to contact the CAPS, we get in touch. If it's a patient, for example* […] *there was a suicide attempt, we can get in touch.* (E7)

There is an understanding here that, in order to ensure transversality and continuity of care for people in urgent situations served by NUSAM, it is necessary that the internal components of the RUE act in an integrated, articulated and synergistic way with each other, as well as with the other components of the HCN, including here the RAPS and Primary Health Care (PHC).

***Follow-up*: meanings and practice in the context of the Mobile Emergency Care Service (SAMU) mental health center**

Follow-up has been considered a differential in the set of NUSAM's actions. This is the telephone contact made in an active search for patients seen at the Center to verify the follow-up of cases. The interviewees refer to this moment, emphasizing its importance to ensure the continuity of mental health care.:

> *We do, in regulation, the follow-up, which are the follow-ups, during a certain period, to the events that we attend to* […], *this follow-up aims to assess how the patient's symptoms are, to check his insertion in the RAPS, Psychosocial Care Network. And if he hasn't been inserted yet, sensitize him and encourage him for this insertion. So the job of regulation is very important.* (E5)

The main focus of the follow-up is on verifying whether the user had access to the services to which they have been referred or directed to seek. At that moment, new demands can be identified for which new orientations and referrals will be offered, minimizing the risks of discontinuity of care or of returning to a crisis situation.:

> *NUSAM has an intervention that is punctual in the crisis, this welcoming, this intervention in crisis, and then the work continues. So, here at the regulation center, we make a follow-up contact to check if the referral, guidance, if the patient's situation has been resolved, if he has managed to adhere to the psychosocial support network, if they had difficulty, if they are having access to this support* [...] *they should seek NUSAM in the need of the crisis and seek the psychosocial care network as an intermediate unit for care. There is the psychosocial care center* [...] *we reinforce the search for care.* (E8)

Each call of the team for follow-up makes it possible to confirm the effectiveness of the service, considering the care offered, the guidance provided and its consequences. The Nucleus does not establish the amount and frequency of the follow-up, leaving it to the team responsible for the call.

At the end of the contact, if the stabilization of the crisis is confirmed, the professional adds the therapeutic segment given by the patient or his family to the electronic medical record. However, it was not possible to access specific information regarding the outcomes of the cases, after the follow-up, as there was no discrimination of them in the care records, with these contacts overlapping with those of the first time.

It is noteworthy that patients and their families often find it difficult to access the mental health or primary care services to which they were referred. For the interviewees, the distance from the home to the psychosocial care service contributes to this, the absence of support from the family to follow the treatment, dissatisfaction with the service provided when they get it and the service infrastructure itself.:

> *There are many factors that are involved, for example,* [...] *if the RAPS is close to your home, this makes it easier for people to look for it. If it is too far away and the family is on a low income, they have access difficulties. Another difficulty is if the family understands the importance of treatment because some patients will need the*

> *support of the family to go and if the family does not understand, we try to raise awareness, depending on whether the family does not think it is important, it can also make access difficult. The other point, which is something that we have no control over, the RAPS, it goes through all the difficulties that the SUS goes through, in fact not the SUS, the Health Department, the SES, then, lack of HR, if the patient arrives at the CAPS or some service and is not well cared for or does not get what he wants, sometimes they stop going, so we call them and they even went, but they say they will not go again.* (E15)

Frequent expressions of gratitude were identified by users and their families at the time of the follow-up, in the sense that patients and family members felt valued at this moment, extolling the attention received by the team. This inscribes the benefits of the follow-up not only in terms of reinforcing the guidelines offered for each case and adding relevant guidelines, but in terms of promoting self-esteem by valuing the user:

> *The follow-up ends when we are sure that the situation is under control, the family is oriented, the patient is inserted, the issue is already well addressed* [...] *Approaches that are made on the spot or by telephone generates this follow-up for us to follow up, to know how the situation turned out and to be aware if the case was really inserted in RAPS, which is our psychosocial care network.* (E11)

It is verified how essential it is the articulation between the various devices of the RAS so that there is a follow-up of the cases attended by NUSAM in emergency situations:

> *To articulate this Network is to make it work and to have reference and counter-reference. Because there is no point in just having the demand stopped here, we have to make it happen.* (E3)

DISCUSSION

All the diversity of experiences related to severe psychological distress and situations of psychic crisis are charged, respectively, with an intense feeling of anguish linked to the psycho-emotional disorganization that limits their performance in the world. This level of suffering and mental imbalance can lead to life-threatening situations, thus requiring qualified case management, which has been offered by NUSAM/SAMU/DF as a constitutive device of the RUE[14-15].

Each RUE device should be used strategically according to the level of complexity of the demands that reach the regulation, being categorized as follows: Emergency Regulation Center, Basic Life Support (BLS), Advanced Life Support (ALS), Health Care Team Aeromedical, Vessel Team, Rapid Intervention Vehicles (RIV) and Motolance[16]. The central objective of these devices is to intervene quickly and effectively in the care of Urgencies and Emergencies.

What can be seen, therefore, is that, in the DF, as in most of Brazil, emergency care for people in psychological crisis relies on pre-established medical protocols, with diagnoses and medications aimed exclusively at normalizing psychic changes, including pharmacological and/or mechanical containment measures, however, the services lack a more comprehensive, singular and humanized approach, such as that offered by the interdisciplinary team at NUSAM/SAMU/DF[17-18].

The humanized approach to care is achieved mainly by sharing among professionals from different categories, users and family members, valuing the participation of all in the therapeutic management, within ethical and solidary precepts[19]. In this sense, the work of professional nurses stands out for their welcoming stance, a sensitive view of the integrality of the demands of the subjects served and their families, and attention to the precepts of the psychosocial clinic to the detriment of asylum positions[20].

It is observed that the aspect of communication and the therapeutic bond are qualifiers of care; and, since NUSAM professionals have specific knowledge in the field of mental health, these skills will be favored in care[19]. Based on this, it is inferred that the service possibilities reach greater resolution and effectiveness.

For its performance, NUSAM/SAMU consolidates itself as a fundamental assistance component, which has promoted a flow of humanized, integral, and singularized care, avoiding violent or excluding measures that could further compromise the already fragile conditions of the patient in psychic crisis. The importance of its implementation lies in the opportunity to articulate and integrate all health equipment, aiming to expand and qualify the assistance to users with emergency mental health demands[15].

The Advanced Life Support Protocol, of the Ministry of Health, when considering the suspicion of situations that involve crises in mental health, recommends management through pre-established conducts. The care provided by the team, associated with the scenario, will be established through the protocol/regulation, which describes the stages of assistance to people in psychological crisis[21]. The initial evaluation by the ACENA method stands out: A - Assess the environment ; C - Observe social network ; E - Assess the expectations and receptivity of the social network and the patient himself ; N Assess the level of awareness and suffering ; A - Assess substance use and aggressiveness. After the team's approach to the patient, a mediator is defined, who must act calmly, identifying himself/herself in terms of name and function, explaining the reasons for the approach and paying attention to the verbal and non-verbal language of the patients (user and family). The approach may include physical and mental examination and needs assessment. At this moment, the professional contribution of a team specialized in mental health expands the resolving possibilities for the adverse situations identified[21].

The term follow-up, in its original language, literally means "follow-up". This practice has become a viable method to assist and complement the provision of mental health care. People with mental disorders are responsible for a large and growing portion of emergency care, and follow-up is an effective way to increase these patients' access to psychosocial assistance, ensuring assistance by health professionals specialized in such demands and collaborating for the more appropriate treatment, in addition to reducing hospital admissions[22]. The zeal for the continuity of the care provided by the follow-up can prevent further damage to the patient's psychological, physical and social health, in addition to guaranteeing him opportunities for psychosocial rehabilitation by being linked to the Assistance Network[23].

International experiences show the benefits of monitoring and providing health care through mental health call center. In some countries, such as the United States, it is common to use videoconferencing systems, defined as a service mode to connect

patients and mental health professionals, in addition to being an example of a remote intervention modality[23]. The DF's experience corroborates the value of the call center, including the follow-up, for the follow-up of patients who previously had psychic crises. It appears that, despite the difficulties in accessing other health devices in the Network, users who went through the call center frequently report the initiative to seek psychosocial care services and adhere to treatment, minimizing the risks of future psychiatric emergencies due to discontinuity of treatment[22]. Considering that psychiatric emergencies are situations that involve risk to the physical and mental integrity of people in psychological distress and that must be handled promptly and in a humanized way[14,24], initiatives such as that of the Mental Health Center of SAMU favor qualification of this service and go to minimize the current perception of a mechanized and dehumanized service to such a particular public, when not performed by professionals with specific qualifications for handling mental health demands[25].

From the set of observations and analyzes and the results achieved by the service, it appears that NUSAM/SAMU/DF evidenced its capacity to offer interdisciplinary care in a humanized and resolutive way to urgencies and emergencies of a psychosocial nature, providing face-to-face care to people in situations of psychic crises and their families, as well as providing guidance, clarifications and referrals, favoring the attachment of patients to the devices of the RAS, especially the RAPS to follow the therapeutic process[15,26]. The NUSAM/SAMU service, since its guidelines, and due to its *modus operandi*, has been operating the precepts of Psychiatric Reform, offering users care routes in the Health Network, substituting hospitalization and an approach focused on respecting singularity and potential for psychosocial rehabilitation, promoting comprehensive, dignified and respectful care to its clientele[2,5,10]. Some limiting aspects of NUSAM's work are related to the reduced number of vehicles available for assistance, difficulties with the replacement and updating of equipment and the fact that part of NUSAM's workforce consists of professionals who work overtime, being definitely not overcrowded in the service. The frequent changes of managers in the instances of SES / DF also contribute to the eventual discontinuity of projects and actions initiated in managements that end abruptly.

Study limitations

The limitations of the study refer to the pioneering nature of the area addressed, which is specialized, interdisciplinary and humanized emergency care for people in severe psychological distress, lacking the field for further research capable of enabling greater exchange of experiences as well as greater production of health data services that allow comparison with productivity indicators. The presence of researchers, in the exercise of participant observation, may have been the cause of some interference in the observed scenes; however, due to the training carried out by the researchers to work in the contexts of observation and interaction with the work teams, there was no impact on the scenario to the point of modifying their routine.

Contributions to the area of Nursing and Health

The research shows an important field of action for nurses, which is that of care in urgent and psychiatric emergency services, as well as pre-hospital care, allying this field, in the case of the research, with that of mental health care, scenario in which the nurse also finds wide possibilities of performance. It is noteworthy that, as a member of an interdisciplinary team, the role of nurses is all the more valuable the greater their alignment and synergy with the logic of inter-professionality, adding their contributions to those of doctors, psychologists, social workers and nursing technicians with whom they come to share health care. The research shows the indispensability of nurses as a component of this team that works in the care of people in situations of psychic crisis, an environment that gives nurses the opportunity to exercise the facets of care management, assistance itself, health education directed to the clientele and of permanent education with the work team, in addition to the production of health information that allows it to invest in the construction of scientific knowledge through research.

FINAL CONSIDERATIONS

Throughout this study, it was possible to verify the importance of the work of NUSAM/SAMU as a pre-hospital care device for people in situations of psychic crisis, in line with the principles and guidelines of Psychiatric Reform, promoting continuity of care with based on humanization, integrality and respect to the user and his family.

The study made it possible to elaborate the flowchart of assistance from NUSAM from the activation of SAMU, through Telehealth 192, to the outcome of cases and their follow-up by follow-up. It also made it possible to highlight the principles that underlie the management of these cases, highlighting that NUSAM has ensured excellence in specialized, interdisciplinary and humanized emergency care for people in severe psychological distress in DF, in which the figure of the nurse as a component of the interdisciplinary team become essential.

It is concluded that NUSAM has been effective in reducing hospital admissions and in integrating the RUE and RAPS, in addition to playing an important role in helping to organize the flow of patients within this network, which corroborates the recommendation that initiatives such as this, a pioneer in the country, should be evaluated by the government, with a view to its replication in the Federal District and in all Brazilian states, in order to contribute to the improvement of mental health care at the national level.

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