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Psychiatric observation of patients in crisis: an experience report

Observação psiquiátrica de pacientes em crise: relato de experiência

Observación psiquiátrica de pacientes en crisis: relato de experiencia

ABSTRACT

Objective: To report the experience of psychiatric observation of patients in crisis followed at a Psychosocial Care Center in the interior of Ceará, Brazil. **Methods:** Experience report developed by a nursing resident from May 2022 to February 2023, carried out in the observation unit of a CAPS III. The reflections were based on professional perceptions during care delivery. **Results:** A strong hegemony of the medical-centered model was identified, with emphasis on chemical restraint and limited use of non-pharmacological practices. The absence of a systematic routine of the multiprofessional team in the observation beds was observed, as well as low inclusion of stable patients in therapeutic groups and significant fragility and overload of family members in the caregiving process. **Final considerations:** Gaps in post-discharge follow-up were noted, highlighting the need to strengthen crisis care through expanded clinical practice and family support.

Keywords: *Mental Health; Crisis Intervention; Comprehensive Health Care.*

RESUMO

Objetivo: Relatar a experiência da observação psiquiátrica de pacientes em crise, acompanhados em Centro de Atenção Psicossocial no interior do Ceará, Brasil. **Métodos:** Relato de experiência de uma enfermeira residente, no período de maio de 2022 a fevereiro de 2023. O cenário do estudo foi a unidade de observação do Centro de Atenção Psicossocial (CAPS) III, no interior do Ceará. Utilizaram-se as percepções para subsidiar as reflexões. **Resultados:** Evidenciou-se potencial hegemonia do modelo medicalocêntrico, com foco na contenção química e pouca utilização de práticas não farmacológicas. Identificaram-se a ausência de rotina

sistemática da equipe multiprofissional nos leitos, a baixa inserção de pacientes estáveis em grupos terapêuticos e a acentuada fragilidade e sobrecarga dos familiares no processo de cuidar. **Considerações finais:** Notaram-se lacunas no monitoramento pós-alta. Enfatiza-se a necessidade de potencializar o atendimento às crises, por meio da clínica ampliada e do fortalecimento do suporte à família.

Palavras-chave: *Saúde Mental; Intervenção em Crise; Assistência Integral à Saúde.*

RESUMEN

Objetivo: Relatar la experiencia de la observación psiquiátrica de pacientes en crisis atendidos en un Centro de Atención Psicosocial en el interior de Ceará, Brasil. **Métodos:** Relato de experiencia desarrollado por una enfermera residente entre mayo de 2022 y febrero de 2023, realizado en la unidad de observación de un CAPS III. Las reflexiones se basaron en las percepciones profesionales durante la atención. **Resultados:** Se evidenció una fuerte hegemonía del modelo medicalocéntrico, con énfasis en la contención química y escaso uso de prácticas no farmacológicas. Se identificó la ausencia de una rutina sistemática del equipo multiprofesional, la baja inclusión de pacientes estables en grupos terapéuticos y una marcada sobrecarga y fragilidad familiar. **Consideraciones finales:** Se observaron lagunas en el seguimiento post alta, destacándose la necesidad de fortalecer la atención a las crisis mediante la clínica ampliada y el apoyo familiar.

Descriptores: *Salud Mental; Intervención en Crisis; Atención Integral de la Salud.*

INTRODUCTION

In the 1970s, amid Brazil's re-democratization movements, the Brazilian Psychiatric Reform emerged, proposing to move beyond the hospital-centered and medicalizing model, which led to a restructuring of care based on deinstitutionalization. This shift entailed transformations in the cultural, political, and ethical spheres, redefining how psychological distress is addressed and prioritizing the individual's subjectivity over isolation[1].

This paradigm transition was consolidated with the implementation of the Brazilian Unified Health System (SUS), which broadened the perspective on mental health practices. In this scenario, the Psychosocial Care Centers (CAPS, acronym in Portuguese) became public facilities dedicated to health promotion and the treatment of severe and persistent cases. As substitute devices, CAPS aim to facilitate the user's social integration and organize the care network, acting directly in crisis management[2].

In the daily routine of these services, crisis care reveals itself to be a complex challenge that goes beyond merely suppressing symptoms or relying on pharmacological containment; it demands the ability to deal with uncertainty and the reorganization of work processes. However, despite theoretical advances, a gap is observed in clinical practice regarding the effectiveness of observation protocols and multidisciplinary management, which often results in discontinuity of care and the recurrent return of patients to psychiatric observation services.

In this way, this study is justified by the identification, based on the experience at the Community Mental Health residential facility, of areas that require improvement, including: coordination among the multidisciplinary team, the insertion of alternative therapies, and post-discharge monitoring. Consequently, understanding the conduct of the process from admission to counter-referral in the community is necessary to develop strategies that ensure the maintenance of the individual's mental health and their effective social reintegration.

The presentation of these processes, including admission flows, the observation period, and post-discharge follow-up, proves to be of great relevance to the Psychosocial Care Network (RAPS, acronym in Portuguese). Identifying shortcomings in these stages allows for the strengthening of care and the restoration of users' health.

In light of the above, this study aimed to report on the experience of psychiatric observation of patients in crisis, treated at a CAPS in the interior of Ceará, from the perspective of a multidisciplinary residency program.

METHODS

This was a descriptive, case-report study with a qualitative approach, conducted from May 2022 to February 2023 during the theoretical and practical

training of a nursing resident in the Community Mental Health Residency Program at the Ceará School of Public Health (ESP-CE).

The scenario of the study set was a Psychosocial Care Center (CAPS III) located in the municipality of Iguatu, Ceará, Brazil. The municipality has an extensive mental health network, comprising three CAPS centers: CAPS III, the Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD), and the Psychosocial Care Center for Children and Adolescents (CAPS II), as well as the Therapeutic Residence.

The participants of the experiential learning activity were patients experiencing acute psychological distress who required psychiatric observation at CAPS III. To organize the experience, the framework for the systematization of nursing care and the guidelines of the National Mental Health Policy were adopted. The perceptions were structured around the following themes: crisis reception, multidisciplinary management during observation, and coordination with the network for discharge.

As this is an experience report, the study was not submitted to the Research Ethics Committee. However, the ethical principles of Resolutions No. 466/12 and No. 510/16 of the National Health Council[3] were respected.

RESULTS

The study enabled the systematization of the care pathway for users in crisis at the CAPS. The service serves as a referral center for the host municipality and nine other surrounding municipalities. Access occurs through walk-ins or referrals from the healthcare network. Initial intake is conducted by a multidisciplinary team (Nursing, Social Work, Psychology, Education, Physical Education, and Occupational Therapy).

CAPS has five observation beds, which require a family member to be present full-time. It was observed that daytime care is provided by a full staff, while nighttime care, until February 2023, was limited to technical nursing support and monitoring. After that period, a nurse was assigned to the nighttime intake team.

When a patient is evaluated by the multidisciplinary team, the professionals decide on the course of action: whether the patient can be treated with medication at home or will remain under psychiatric observation for stabilization and monitoring. In most cases, chemical restraint is used; in other cases, mechanical restraint is employed.

In the daily routine of the facility, patients undergo an intensive process of medicalization. The nursing staff administers prescriptions, and the service has laboratory support to ensure timely release of results. When highly complex tests, such as CT scans, are requested, the team coordinates with the Municipal Health Department to refer patients to the municipal polyclinic, subject to approval by the municipal consortium and the patient's clinical stability.

During their stay, meals are provided by the CAPS for both the patient and their companion. The observation period generally ranges from one to two weeks but may be extended to three weeks to ensure complete stabilization. Once the patient has improved, they are discharged with a follow-up appointment scheduled for a psychiatric evaluation; patients from other municipalities are advised to seek follow-up care in their cities of origin.

The resident's insertion into the health service was active and integrated into the multidisciplinary team, with direct participation in the implementation of the care pathway. Her duties included conducting the initial intake and applying the triage protocol for psychiatric risk classification. In the unit's daily routine, the resident managed patient care in the observation beds, documenting progress in medical records, monitoring vital signs, and administering medication under the supervision of the unit preceptor.

Additionally, the resident participated in team meetings to develop Individualized Treatment Plans (PTS), facilitated communication between the service and the social assistance support network, and conducted health education activities with family members, focusing on crisis management and treatment adherence. We identified weaknesses in this experience. Chart 1 presents a summary of the main weaknesses identified in the care pathway and their respective impacts on the quality of care provided.

Chart 1 – Weaknesses observed in the flow of care and impacts on crisis care.

Flow stages	Identified fragilities	Impacts on Care
Multiprofessional assistance	Reactive care and the absence of a systematic routine for patients under observation.	Fragmentation of care and centralization of conduct in medical knowledge.
Therapeutic management	Low insertion in non-pharmacological practices.	Underuse of therapeutic resources and reduction of the subject's autonomy.
Family support	Deficit in guidance for home management and caregiver burden.	Difficulty in medication adherence and post-discharge family insecurity.
Post-discharge	Lack of systematic monitoring in the territory.	Occurrence of the "revolving door" phenomenon (frequent readmissions).

Source: Prepared by the authors.

The lack of a standard protocol for the multidisciplinary team to assist patients in crisis was highlighted. However, it was noted that, in specific cases, these professionals did intervene. It is worth mentioning that upon arrival at the

facility, the patient is taken for psychiatric observation, during which the screening team—typically consisting of nurses, social workers, and educational specialists from the service—assesses whether there is a need for social services. Based on this assessment, the case is referred to a social worker, who may then coordinate interventions with the care team.

It was noted that family members were feeling overwhelmed by this caregiving process. Challenges were observed in dealing with behavioral changes. Thus, it is noteworthy that relatives were unable to administer medications as prescribed and had difficulty understanding the guidelines provided by professionals to assist in the care and improvement of patients' mental health. Furthermore, after discharge, there was no monitoring of how the patient was progressing at home.

The observation allowed us to list points that impacted the effectiveness of comprehensive care. It was noted that the multidisciplinary team's actions were reactive to specific demands, lacking a joint and systematic care routine focused on the observation beds. Additionally, the dominance of the medicalizing model was evident, reflected in the absence of alternative therapies or non-pharmacological practices in crisis management, as well as the low insertion of patients under observation in the unit's therapeutic groups.

It became evident that families were in a vulnerable state at the time of discharge and had difficulty understanding medication management. The lack of a systematic post-discharge monitoring process was identified as a major factor contributing to the recurrence of crises and the "revolving door" phenomenon at the facility. This refers to the phenomenon of successive and frequent hospitalizations, in which the patient is discharged after symptoms stabilize but returns to the service within a short period of time due to a lack of support, monitoring, or continuity of care in the community.

In contrast to the weaknesses identified, the fieldwork allowed us to identify facilitating factors that supported care, as summarized in Chart 2.

Chart 2 – Potentialities and strengths identified in the CAPS care flow.

Strengthening elements	Potentialities	Impacts not taken care of
Easy access	Opening for spontaneous demand and support to ten municipalities in the region.	It guarantees an open door and immediate reception in situations of acute crisis.
Team composition	Presence of a diversified multiprofessional team and specialized preceptorship.	It allows multiple perspectives on the case and qualified technical support for residents.
Diagnostic Support	Articulation with the network for laboratory and imaging tests (Polyclinic).	Agility in the exclusion of organic causes and safety in clinical stabilization.

Risk stratification	Use of a specific triage instrument for psychiatric emergencies.	Systematization of the priority of service and safety in decision making.

Source: Prepared by the authors.

The service was verified to be effective at the RAPS in the region. The CAPS, as a walk-in facility for spontaneous visits, combined with its support for nine surrounding municipalities, establishes the facility as a model for managing acute crises outside the conventional hospital environment. This accessibility is enhanced by the presence of a diverse, multidisciplinary team.

Furthermore, the agreement with the municipal network to perform highly complex laboratory and imaging tests provides clinical assurance for interventions, enabling rapid differential diagnosis. In addition, the provision of comprehensive logistical support serves as a factor promoting humanization and equity.

Furthermore, the use of a proprietary triage and risk classification tool demonstrates an effort to systematize psychiatric care. This tool ensures that cases of greater clinical or subjective severity are prioritized, guaranteeing a rapid response from the psychiatry team and residents.

DISCUSSION

Psychiatric deinstitutionalization reflects the transformation of the Brazilian mental health landscape, promoting shorter periods of hospitalization and prioritizing care in open and community-based services. This process directly impacts the consolidation of an integrated, community-based care model[4], as observed in the care pathway of the unit studied.

The “revolving door” phenomenon is a major challenge in mental health care. Rehospitalization rates are linked to the disjointed nature of the primary care network and the isolation of specialized care centers. The crisis is resolved clinically, but the individual returns to an underserved community, which demonstrates that the effectiveness of a crisis service is not measured solely by in-hospital stabilization but by the capacity for intersectoral integration[5].

In this context, the inclusion of the family in the process of rehabilitation and psychosocial reinsertion becomes indispensable. As evidenced, the requirement for a full-time caregiver in the observation unit reinforces that the family is an essential component for the continuity of treatment. However, it is imperative to consider the impacts on the family unit, which often experiences changes in routine, financial circumstances, and emotional relationships[6]. Shared responsibility for care, which ranges from crisis management to support with daily activities, can lead to significant caregiver burden[7].

The reactive action of the multidisciplinary team points to a crisis among mental health professionals when faced with psychiatric emergencies. In the literature, it is observed that psychosocial “practice” often takes a back seat in the

face of an acute crisis, delegating exclusive responsibility for management to the physician. This trend undermines the interdisciplinary approach mandated by Law 10.216/2001 and limits the potential of nonpharmacological therapies as tools for behavioral and subjective management[8].

The regional coverage of the service, which assists ten municipalities, imposes logistical challenges to the continuity of care. The centralization of crisis response facilities in hub cities can, paradoxically, weaken the matrix-based care model in Primary Care in satellite cities. This geographic distance between the discharge location (CAPS) and the user's place of residence hinders systematic monitoring, making the network vulnerable and contributing to treatment discontinuity, which culminates in the recurrence of the crisis[9].

Furthermore, the availability of diagnostic support and coordination with the network of highly complex tests establish CAPS as a robust health service. The integration with the Polyclinic demonstrates that the psychosocial model does not forego technological support but rather uses it to ensure clinical safety and differential diagnosis[10]. This support system is essential for the team of residents and preceptors to make sound decisions.

The insertion of multiprofessional mental health residency programs contributes to the strengthening of the SUS. Beyond the on-the-job training process, residents act as social agents who carry out care practices, fostering critical thinking and the application of scientific evidence in the day-to-day operations of CAPS. The work of these professionals enhances interdisciplinarity and expanded clinical practice, in addition to proposing interventions that improve the quality of care.

FINAL CONSIDERATIONS

An observation of crisis care revealed a contrast between a commitment to human connections and the persistence of a medical-centric model, exacerbated by structural weaknesses and a still-fledgling multidisciplinary approach. In this sense, it is essential to address the shortage of non-pharmacological practices and invest in care strategies that robustly include the family and health education.

In this scenario, the multidisciplinary residency program serves as a strategy for driving change, enriching the technical discourse and proposing new approaches that seek to break away from outdated institutional practices. The insertion of these professionals fosters the implementation of an expanded clinical approach and shared responsibility within the community, aiming to transform care beyond mere symptom stabilization. The development of practical interventions that ensure effective care and intersectoral coordination has been instrumental in promoting citizenship and social reinsertion.

As limitations, the study highlights the subjective nature inherent in the experiential account, which is based on the experiences of a single professional category in a specific setting; this prevents the generalization of the findings to other contexts within the Psychosocial Care Network. It is hoped that this study

will foster reflection on everyday crisis care practices. It was concluded that strengthening this level of care depends on intersectoral coordination that ensures continuity of care.

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Conflicts of Interest

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