Article

Psychiatric Crisis Management in the Emergency Care Hospital Network[1]

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Abstract: Since psychiatric crisis treatment is crucial in mental health care, this study aimed to characterize the psychiatric crisis in the hospital emergency services of Natal/RN. Semi-structured interviews were conducted with 33 professionals employed in four local public hospitals. The results revealed the absence of adequate beds for psychiatric conditions, scarcity of psychiatric drugs, lack of clarity regarding diagnostic criteria, treatment based on chemical restraint and inpatient care as a priority strategy. Furthermore, there is fragmentation of the work processes with physician centrality in the management of crisis, disarticulation between hospitals and other services of the psychosocial care network and systematic referrals to psychiatric hospital. We conclude that the configuration of the local hospital network does not present satisfactory responsiveness to psychiatric crisis situations and its clinical and institutional weaknesses reflect the process of psychiatric reform in the region.

Keywords: mental health, crisis intervention, general hospital

Manejo da Crise Psiquiátrica na Rede Hospitalar de Urgência e Emergência

Resumo: Tendo em vista que o tratamento nos episódios de crise é parte fundamental do cuidado em saúde mental, objetivou-se caracterizar o manejo da crise psiquiátrica em hospitais de urgência e emergência de Natal/RN. Foram realizadas entrevistas semiestruturadas com 33 profissionais dos quatro hospitais públicos locais responsáveis pelo atendimento às situações de crise. Os resultados revelaram inexistência de leitos adequados ao atendimento psiquiátrico, escassez de psicofármacos, falta de clareza quanto aos critérios diagnósticos utilizados, acolhimento via contenção química e internação como estratégia de cuidado prioritária. Evidenciou-se a fragmentação do processo de trabalho com centralidade do médico no manejo da crise, desarticulação entre hospitais e demais serviços da rede de atenção psicossocial e encaminhamento sistemático para o hospital psiquiátrico. Conclui-se que a configuração da rede hospitalar local não apresenta capacidade satisfatória de resposta às situações de crise e que suas debilidades clínico-institucionais refletem o processo de reforma psiquiátrica em curso na região.

Palavras-chave: saúde mental, intervenção na crise, hospitais gerais

Manejo de la Crisis Psiquiátrica en la Red Hospitalaria de Urgencia y Emergencia

Resumen: Dado que el tratamiento de la crisis psiquiátrica es fundamental en la atención en salud mental, el objetivo fue caracterizar su manejo en hospitales de urgencia y emergencia de Natal/RN. Fueron llevadas a cabo entrevistas semiestructuradas con 33 profesionales de cuatro hospitales locales. Los resultados revelaron inexistencia de espacios de internación adecuados, escasez de psicofármacos, falta de claridad en cuanto a los criterios diagnósticos, tratamiento basado en la contención química y la internación como estrategia de cuidado prioritaria. Fueron evidenciadas fragmentación del proceso de trabajo con centralidad del médico en el manejo de la crisis, desarticulación entre hospitales y demás servicios de la red de atención psicosocial y derivación sistemática para el hospital psiquiátrico. El estudio llegó a la conclusión que el funcionamiento de la red hospitalaria local no presenta capacidad satisfactoria de respuesta a la crisis psiquiátrica por sus debilidades clínico-institucionales, que reflejan problemas en el proceso de reforma psiquiátrica.

Palabras clave: salud mental, intervención en la crisis, hospitales generales

In recent years, Brazil has registered significant improvements in decentralization and equity in mental health care by expanding accessibility levels to services and gradually reducing the number of beds in psychiatric hospitals. There is an attempt to implement a diverse network of services the function of which is to produce care integrality, avoiding hospitalization and encouraging social reintegration. However, national data are scarce on the course of implementation and functioning of psychiatric crisis care in general hospitals, as well as the articulation of these with the other components of the Psychosocial Care Network (RAPS) (Barros, Tung, & Mari, 2010).

Emergency intervention and treatment in crisis episodes are key parts of mental health care. In some clinical situations, the inpatient service is requested, in particular, in moments when the exacerbation of the mental disorder is combined with another clinical emergency comorbidity and suicide risk (Bertolote, Mello-Santos, & Botega, 2010). For such situations, hospital support provides the differential diagnosis

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and the necessary stabilization of the patient (Del-Ben, Rufino, Azevedo-Marques, & Menezes, 2010), assisting in the reduction of risks to themselves or others, adjusting their pharmacological treatment (Amaral, Malbergier, & Andrade, 2010) and providing tests and additional examinations, sometimes required by the construction of differential diagnosis or clarification of clinical questions (Cardoso & Galera, 2011).

In the international literature, there are several studies regarding specific aspects of the psychiatric emergency room – the majority of which aim to describe groups of cases classified according to pathological charts – with those related to suicide attempts and aggressive behaviors being highlighted. Thus, in the descriptive analysis of psychiatric emergencies assisted at a hospital complex in the region of Sevilla (Spain), Conde Díaz, Esteban Ortega, Rosado Jiménez, Barroso Peñalver and Romero González (2009) found a growing increase of personality disorders and cases of aggression as the main reason for consultation. Similar data were found in the study by Swanson et al. (2008), performed in North Carolina, United States, and Thornicroft, Alem, et al. (2010) and Thornicroft, Farrelly, et al. (2010) conducted in London and in the English cities of Manchester and Birmingham. Both studies aimed at the evaluation of protocols for the reduction of coercive interventions in crisis situations and action plans for mitigation of compulsory hospitalizations, in order to enlarge the gradients of autonomy and engagement of patients in the choice of therapeutic measures and in exercising control over their treatments. We also highlight the observational study of Knott, Pleban, Taylor and Castle (2007) about the therapeutic management of patients with mental disorders assisted in emergency departments of the Australian State of Victoria, in which they evaluated how people had access to appointment attendances, the average time of attendance and the main diagnostic features of patients.

In Brazil, we observe a low number of studies on technologies and hospital Crisis Standards of Care Protocols. Little is known about the organization of emergency teams, considering problems they face on a daily basis or their abilities to establish connections with the substitute services (Brasil, 2010; Del-Ben & Teng, 2010). Among the national studies, we include the study by Dalgalarrondo, Botega and Banzato (2003), who conducted a data collection of 2,047 consecutive admissions in a psychiatric unit in the metropolitan region of Campinas, with a view to socio-demographic and clinical variables associated with the success or failure of hospitalization; a study conducted by Larrobla e Botega (2006) concerning the implementation of a therapeutic model of reference and current situation of psychiatric wards in general hospitals of various cities of Minas Gerais, Sao Paulo and Santa Catarina States, as well as the exploratory study of Cardoso and Galera (2011), who identified the common characteristics between patients that were recently discharged from psychiatric hospitalizations in the outpatient service of Ribeirao Preto city.

Currently, it is essential to expand the studies about the reality of psychiatric emergencies services in order to support the organization of the psychosocial care network and properly meet the demands of Brazilian population. In this sense, the present study aimed to characterize the psychiatric crisis services offered by general and emergency hospitals of a northeastern state capital, aiming to contribute to the qualification of practices and technologies of hospital care for psychiatric services, from the local experience, producing empirical inputs for the process of consolidation of the National Mental Health Policy.

Method

This is a qualitative study with an exploratory-descriptive-interpretive perspective aimed at RAPS workers' experiences from the city of Natal/RN concerning the psychiatric crisis management in the context of urgency and emergency hospital care. This is part of a broader research project entitled "Network of Integrality of Care to the Crisis and Care Strategies With Risk Classification in Mental Health", whose methodological path consisted of different stages developed over 24 months (August 2010 to July 2012) with the following components of the local RAPS: Mobile Emergency Attendance Service (SAMU), four psychosocial care centers/CAPS (being one type II, one type III and two alcohol and drugs/ad), three Immediate care centers (UPA), three public urgent care and emergency hospitals, one psychiatric hospital. There was no prior delimitation of number, category and level of professional training of study participants. The strategy was to visit each institution as often as required to reach a greater number of participants, covering different shifts and occupational categories. The inclusion criterion was the free consent of each technician consulted and willingness to collaborate with the research. A total of 137 interviews were conducted (63 in CAPS, 41 in UPAs and SAMU, 33 in the hospital network).

Participants

In this step of the study 33 workers allocated in four public hospitals which provide care in psychiatric urgencies and emergencies in the city that composed the sample. Of this total, nine worked at a University hospital, nine worked in a psychiatric hospital and 15 in two general hospitals, being the University Hospital of the federal jurisdiction and the rest of State responsibility. Regarding the classification of the sample by professional category, we had 27 technicians, from these five were social workers, seven nurses, six psychologists, one psychiatrist and eight nursing technicians; six managers, of which one was a nurse, one a psychologist and four physicians.

Instruments

The instrument used was the semi-structured interview, which script focused on the following themes: psychosocial care; network of care; psychiatric crisis; management; train-

ing and health working process. Based on Campos (2000), the semi-structured interview is a participatory instrument that allows researchers to listen to questions and dilemmas of everyday life of the worker, from triggered themes to reflections concerning both their environment and their working process.

Procedure

Data collection. After approval of the study by the Research Ethics Committee, three operational steps were established: (a) institutional contacts, (b) listing of occupational categories and potential participants in the different components of the RAPS, (c) performance of individual interviews in the healthcare institutions at the convenience of workers. Data collection on the hospital network was held between the months of August and December 2011.

Data analysis. For data analysis, the interviews were transcribed and categorized from the perspective of the thematic/categorical content analysis of Bardin (1977). The categories were organized and classified on the basis of the thematic blocks that guided the interview and the frequency with which were cited in the total set of interviews analyzed. The categorization and interpretation of empirical material from critical-interpretive perspective showed three thematic axes: architecture and mode of operation of the local crisis care network; diagnostic criteria; management of psychiatric crisis in hospitals settings. The data were interpreted in accordance with the principles and procedures that guide National Policy of Mental Health, with the paradigm of Psychosocial Care, as well as discussions about the modeling of Health Care Networks in relation to improving access, effectiveness and efficiency of actions and services in the Unified Health System/SUS.

Ethical Considerations

The study was approved by the Research Ethics Committee Involving Humans of the Hospital Onofre Lopes at the Universidade Federal do Rio Grande do Norte (Process no. 330/09) and the participants agreed to participate by signing the Consent Form. This research was financially supported with funds from CNPq regarding research grant of Humanities and Social Sciences and FAPERN (PPSUS III).

Results

Axis of Analysis I - Architecture and Mode of Operation of the Network

We identified a clearly precarious Health network in the city. There was one CAPS II, one CAPS III, two CAPS-ad, one children's CAPS, one Mental Health outpatient clinic, one outpatient Treatment and Prevention of Smoking, an Alcohol and other drugs and two Therapeutic Residential Services in operation. The network had no center of coexistence and culture and transitional host homes. The Health network also did not have beds for integrality of

care in general hospitals and emergency, only six beds in the psychiatric ward located in the University hospital. The articulation between the substitutive and hospital services with the basic health network was incipient.

The hospital care service of the city had plural and fragmented characteristics, usually unrelated to other healthcare network services. The public hospital network were heterogeneous as to location, characteristics of services and organizational form. Their spatial distribution neither follows the epidemiological profile of the population nor the health needs of the health districts, concentrating on the eastern district, which presents the best health social sanitary conditions of the region. The regulation center, which function is to organize the access to hospital beds, was being structured and the city did not have a specific policy targeting hospital sector restructuring in order to integrate it to the outpatient network, substitute services and primary health care.

In relation to the classification of beds by specialty, it was found that the psychiatric beds represented 18.4%, the third largest portion of SUS beds, staying behind only the clinical and surgical beds. In consultation with the Department of Informatics of the SUS/DATASUS in February 2012, the psychiatric beds available in the city during this period totaled 532 (Brazilian Ministry of Health), exceeding the maximum number of coverage defined by the Agreement and Integrated Health Care Assistance for cities with psychiatric hospital and without substitutionary effective network. Given the insufficient resources to evening care in the CAPS III, the low density of psychiatric beds in general hospitals and the scarcity of alternatives for crisis management in the Community assistance services, we locally observed the gradual stagnation of the closing process of psychiatric beds.

According to hospital managers, the difficulties that occurred in the transition of the care model in the city emerged as symptoms of low effectiveness and articulation of mental health care network, from the absence of regulatory mechanisms and from the financing model, for which the reallocation of the financial resources of disaccredited psychiatric beds made through its incorporation into the budget ceiling of the city without clear definition about what destination would be given to the respective Authorizations for Hospitalizations (AH) or any computerized information system for monitoring and assessment of this relocation.

Over the past few years, the problems pointed out by participants have impaired the transformation and the advancement of management practices to the people in psychiatric crisis, putting in check the quality of care offered and the capacity of the hospital network to elaborate resolute and integrated responses. The deficits in the care service caused by the indolence of the public administrative apparatus are known: long waiting queues, overcrowding, overload of work, inadequacy of the physical structure, shortages of medicines, among others.

On the foundation of these problems are, according to the managers interviewed, the precariousness of the basic

network, the lack of control related to the allocation of financial resources, the lack of planning, lack of knowledge concerning territories weaknesses, the selective logic of organization of services based on their own skills and the process of fragmentation of health needs and responses.

Analysis Axis II - Diagnostic Criteria

In the diagnosis of episodes of crisis, participants reported the prevalence of use of clinical criteria related to identification of aggressive behavior, psychomotor agitation and psychotic symptoms (delusions and hallucinations), followed by the observation of depression and serious anxiety disorders. Such data are consistent with those found in the research findings of Cardoso and Galera (2011), Conde Diaz et al. (2009) and Dalgalarrondo et al. (2003). In every hospital analyzed, the diagnosis focuses on the medical assessment, being conducted unilaterally by the prescriptions provided by their psychiatrists with views to the information collected, allowing the mitigation of psychic disorganization characteristic of crisis situations.

Admission in beds or referral to other units, planning of clinical management and the organization of therapeutic resources gravitate around the treatment regimens, which arise from medical assessment on symptomatology manifested by patients. Scarce references were found in the interviews about the expansion of the diagnostic through the addition of information such as habits and daily routines, family background, clinical developments and psychotherapeutic and pharmacological preexisting plans. However, isolated reports presented data related to the collection of clinical data, patient identification and the establishment of contact with mental health units where they are usually treated.

There is no agreement among technicians of the hospitals investigated, concerning the criteria used for the assessment of risk and definition of the clinical degree of severity of people with mental disorders. It was observed that the modes of recognition of psychiatric urgency are derived from different conceptions about the situation of crisis assumed in practice of each professional. For most participants, the crisis is perceived as a state of mental imbalance which must be stabilized with the greatest agility possible, in order to prevent further mental disorder. For others, it represents a transgression of social norms whose outburst offer danger and requires containment. A few participants, allocated at the University hospital and the psychiatric hospital, consider the crisis a moment of deep suffering, to which everybody is susceptible, which must be carefully upheld and recognized in their transforming and creating possibilities. Such conceptions are not clearly present in the speech of all the participants, responses with orthodox concepts are frequent and appear condensed to contextual representations of the crisis.

It is necessary to specify, however, that, despite the different forms of assessment and recognition operated by interviewed about the experience of the crisis, the diagnosis, which will define the psychiatric emergency and will guide decisions that will lead the therapeutic management, remains centered on the physician's opinion. Such situation was also detected by Amaral et al. (2010) and Del-Ben et al. (2010).

In the hospitals analyzed, the diagnosis conducted by physicians in elucidation of psychiatric cases remains strongly tied to the use of biomedical criteria for the identification and description of pathological behaviors. However, it is not so much the nosological accuracy of crisis episodes, but rather whether it occurs or not in a given individual. Before any characterization, the diagnosis is given through a binary opposition produced to guide an institutional decision: whether to accept or not the hospitalization of the patient. Thus, the recognition of situations that, for alarm or seriousness, should be conducted for the hospitalization is limited by the parameters of traditional psychiatric nosographic and disregards any factor that goes beyond the symptomatic manifestations of the crisis.

Axis of Analysis III - Therapeutic Management of Psychiatric Crisis in Hospital Setting

The investigation showed the absence, in all hospitals analyzed, of organized protocols of crisis management. There are few agreements in the responses obtained with regard to modes of care, diagnostic criteria for identification of exacerbation of distress and the measurement of risks presented by users with mental disorders. The disagreements regarding the therapeutic management are not linked to specific professional category or the working time in service, but emerge as a consequence of the perception that each professional have about the operation of the hospital and/or limits to the exercise of its powers. Some participants think about the obligation of care for psychiatric patients, when the absence of specialized teams or the expansion of available human resources, as a form of catalysis of present-day hypertrophy of functions that they experience. Others point to the lack of physical structure and adequate material resources for the provision of care during the crisis: shortage of appropriate equipment for carrying out the procedures of containment, stocks of psychotropic drugs are insufficient to keep up with the growing demand, the number of beds in the wards and immediate care centers does not correspond to the amount required to meet the emergency and urgent reference territories, neither they are adapted for patients in psychiatric crisis.

The investigation also revealed recurring complaints regarding training for the management of crisis intervention technologies. Given the absence of any continuing education program for diagnosis and management to the crisis, doubts arise about the clinical criteria for the identification and characterization of psychopathological charts, their etiologies, dysfunctions arising from possible effects of comorbidity and expected prognosis depending on the severity of symptoms identified. Added to these questions, the ignorance of the provision and the modes of operation of the health network – translated in uncertainty as to the

law governing the establishment and organization of health services, health guidelines and the financing systems that support them, their levels of hierarchy, etc.

Overall, the responses produced in the crisis of investigated hospitals tend to vary according to the conduction adopted by the physician, however, for the majority of the reported cases are summarized to mechanical and/or drug containment with later referring of the patient – when there is no stabilization of crisis and lack of material and human resources for the care of this demand – to the psychiatric hospital. Reports in which patients in crisis, after superficial examination and without considering the nature or the reasons for the emergency, were directly referred to the psychiatric hospital were also common. Such forms of treatment revealed the close relationship that general hospitals remain with the psychiatric hospital on the itinerary of the patient in crisis, demonstrating the typification of the traditional psychiatric model in local management of the demands of psychic suffering.

From this scenario, the commitment of operation and of the working conditions of hospital services, whose professionals see themselves obliged to handle, without any type of technical and material support, the complexity of crises. For most participants, the attempt of resolution of the referred problems is in the act of referral of patients to the psychiatric hospital. The consequences of this action can be observed in the resizing of network flows, which continue to condense into the psychiatric hospital.

Discussion

The current care model in mental health reorientation moment in Brazil becomes a priority to the articulation of replacement services of primary care and hospital network in order to strengthen and decentralize the integrality of care. This reorientation implies the understanding that the therapeutic solutions are in singularized use of a different set of offered care provided by territorially referenced and articulated services according to clinical guidelines and public health (Calfat, Pan, Shiozawa, & Keys, 2012; Dias Gonçalves, & Delgado, 2010).

With regard to the emergency psychiatric service, the substitute services of mental health need to be connected to SAMU's and tertiary care, and should be able to provide assistance to acute cases of psychiatric nature and take responsibility for their referral to health services, when they do not have the resources needed to proper treatment. Therefore, they need to be tied through regulated referral mechanisms and back reference, to hospital resources, sharing the care. In these situations, the speed of service and previous planning of protocols are critical to provide an effective response and avoid unnecessary hospitalizations, suffering and therefore chronicity.

The study conducted by Del-Ben, Marques, Sponholz and Zuardi (1999) in the psychiatric emergency service of the University hospital of Ribeirao Preto – SP correlated the annual increase in the number of hospitalizations made, to the progressive involvement of the service in the mental health network promoted by the deinstitutionalization process. The research has indicated that the reduction in hospitalization and changes in the profile of the patients assisted were linked to changes in the mental health policy in the region, responsible for the initiation of central psychiatric vacancies, by the reduction of psychiatric beds in specialized hospitals and through the creation and expansion of extra hospital services in the investigated period. The authors conclude that such measures produced the most efficient use of beds, increasing the availability of therapeutic service resources, lowering costs and reducing the saturation of the local health system as a whole.

In the city of Natal, the progressive deactivation of psychiatric beds in specialized hospitals, expected under Brazilian law, is still far from finding corresponding expansion of integrality of care beds in general hospitals and substitute services. Among the various barriers that contribute to the gap between the rate of deinstitutionalization required by the current state of the Psychiatric Reform (regulated by the National Assessment of Hospital System Program/Psychiatry) and the expansion of the accessibility of mental health treatment in general city hospitals, we highlight the stigma and circumscribed rejection of mental disorders and low insertion of the hospital apparatus in psychosocial care network.

The local health network services coexist with psychiatric hospitals as they are not able to replace it completely, as it is needed. It works as an inarticulate circuit of services whose therapeutic proposals, marked by inflexible and fragmented procedures among themselves, which do not guarantee care extended to the patient. The disarticulation observed results from the absence of agreement in the flow diagrams and spaces open to dialogue and to the construction of parity agreements, producing, on what matters to the integrated operation of healthcare services, disruptions in care sharing and in the co-responsibility of cases.

As a result of this process, individuals have disordered itineraries in search for therapeutic resources needed to achieve their treatments or, as often tends to occur, sedated and conducted to the emergency room of the psychiatric hospital. This problematic system of intersectorial health connections produces, at the same time, the discontinuity of care and maintenance of the centrality of the mental institution infrastructure in management of the crisis.

As highlighted one of the main challenges for integrality of care in mental health, crisis management has a place of great importance in the current attempts to reorder the network and transform the relationship of madness-society. Its monopoly by a psychiatric hospital represents, therefore, the expansion of political and administrative power of the psychiatric hospitals apparatus, pointing to the hegemony of the psychiatric hospital in the definition of treatment parameters to the crisis and in the planning of mental health network flows.

As noted, the demand concentration model in the psychiatric hospital is grounded on precarious operation of the city health system, featuring a network subject to mental institutions and therefore unable to promote any equitable distribution of resources. Under such conditions, the psychiatric hospital is established as the main therapeutic agent of the crisis, working in the architecture of the network as the broadest gateway and final destination of referrals. Emergency services of general hospitals, overwhelmed with deficits become mere referrals to hospitalization.

The problems described in the quality of care, instead, as an important challenge to the performance of access and resolution in moment of crisis. It is known that knowledge about health policy governing the organization of the health system, the understanding of clinical guidelines that guide the model of psychosocial care and training or previous experience in the therapeutic treatment of psychiatric emergencies are fundamental prerequisites in care and responsible by people in crisis (Nicácio & fields, 2004). The results obtained in the hospital network investigated corroborate to this data, indicating difficulties in diagnosis, in appropriate techniques of containment and emergency conduction of psychiatric treatment crisis tend to result in the intransitive referring of patients to psychiatric hospitals.

The lack of training for the care of severe psychiatric nature patients impair appropriate care, on the other hand, the construction of natural therapeutic projects and the implementation of risk classification procedures, may hinder the planning and production of strategies for the management of crisis and continuity of care plans to the need of patients. As explained by Vasconcelos (2003), these needs are not limited to psychological problems services of worsening psychiatric charts, so health teams should be able to intervene with the socioeconomic vulnerabilities and situations of rights violation, in which users suffer the most. At the same time, they need to deal with conflicts of interest and pathogenic family bonds with the iatrogenic consequences of long periods of previous hospitalizations and with cognitive and communicative limitations induced by mental disorder, and institutionalization and the prolonged use of certain psychiatric drugs.

Interventions in crisis episodes require transdisciplinary and flexible solutions, only possible when based on a continuous dialogue between the various actors and services participating in the care (Jardim & Dimenstein, 2007). This communication requires the transformation of clinical and political aspects, imperatives to make practical and emotional interests of individuals, caregivers and experts in plans of more democratic knowledge and power. However, for such transformation to gain concreteness, the health teams need to be prepared to question and denature their practices in psychiatric categories that add only hazard, dysfunction and disability to the crisis (Ferigato, Campos, & Ballarin, 2007).

The centering of the diagnosis on a single analytical axis, which is descriptive observation of anomalies produced in the crisis shows, therefore, the weakness in the integration of psychosocial knowledge to hospital care modes in the city. The adoption of the biomedical model and the low incorporation of soft technologies in diagnostic construction, put in the field analyzed, practical identification of crisis which operates from a set of forms and patterns as patients experience their own condition. Therefore, the mental suffering of these, interpreted in isolation from its ontological sense, exclusion to its manifold economic and socio-cultural causations. The flattening of all of etiologic factors of crises met the size of naturalized failures, deficits and mental disorders pointed to the perpetuation of the psychiatric hospital management logic, able to produce the pathological deviant and silence the transforming power that also breaks out in times of crisis.

To Dell'Acqua and Mezzina (2005), the maintenance of psychiatric hospital practices in the operation of mental health networks are directly referred to the rigidity of the procedures that they adopt. According to the authors, the inability of flexibility of the responses to the crisis signals, the difficulty of services on a network as the recognition of the various subjective ways of experiencing psychological distress and socio-cultural contexts to which these experiences are articulated. By focusing only in symptomatic aspects and physician-centered use of hard technologies, they tend to exclude from the intervention all that relates to the materiality of everyday life of the patient, producing a dialogue barrier and preventing the exchange of knowledge between several individuals participating in the crisis management.

Overall, a similar logic assistance was detected in the clinical management produced by the units investigated: the crisis acquires negative aspects and all the feelings and meanings related to it are reduced to a set of symptoms that require immediate suppression. The crisis is understood as a harmful process that must be extinguished by means of physical restraint and pharmacological sedation in the search for recovery of body stability.

What happens is that this understanding ignores the complex existential situation of the individual and also the family and social reality in which the crisis episode was produced. We care to psychiatric symptoms as a dissociated clinical practice of local political and health scenario, which is interpreted as a totality of the intervention and not for what factually must represent, that is, part of a broader treatment, articulated with interests of patients and their families linked to the therapeutic model, care strategies and architecture of the existing health services.

The management is guided, therefore, in order to equalize the psychic dimensions and bring the patient back to normal, escaping their containment threshold. The aim is to adapt the unadjusted individual, promoting interventions aimed to his/her control, so as to restore the supposed balance that there had been lost. Unilateralism through which conducts this management ignores the temporal and unique

meaning that the crisis takes for each subject, embarrassing the care of subjective weakness and the enhancement of the possibilities of transformation and emerging deviation in these critical moments. As such, it also takes up the patient's responsibility for his/her state, as it is assumed that what is manifested is the disease and not the subject.

In summary, the clinical procedures adopted in the hospitals analyzed seek, through the removal of abnormal behaviors, direct the crisis to a controlled and predictable reality in which they would promote a return of the patient to the "normal" operation. However, as it is known, the individual's subjection to the rules already in place, namely those which, for failing to adapt, the individual would try to escape from these rules, only produces the expansion of their suffering (Moraes & Nascimento, 2002). Therefore, procedures used for the psychiatric emergency service decrease the chances of patients to build new subjective configurations and try other ways to deal with discomfort. This way, institutions become thereby responsible for the chain of a process of ongoing crisis-suppression-crisis able to convert psychological distress in a recurring and chronic event, which multiplies the costs of emergency services, limits their availability of resources and increases the saturation of health system. Such saturation of emergency services and the hospital network's inability to provide answers to solve cases of psychiatric crisis were reported by all participants, and they perceived the increased workload and the growing gap between the number of hospitalizations and the means available for treatment.

It should be noted that the difficulties in caring for intense subjective fragilization and social vulnerability of the population attended, whose demands for support go beyond what is considered strict health problems, the devaluation of the work and the scarcity of resources for assistance represent significant sources of psychological distress for these workers, which tends to compromise the quality of care offered. Similar problems have been verified by Sá (2006) in research work processes at the gateway of an emergency hospital in Rio de Janeiro. The author concluded that defensive strategies which use teams to deal with the suffering caused by precariousness and risk of work gradually erode the solidarity spaces, cooperation and care for life.

The care model employed in the present study invariably tends to the pathologization of all sorts of behaviors manifested in episodes of crisis and the consequent institutionalization of individuals. It consists in naturalization of the demands of psychiatric emergency, individualizing the crisis through the exclusive treatment of disorder. However, as we know, by focusing only on individual and symptomatic aspects of the crisis, the emergency services refer to patients' problems that touch on institutional weaknesses and ultimately hinder the questioning of therapeutic management (Costa, 2007). The difficulties already pointed to the questioning of practices and knowledge put into circulation the functioning of the investigated hospital services resulting hardening of the

answers that offer the crisis and, therefore, its ability to adapt to mutagenic actions of psychological distress. As the logic of the revolving door that keeps coming back and forth, this process prevents the creation of more autonomous ways of life, contributing to an increasing dependence on psychiatric hospitalization structure in the city.

This research focused on the management of psychiatric crisis in the hospital network of urgent and emergency care identified a number of difficulties: lack of adequate beds to meet the crisis, shortage of psychiatric drugs, lack of clarity regarding the clinical diagnostic criteria and modes of care based on the chemical restraint and hospitalization. We observed fragmentation of the work process of the teams with the centrality of medical care in the construction of proposals and therapeutic management of the crisis, disarticulation between general hospitals and other network services, systematic referral to the psychiatric hospital as a strategic priority of care.

Therefore, the local health system has kept the technical and ideological support of the psychiatric hospitals model, responding to crisis situations with priority to hospitalization and/or increased medication. The system as it is can neither close all psychiatric hospitals, nor bring about the dismantling of the demand historically constructed by social and political function of traditional psychiatric knowledge, we perceived in its operation the maintenance of old madhouse strategies of containment and appeasement of the crisis, for which all psychological distress may be referred to a solution, often standardized and of universal value. This is to remit the symptoms of a disease in exacerbation by a timely intervention, pre-formulated and, because he/she has not been integrated into the life context of the patient, with no plan of care continuity. The scenario studied indicates that the configuration and the operating parameters of the local hospital network do not develop satisfactory answers to cases of psychiatric urgency and emergency, being a powerful analyzer of the current course of psychiatric reform in the region.

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