# Nursing care for psychiatric emergencies

# Assistência de enfermagem às emergências psiquiátricas

# Asistencia de enfermería para emergencias psiquiátricas

*Aizia Salvador[1], Agnete Troelsen Pereira Nascimento[2], Manuela Bastos Alves[3], Valéria Ribeiro Santos[4], Rosany Cláudia Dantas Pereira[5], Crislene Rodrigues da Cruz[6]*

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1. University of the State of Bahia. Senhor do Bonfim, Bahia, Brazil. https://orcid.org/0000-0003-2015-2418

2. University of the State of Bahia. Senhor do Bonfim, Bahia, Brazil. https://orcid.org/0000-0002-8565-653X

3. University of the State of Ba.hia. Senhor do Bonfim, Bahia, Brazil https://orcid.org/0000-0002-4073-5146

4. University of the State of Bahia. Senhor do Bonfim, Bahia, Brazil. https://orcid.org/0000-0002-0478-3829

5. University of the State of Bahia. Senhor do Bonfim, Bahia, Brazil. https://orcid.org/0000-0003-2348-6712

6. University of the State of Bahia. Senhor do Bonfim, Bahia, Brazil. https://orcid.org/0000-0003-2725-7255

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## RESUMO

Objetivo: Analisar a assistência de enfermagem e os seus entraves frente às urgências e emergências psiquiátricas no Serviço de Atendimento Móvel de Urgência. Método: revisão integrativa realizada nas bases de dados SciELO, LILACS, BDENF e MEDLINE (via BVS). Utilizou-se a estratégia PICo. Exportou-se as referências identificadas para o gerenciador EndNote e depois para o aplicativo web Rayyan para a seleção dos estudos. Resultados: dos 2651 estudos identificados, 07 foram incluídos para a análise final. Evidenciou-se déficit na capacitação profissional, fragilidade na rede de saúde mental, concepção fragmentada da crise psiquiátrica, uso de protocolos gerais, práticas coercitivas, contenções e apoio policial, que reverberam em uma assistência de enfermagem inadequada aos indivíduos em crise. Conclusão: A assistência prestada às urgências e emergências psiquiátricas no Serviço de Atendimento Móvel de Urgência é ineficiente, ineficaz, mecanizada e desumana, infringindo as legislações e normas vigentes, indo de encontro ao ideário da reforma psiquiátrica brasileira e fortalecendo a psiquiatria clássica.

**Descritores:** Enfermagem; Serviços de Emergência Psiquiátrica; Atendimento Pré-Hospitalar; Saúde Mental; Intervenção na Crise.

## ABSTRACT

**Objective:** To analyze nursing care and its challenges in the face of psychiatric emergencies in the Mobile Emergency Care Service. Method: An integrative review was conducted using the SciELO, LILACS, BDENF, and MEDLINE (via BVS) databases. The PICo strategy was used. References identified were exported to the EndNote manager and then to the Rayyan web application for study selection. Results: Of the 2,651 studies identified, 7 were included for final analysis. It was evident that there is a deficit in professional training, a fragile mental health network, a fragmented conception of psychiatric crises, use of general protocols, coercive practices, restraints, and police support, which result in inadequate nursing care for individuals in crisis. Conclusion: The care provided for psychiatric emergencies in the Mobile Emergency Care Service is inefficient, ineffective, mechanized, and inhumane, violating current legislation and regulations, opposing the ideals of the Brazilian psychiatric reform, and reinforcing classic psychiatry.

**Descriptors:** Nursing; Emergency Services, Psychiatric; Emergency Medical Services; Mental Health; Crisis Intervention.

## RESUMEN

Objetivo: Analizar la atención de enfermería y sus desafíos frente a las urgencias y emergencias psiquiátricas en el Servicio de Atención Móvil de Urgencia. Método: Se realizó una revisión integrativa en las bases de datos SciELO, LILACS, BDENF y MEDLINE (vía BVS). Se utilizó la estrategia PICo. Las referencias identificadas se exportaron al gestor EndNote y luego a la aplicación web Rayyan para la selección de estudios. Resultados: De los 2,651 estudios identificados, 7 fueron incluidos para el análisis final. Se evidenció un déficit en la capacitación profesional, una red de salud mental frágil, una concepción fragmentada de la crisis psiquiátrica, el uso de protocolos generales, prácticas coercitivas, contenciones y apoyo policial, lo que resulta en una atención de enfermería inadecuada para individuos en crisis. Conclusión: La atención prestada a las urgencias y emergencias psiquiátricas en el Servicio de Atención Médica de Urgencia es ineficiente, ineficaz, mecanizada e inhumana, infringiendo la legislación y normativas vigentes, yendo en contra del ideario de la reforma psiquiátrica brasileña y fortaleciendo la psiquiatría clásica.

Descriptores: Enfermería; Servicios de Urgencia Psiquiátrica; Servicios Médicos de Urgencia; Salud Mental; Intervención en la Crisis (Psiquiatría).

REVIEW

## Introduction

In the past, individuals with mental disorders had both their autonomy and their rights revoked, and were indiscriminately interned in asylums, being subjected to various inhumane treatment practices such as segregation, mistreatment, isolation and use of electroshock. They received their care following the biological model, centered on psychiatric hospitalizations, away from their family and community, and there was no concern or understanding about the implications of these practices on the health status of these individuals.[1]

With the redemocratization and the crisis of the hospital-centered model, at the end of the 1970s, the Brazilian Psychiatric Reform (BPR) movement began, through the dedication of social movements to the rights of psychiatric patients.[2] In this context, the process of deconstruction of asylum practices began, fighting for a society free of asylums, the reformulation of psychiatric care, through the search for the creation of humanized care strategies for individuals with mental disorders.[3-4]

Idealizing a new care model that respects the rights and citizenship of these individuals,[5] occurs in the enactment of Law No. 10,216 and the National Mental Health Policy (PNSM),[6-7] a milestone in the protection and defense of human rights, which consolidates a new model of comprehensive mental health care and aims at psychosocial rehabilitation and the social (re)insertion of individuals in psychic suffering, ensuring rights to them, as well as the establishment of their autonomy and citizenship and instituting prerogatives over internment.[7]

In line with the PNSM, in 2011 the Psychosocial Care Network (RAPS) and policies in the field of alcohol and other drugs were established, being an important member of the Unified Health System (SUS), which enables a new dimension to the set of mental health actions. Among the services that constitute the RAPS is Urgent and Emergency Care, which includes the Mobile Emergency Care Service (SAMU), which is a mobile Pre-Hospital Care (PHC) service, an important component of health care, which aims at the early arrival of the individual after the occurrence of a health problem.[8-12]

Psychiatric crises (as psychiatric urgencies and emergencies are commonly defined), which were previously isolated and hidden behind the walls of asylums and psychiatric hospitals, gain social space, generating the need to create new substitutive services to meet this demand.[13] These crises involve various events such as psychoses, ideations, suicide attempts, depressions, organic brain syndromes, exogenous poisoning due to the use/abuse of alcohol and/or other drugs, among others.[2,14-16] The care provided to these individuals is the responsibility/attribution of SAMU, RAPS, police and fire department.[7-8,10,12]

As an integral part of the SAMU team, the nurse in the PHC has the functions of being a clinical nurse, supervising and evaluating the nursing team, providing more complex nursing care to critically ill and life-threatening patients, offering continuing education to the nursing team, among others.[10]

The deficit and lack of permanent education, deepening and visibility about nursing care in SAMU can promote failures in the care of the team, especially in psychiatric occurrences that, for the most part, are still stigmatized and follow general protocols in this service, indiscriminately using chemical

and mechanical restraints, strengthening the medical-centric practice and the crisis/emergency/hospitalization chain.[17-21]

Thus, the present research can provide a view of the daily practice of nurses who work in psychiatric urgencies/emergencies, broaden discussions and contribute to future research in this area, aiming to fill gaps in technical-scientific knowledge focused on the biopsychosocial model.

Thus, the objective of the study was to analyze nursing care and its obstacles in the face of psychiatric urgencies and emergencies in the Mobile Emergency Care Service.

## Method

### Type of Study

This is an integrative literature review (IR) in which a qualitative approach was used. The present study was conducted in six distinct stages, namely: 1) The identification of the research question; 2) Establishment of criteria for inclusion and exclusion of studies/literature searches; 3) Categorization of studies; 4) Evaluation of the included studies; 5) Interpretation of the results; and 6) Synthesis of knowledge.[22]

### Identification of the research question

The construction of the research question was guided by the model of acronyms of the PICo23 strategy (Chart 1) and consisted of: How is nursing care performed and what are the obstacles encountered by these professionals in the face of psychiatric urgencies and emergencies in the Mobile Emergency Care Service (SAMU)?

**Chart 1 -** PICo-type strategy for the elaboration of the research question. Senhor do Bonfim, BA, Brazil, 2023.

| Acronym | Definition | Description |
|---|---|---|
| **P** | *Population* | Individuals in psychiatric urgency and emergency situations |
| **I** | *Interest Phenomenon* | Nursing care and/or assistance and the obstacles encountered |
| **Co** | *Context* | Mobile Emergency Care Service (SAMU) |

### Data collection

To identify the studies, an electronic search was carried out on October 30 and 31, 2023, via the Virtual Health Library (VHL) in the Latin American and Caribbean Literature on Health Sciences (LILACS), Nursing Database (BDENF), Medical Literature Analysis and Retrievel System Online (MEDLINE), and the Scientific Electronic Library Online (SciELO) databases. The grey literature was not consulted. The search strategy was formulated with the combination of controlled descriptors in Portuguese and English - DeCS (Health Sciences

Descriptors) and MeSH (Medical Subject Headings) respectively - related to nursing care ("Nursing Care") and emergency services ("Emergency Medical Services") and their respective synonyms and/or keywords, combined with Boolean operators (AND and OR). The search strategies were initially carried out in SciELO and, later, in the other databases, recommending the specificities of each of them (Chart 2).

**Chart 2 -** Search strategies used in the databases. Senhor do Bonfim, BA, Brazil, 2023.

| Database | Number of studies identified | Search strategy |
|---|---|---|
| SciELO | 1274 | (*"Cuidados de enfermagem" *OR* "Cuidado de enfermagem" *OR* "Atendimento de enfermagem" *OR* "Assistência de enfermagem" *OR* "Nursing Care" *OR* "*Care, Nursing*" *OR* "*Management, Nursing Care*" *OR* "*Nursing Care Management*") *AND* ("Serviços Médicos de Emergência" *OR* "Pronto socorro" *OR* "Atendimento Pré-hospitalar" *OR* "Atendimento de emergência pré-hospitalar" *OR* "Centros de emergência" *OR* Samu *OR* "Serviços de atendimento de emergência" OR "*Emergency Medical Services*" *OR* "*Emergency Services, Medical*" *OR* "*Emergency Service, Medical*" *OR* "*Medical Emergency Service*" *OR* "*Medical Emergency Services*" *OR* "*Service, Medical Emergency*" *OR* "*Services, Medical Emergency*" *OR* "*Medical Services, Emergency*" *OR* "*Emergency Medical Service*" *OR* "*Medical Service, Emergency*" *OR* "*Service, Emergency Medical*" *OR* "*Services, Emergency Medical*" *OR* "*Prehospital Emergency Care*" *OR* "*Emergency Care, Prehospital*" *OR* "*Emergicenters*" *OR* "*Emergicenter*") |
| MEDLINE | 892 | ("Cuidados de enfermagem" *OR* "Cuidado de enfermagem" *OR* "Atendimento de enfermagem" *OR* "Assistência de enfermagem" *OR* "*Nursing Care*" *OR* "*Care, Nursing*" *OR* "*Management, Nursing Care*" *OR* "*Nursing Care Management*") *AND* ("Serviços Médicos de Emergência" *OR* "Pronto socorro" *OR* "Atendimento Pré-hospitalar" *OR* "Atendimento de emergência pré-hospitalar" *OR* "Centros de emergência" OR Samu *OR* "Serviços de atendimento de emergência" *OR* "*Emergency Medical Services*" *OR* "*Emergency Services, Medical*" *OR* "*Emergency Service, Medical*" *OR* "*Medical Emergency Service*" *OR* "*Medical Emergency Services*" *OR* "*Service, Medical Emergency*" *OR* "*Services, Medical Emergency*" *OR* "*Medical Services, Emergency*" *OR* "*Emergency Medical Service*" *OR* "*Medical Service, Emergency*" *OR* "*Service, Emergency Medical*" *OR* "*Services, Emergency Medical*" *OR* "*Prehospital Emergency Care*" *OR* "*Emergency Care, Prehospital*" *OR* "*Emergicenters*" *OR* "*Emergice nter*") |
| LILACS | 237 | |
| BDENF | 248 | |

**Selection of studies**

After searching the databases, the results were exported to EndNote Basic, online version, a reference manager, in which the duplicate indexed references were extracted. Next, the selection of studies was carried out using the Rayyan web application, which can be accessed through the electronic address https://rayyan.qcri.org. In this study, the studies were first examined

by reading the title and abstract, verifying whether they met the eligibility criteria of the present review. The studies considered eligible were read in full and analyzed according to the eligibility criteria.

**Selection criteria**

Primary studies were included, available in full and free of charge, published in Portuguese, English or Spanish, without time cut, since the objective was to include all studies that addressed the theme. Studies that were not available for free online reading in full, indexed in duplicate, theses, dissertations, congress abstracts, annals, and those carried out in Psychiatric Hospitals, Emergency Rooms (ER), Emergency Care Units (UPA), that did not meet the scope of this review or that touched on the theme were excluded. A total of 2651 studies were identified, of which 1274 were found in SciELO, 237 in LILACS, 892 in MEDLINE and 248 in BDENF, the last three being searched via VHL on an individual basis.

The filters "language" (English, Spanish and Portuguese) were used, excluding 156 studies from MEDLINE, and "full text" excluding 419 studies from MEDLINE, 40 from BDENF and 58 from LILACS. No filters were used in the search carried out in SciELO. Thus, after using the filters, 1978 studies remained that were later exported to the EndNote Basic reference manager, online version, where 532 references indexed in duplicate in at least two databases were excluded, totaling 1446 studies.

Among the 1446 studies identified and evaluated (through the Rayyan web application), 1424 were excluded because they did not meet the eligibility criteria of the present review, by reading the title (1344) and abstract (79). Of the 23 studies eligible for analysis, 1 was excluded due to the unavailability of full/free text and free of charge, leaving 22 studies for full reading. Of these, 15 were excluded because they did not meet the eligibility criteria: 11 because it touched on the topic addressed, 1 thesis, 2 dissertations and 1 because it was carried out in two hospitals in Indiana. Thus, the present review is composed of 7 studies in the final sample.

**Instrument used to collect information**

The data of the included studies were used using the form adapted in the instrument validated by Ursi24 and includes: identification of the studies (title of the article, author(s), language, year of publication, journal), place where the study was conducted, methodological characteristics (study design as used by the author(s) and sample), results and conclusions.

**Data analysis**

They were analyzed qualitatively, synthesizing the evidence from the primary studies in a descriptive way. Considering it fundamental, the level of evidence (NE) was evaluated, ranging from level I (systematic review or meta-analysis - a synthesis of evidence from all relevant randomized and controlled

trials) to level VII (Opinion or consensus - official opinion of the expert committee).[25]

## Results

The present review analyzed the sample composed of 7 primary studies that identified how nursing care is provided in the face of psychiatric urgencies and emergencies in SAMU and the obstacles encountered by these professionals in this context. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart for the selection of studies can be seen in Figure 1.

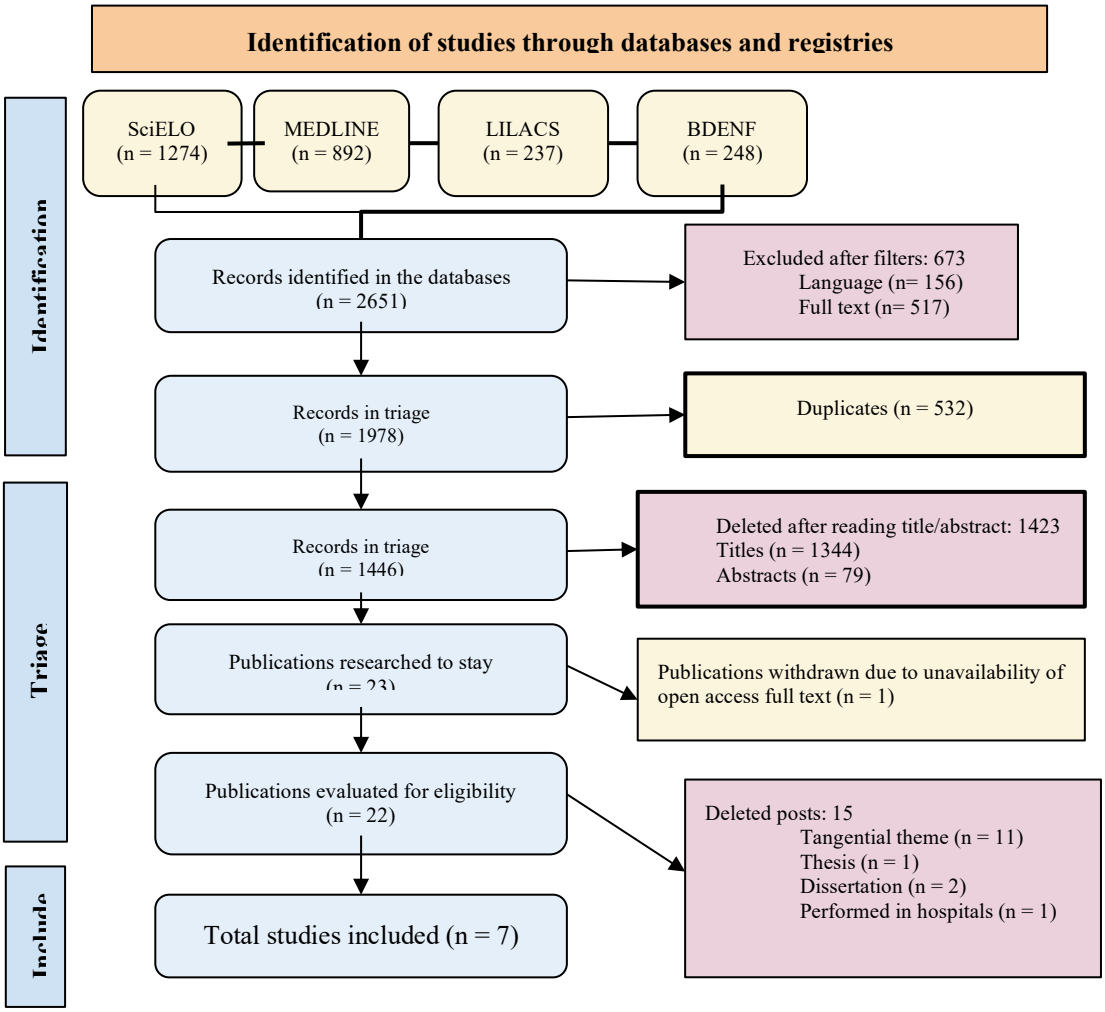


**Figure 1 -** Flowchart for selecting the studies of this integrative review (n=7), according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model. Senhor do Bonfim 2023 in Brazil - Dates.

The general synthesis of the studies included in this review is shown according to the identification of the studies (authors, language, year of publication), title of the article, journal, methodological characteristics (study design according to the nomenclature used by the author(s) and sample), level of evidence (Chart 3) and objectives, results and conclusions (Chart 4).

The sample had the highest number of publications in 2015 (n=2; 28.57%)[19,26] and 2020 (n=2; 28.57%)[29-30], in the years 201628, 2017[20] and 201828 3 study publications were carried out, 1 study per year (14.28%). The studies

were published in English and Portuguese (n=3; 42.85%)[27,30-31] and only in Portuguese (n=4; 57.14%)[19-20,27-28]. Six studies were published in national journals (85.71%)[19-20,26,28-30] and 1 in an international journal (14.28%),[27] of which 6 occurred in nursing journals (85.71%)[20,26-30] and 1 in a public health journal (14.28%).[19] These are descriptive[20,26-30] and exploratory[19,26-28,30] case study studies[19], with a qualitative approach[19-20,26-30]. Most of the studies were carried out in Mossoró/RN (n=3; 42.85%)[20,29,30], the others were carried out in Santa Catarina (n=1; 14.28%),[26] Natal/RN (n=1; 14.28%)[19], Itabuna/BA (n=1; 14.28%[28] and Rio Grande/RS (n=1; 14.28%)[30]. Regarding the level of evidence, all studies had level VI (Chart 3).

**Chart 3 -** Synthesis of the studies included to compose the final sample of the integrative review (n=7), according to identification (authors, year and language), title of the article, journal, type of publication, sample and level of evidence. Senhor do Bonfim, BA, Brazil, 2023.

| ID* | Title | Journal | Type of Publication | Sample | LE† |
|---|---|---|---|---|---|
| Almeida AB, Nascimento ERP do, Rodrigues J, Zeferino MT, Souza AIJ de, Hermida PMV. (2015)[26]<br><br>Portuguese / English | Mobile emergency care in the psychic crisis and the psychosocial paradigm | Nursing Context Text | This is a qualitative, exploratory, descriptive study. | Four teams from the USB‡ of SAMU§ of a municipality of Santa Catarina. | VI |
| Brito AAC de, Bonfada D, Guimarães J. (2015)[19]<br><br>Portuguese | Where Reform Has Not Yet Arrived: Echoes of Psychiatric Emergency Care | Physis: Journal of Collective Health | This study was carried out with a qualitative, exploratory and case study approach. | 24 professionals from SAMU§ in Natal, Rio Grande do Norte | VI |
| Bastos F, Dutra C, Silva JA da, Pacheco K, Silva T. (2016)[27]<br><br>Portuguese | Mental health in mobile PHC** | Portuguese Journal of Mental Health Nursing | This is a descriptive and exploratory study with a qualitative approach | 28 professionals of the SAMU§ of the municipality of Itabuna, Bahia | VI |
| Oliveira LC de, Silva RAR da. (2017)[20]<br><br>Portuguese | Knowledge and practices in psychiatric urgencies and emergencies | UERJ Nursing Journal | Descriptive study with a qualitative approach | 34 nursing professionals from SAMU§ in the city of Mossoró/Rio Grande do Norte | VI |

| | | | | | |
|---|---|---|---|---|---|
| Oliveira LC de, Silva RAR da, Carvalho FPB de, Soares FRR, Souza KMN de, Solano LC. (2018)[28]<br><br>Portuguese | Difficulties in attending to psychiatric urgencies and emergencies at SAMU§ | Nursing in focus | Descriptive, exploratory and qualitative research | 34 nursing professionals from SAMU§ in the city of Mossoró/Rio Grande do Norte | VI |
| Oliveira LC de, Menezes HFde, Oliveira RL de, Lima DM de, Fernandes SF, Silva RAR da. (2020)[29]<br><br>Portuguese /English | Mobile care for psychiatric urgencies and emergencies: perception of nursing workers | Brazilian Journal of Nursing | Descriptive study with a qualitative approach | 34 nursing professionals from SAMU§ in the city of Mossoró/Rio Grande do Norte | VI |
| Silva SDV da, Oliveira AMN de, Medeiros SP, Salgado RGF, Lourenção LG. (2020)[30]<br><br>Portuguese / English | Nurses' conceptions regarding the use of psychiatric emergency protocols in mobile PHC** | UERJ Nursing Journal | This is a qualitative, descriptive exploratory study. | 9 nurses from the SAMU team§ in the city of Rio Grande, Rio Grande do Sul | VI |

*ID = Identification (authors, year and language); †LE = Level of Evidence; §SAMU = Mobile Emergency Care Service; ‡ USB = Basic Support Unit; **PHC = Pre-Hospital Care.

The studies showed that nursing care in the PHC for people in psychic crisis is offered in an inadequate, dehumanized and ineffective way[19,28-29], since it follows protocol[26,30], mechanical and punctual measures[29], based mainly on the use of coercive force, exercised mainly by the help of military police, physical and/or chemical restraint and referral/hospitalization in a psychiatric hospital.[19,26-27,29-30]

The lack of a hierarchical, structured and problem-solving network of mental health services[20,28], the need for training and instrumentalization for nurses' work in psychiatric urgencies/emergencies[19,30], the use of protocols that direct care and interfere in the management of individuals in psychiatric crises[30], are evidenced as obstacles to the provision of humanized care and consolidation of BPR guidelines in PHC. [19-20,29-30] (Table 4)

**Chart 4 -** Synthesis of the studies included to compose the final sample of this integrative review (n=7), according to identification (authors and year), objectives, results, and conclusions. Senhor do Bonfim, BA, Brazil, 2023.

| ID* | Objectives | Results | Conclusions |
|---|---|---|---|
| Almeida AB, Nascimento ERP do, Rodrigues J, Zeferino MT, Souza AIJ de, Hermida PMV. (2015)[26] | To know the perception and interventions of SAMU basic support teams§ in the situation of psychic crisis. | 3 discourses emerged: crisis as a change in behavior and psychological instability; manifestation with the presence of hallucinations and aggressiveness. | The professionals' conception of crisis is linked to the positivism of psychiatry, and pre-hospital care follows protocol measures in the care of people in psychic crisis, far from the principles determined by the psychosocial paradigm. |

| | | | |
|---|---|---|---|
| Brito AAC de, Bonfada D, Guimarães J. (2015)[19] | To discuss the care provided to psychiatric crises by SAMU health professionals§ | 4 categories of analysis emerged: the military police and psychiatric occurrences; characteristics of the care provided by SAMU§ in psychiatric emergencies; need for professional training; responsibility of SAMU§ with psychiatric emergencies. | The discussion points out that elements associated with the asylum practice, such as the use of coercive force, exercised mainly with the help of military police, still support the ideas and assistance provided by the professionals interviewed. |
| Bastos F, Dutra C, Silva JA da, Pacheco K, Silva T. (2016)[27] | To apprehend the conceptions of the professionals involved in PHC** about mental health care. | Negative conceptions were observed in relation to mental health, which reproduce a fragmented care model, which segregates the "crazy" to other spaces, not allowing the expanded dimension of care, with equal access, because it understands this subject as different, threatening, leading to exclusion. | Fragmented concepts about health reduce access to services and the reorientation of this logic is necessary to qualify care and promote in these professionals the commitment to expanded and comprehensive health care, regardless of the user who will use SAMU§. |
| Oliveira LC de, Silva RAR da. (2017)[(20)] | To identify the existing difficulties in the implementation of emergency care for users in psychiatric suffering in SAMU §. | The following categories emerged: obstacles in care for psychiatric urgencies and emergencies; strategies for the consolidation of comprehensive care in psychiatric urgencies and emergencies. | The lack of an organized and hierarchical mental health care network constitutes an obstacle to the consolidation of the BPR guidelines† in practice. |
| Oliveira LC de, Silva RAR da, Carvalho FPB de, Soares FRR, Souza KMN de, Solano LC. (2018)[28] | Identify the existing difficulties in the implementation of emergency assistance to the user in suffering psychic in SAMU§. | The nursing care offered to users in urgent and psychiatric emergency situations is performed inadequately, mainly due to the lack of a structured and problem-solving mental health service network. | The lack of an organized and hierarchical mental health care network is an obstacle to the RPB† guidelines being implemented in practice. |
| Oliveira LC de, Menezes HF de, Oliveira RL de, Lima DM de, Fernandes SF, Silva RAR da. (2020[29] | To understand how nursing workers perceive the care of people in situations of urgency and psychiatric emergencies in SAMU §. | The analysis of the interviews allowed the identification of three categories: mechanistic practice, need for qualification and (de)humanization of care. | Nursing workers perceive that care for people in situations of urgency and psychiatric emergencies in SAMU§ is mainly based on physical and chemical containment measures, making care less resolutive and dehumanized and raising the need for professional qualification. |
| Silva SDV da, Oliveira AMN de, Medeiros | To know the nurses' conceptions | Two categories were listed: Psychiatric emergency care protocols and their use in the | The study showed the context of nurses' practice in psychiatric emergencies and |

| | | | |
|---|---|---|---|
| SP, Salgado RGF, Lourenção LG. (2020)[30] | regarding the use of protocols in psychiatric emergency in the mobile pre-hospital environment. | PHC service**; and Factors that influence psychiatric urgent and emergency care. | evidenced that SAMU nurses§ are not properly equipped to work in psychiatric urgencies/emergencies. |

*ID= Identification (authors, year); §SAMU= Mobile Emergency Care Service; **PHC = Pre-Hospital Care; †RPB = Brazilian Psychiatric Reform.

## Discussion

The present review summarized the evidence in the primary studies included related to nursing care in the face of psychiatric urgencies and emergencies in SAMU and found that the obstacles, related to the lack of training of professionals and the fragility in the mental health network, which is mainly based on coercive practices, chemical, physical and mechanical restraints, with the support of military police and resulting in the referral/hospitalization of the individual in crisis in the mental hospital[19,20,26-30].

SAMU, which is a mobile PHC service - aims at the early arrival of the individual after the occurrence of a health problem and provides assistance and/or adequate referral to a health service duly hierarchized and integrated with the SUS - is the gateway for individuals with mental disorders in crisis situations, being responsible for articulating the flow of mental health care and providing care to these individuals, together with the RAPS, police and fire department, as determined by Ordinance 2048/2002.[7-13]

However, despite occupying a strategic place in the SUS, they are a troubled point in the RAPS, because most of the time, the professionals who are there end up prioritizing the sedation of the individual and the referral of the individual to hospitalization, when they are faced with manifestations of a psychic crisis.[21]

Sometimes, psychiatric occurrences show situations that determine the performance of verbal management, through therapeutic communication and the use of a more comprehensive approach, demanding an atypical time of care from the other occurrences of SAMU, which advocate response time, compromising the protocol bases of agility in care, based on effective and problem-solving care.[13,31] This is evidenced in studies, who pointed out as obstacles: the use of general protocols, the fragmented conception of the crisis and lack of professional training on psychiatric emergencies.

SAMU acts based on protocols, which were designed to effectively promote the reduction of probable traumatic situations to the victim, even at the scene of the occurrence. However, the protocol used in psychiatric emergency refers to verbal management, and is similar to the other general protocols used in daily practice, standardizing the performance of systematized care in stages.[32]

Configuring itself as a challenge with regard to nursing care in psychiatric emergencies, acting in the face of the unexpected can cause nurses to emerge from fear, with the strengthening of the stigmatization of the psychiatric crisis, due to the fragmentation of its conception and the perception

of the possibility of aggression, which may be related to the academic education of nurses and the lack of specific training for psychiatric emergency care.[32-34]

This practice is widely used in SAMU, in general hospitals, UPA, and goes against the ideas of the RPB, harms humanized care for individuals in psychiatric crisis in the context of mobile PHC and evidences the power relations that characterize classical psychiatry and its authority to take the body as the object of its practices.[35]

The restraints aim to restrict the patient's physical movements, due to the risk they present to themselves and to third parties, and are supported by the resolutions of the Federal Council of Medicine (CFM)[36] and Resolution No. 427/2012 of the Federal Council of Nursing (COFEN)[37]. In SAMU, the three types of restraint are sometimes carried out indiscriminately, permeated by prejudice and fear of aggressiveness. Physical restraint is performed manually by health professionals; in mechanical restraint there is the use of ties or bands and in chemical restraint medication administration is used.

Since individuals in crisis are guaranteed rights, such as the right to have their care provided in a therapeutic environment with the use of less invasive practices possible, the physical and/or mechanical restraint of the individual in psychiatric crisis should be avoided as much as possible, and the last intervention resources should be used after all attempts to calm him have been exhausted. through therapeutic communication, in order to establish a relationship of trust.[7,38-39]

However, this is not what happens in the daily routine of psychiatric emergencies, since police support is activated even before the team is sent to the place of care, based on the information provided by the family member or guardian during the call and request for care and not on the presence of observation of the psychiatric crisis.[10,31]

Thus, nurses need to be able to identify situations that pose a risk in psychiatric emergencies, moving away from interventions based on stereotyped and stigmatized judgments, based on the ideas of traditional psychiatry.[7-10,31]

The care offered by the SAMU team to psychiatric crises should occur in a humanized way and prioritize the stabilization of the individual's clinical condition, through the control of the target symptom, the recognition of pathologies and/or organic alterations that may interfere with mental alterations and contemplate the guidelines of the BPR, decharacterizing itself as a mere instrument of asylum transport.[14,34]

Thus, it needs professionals trained in dealing with situations of psychic crisis, solid articulation with the other services of the mental health network, for guidance and continued care, following the principles and guidelines of the SUS and respecting the PNSM.[7,12] In view of this, psychiatric urgency and emergency should be apprehended as a moment that needs caution on the part of qualified professionals, to enable the individual to have his creative and transforming potential, since the suffering experienced by him is not perceptible to the eyes.[40]

**Study limitations**

Despite the importance of the results brought by this study, it should be considered within the scope of its limitations: the number of databases searched, which may have limited access to other data; the lack of studies that

addressed the object of research; Among the selected studies, 3 were conducted at the same institution and with the same sample; and the classification of the level of evidence, in which all 7 studies included had level VI, which may compromise the generalization of the study to other contexts.

Therefore, it is recommended that further research be carried out regarding aspects involving nursing care in the daily care of psychiatric urgencies and emergencies in SAMU, given that the present study does not intend to exhaust the theme, but rather to open perspectives about it.

## Conclusion

This integrative review allowed us to analyze the evidence in the literature regarding nursing care for psychiatric urgencies and emergencies in SAMU and to identify the obstacles to fulfilling this role. It was observed that the training of professionals is inadequate both in initial training and in continuing education. The care provided to individuals in psychiatric crisis by the SAMU team is still performed in an inadequate, mechanized, dehumanized, and poorly resolutive way, based on general protocols, already institutionalized, which prioritize speed more than verbal management and therapeutic approach, which are essential for the care of individuals in psychiatric crisis.

It is considered that the present research was successful in the proposed objective and provided a view of the practice of nurses who work in SAMU in psychiatric urgencies and emergencies, favoring the development of future research aimed at expanding knowledge in this specific area, in order to provide patients with a more humanized care that is appropriate to the unique needs of this population.

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**Correspondent Author**
Aizia Salvador
600 Agricultura Av. ZIP: 48970-000- Derba. Senhor do Bonfim, Bahia, Brazil.
aiziasalvador@hotmail.com