Cogitare Enfermagem

ORIGINAL ARTICLE

# PSYCHIC CRISIS CARE DURING THE COVID-19 PANDEMIC IN THE LIGHT OF NECROPOLITICS*

## HIGHLIGHTS

1. COVID-19 has aggravated the denial of crisis care.
2. Shortage of services affects care; CAPS directs cases to SAMU.
3. CAPS does not treat people in crisis, especially during the pandemic.

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## ABSTRACT

**Objective:** to analyze care in severe psychic crises from the perspective of health professionals, people, and family members during the COVID-19 pandemic. **Method**: a multiple-case study, carried out with eight health professionals, six people in a crisis, and seven family members, monitored for three months, from October 2021 to June 2022, in a Brazilian capital. The data was analyzed using content analysis and the theoretical framework of necropolitics. **Results**: three categories emerged: "Scrapping the Psychosocial Care Network," "Outpatient Psychosocial Care Centre," and "Attending to the psychic crisis in the pandemic." This confirms a necropolitics that cuts across the field of mental health and affects vulnerable people, and the debate on funding and race is urgent. **Conclusion**: The lack of specialized mental health services, coupled with outpatient mental health services that began before the pandemic, has worsened crisis care.

**KEYWORDS:** Crisis Intervention; Pandemics; Covid-19; Black or African American; Health Services.

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## INTRODUCTION

The COVID-19 pandemic has impacted mental health globally, especially for those with pre-existing mental distress. The immediate effects of the virus on health, isolation, fear of infection, death, and loss of family members are risk factors for people in severe mental distress[1-2]. In addition, the reduction and closure of mental health services, which were already occurring before the pandemic, have further affected this population[2].

In 2020, the World Health Organization (WHO) launched a document with actions to deal with mental suffering during and after the pandemic, including ensuring uninterrupted face-to-face care for severe mental health conditions[3]. A systematic review and meta-analysis indicated that people with pre-existing mental disorders are at greater risk of Covid-194 worsening. In addition, a study also revealed that the pandemic has led to an increase in psychosis-related hospital admissions in France, with more people facing new severe psychic crises in specialized health units[5].

A severe psychic crisis is conceptualized as moments of evocation and expression that promote personal resignification. During these periods, the Self becomes diffuse or lost, with changes in feelings, behavior, and sensory perception. This can result in ruptures in the perception of reality and affect family and social relationships. However, these moments also offer opportunities for transformation, providing new meanings for the person[6].

However, the possibilities of caring for these people have been impacted during the pandemic and aggravated by the state's necropolitics[7]. Necropolitics refers to how government policies and practices directly affect people's lives and deaths in public health contexts. And how policies can promote death or neglect the preservation of life[8], especially in vulnerable groups such as people in psychic crisis.

In mental health, necropolitics can manifest itself in various ways, with changes to the Psychosocial Care Network, through Ordinances, Resolutions, and Technical Notes, favoring increased support for psychiatric hospitalization, representing the antithesis of the care model proposed by the Brazilian Psychiatric Reform. In addition, the stagnation in the pace of implementation of community services was evident and has been scientifically contested[9].

This represents the ongoing psychiatric counter-reform in the country, which began before the COVID-19 pandemic, excluding and oppressing vulnerable groups. Mental health, alcohol, and other drugs policy in the Brazilian context is also affected by economic and political interests, dismantling what was achieved by the Brazilian Psychiatric Reform[2], resulting in segregation and discrimination.

Thus, during the COVID-19 pandemic, despite the efforts to adapt mental health care in Brazil[10-12], research is needed on the care provided for mental health crises during this period that can contribute to a comprehensive understanding of the complexities involved in mental health care during the pandemic; as well as to the development of more effective intervention strategies and public policies aimed at this area. Thus, this study aimed to analyze care in severe mental health crises from the perspective of health professionals, individuals, and family members during the COVID-19 pandemic.

## METHOD

In a qualitative multiple-case study, two cases were selected: a Psychosocial Care Center (CAPS, in Portuguese) and an Emergency Care Unit (UPA, in Portuguese) in a capital city in the Midwest region of Brazil. Both services are fields for practical classes and receive a significant number of crisis cases. The crisis-related situations were selected for convenience, as they came to light during the researcher's time there.

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The inclusion criteria were people in intense or recent psychotic crises, with hallucinations and/or delusions, having a permanent home, and living with family. A protocol was used to collect data and monitor crises. The protocol is essential in multiple case studies. It is a document that contains the instruments, procedures, and general rules followed during data collection, increasing the reliability of the investigation[13].

For the person in crisis and their family members, a discursive interview was used about the experience of the mental health crisis. For professionals, a semi-structured instrument was constructed with questions about crisis care, workflows, and work processes before and during the pandemic. In this way, six crises were monitored, and data collection took place between October 2021 and June 2022, using interviews with professionals who attended to the crises, with people in crisis and family members, as well as field notes and medical records. They were conducted exclusively by a doctoral student with experience in research and crisis care.

Each case was followed up for three months, with a face-to-face interview in the health services, two home visits, and fortnightly telephone contacts, totaling at least five interactions. This period made it possible to observe possible changes in crises and identify new needs. In total, three people in crisis, three family members, and four CAPS professionals (a nurse, two psychologists, and a social worker) were interviewed and monitored; and, at the UPA, three crises, four family members, and four professionals (two nurses, a doctor, and a social worker). In both services, the professionals interviewed were those involved in caring for these families.

The interviews were recorded with the consent of the participants and lasted an average of 90 minutes. Field notes and data collection from medical records were carried out in the health services, following a script created by the researcher. The audio and records were organized in the MAXQDA-Analytics Pro 2022 program.

The categories were created using content analysis[14]. In the pre-analysis, the data was organized and separated by case study (CAPS and UPA). During exploration, the words were classified and grouped, resulting in 123 fragments: CAPS outpatient services (17), scrapping (63), and Covid-19 (46). After further reading, four fragments were discarded, resulting in three analytical categories: scrapping of the Psychosocial Care Network (57), CAPS outpatient care (17), and crisis care during the pandemic (45).

The analytical categories were discussed based on Achille Mbembe's theoretical framework on necropolitics, considering that, during the pandemic, mental health strategies

can reflect on care, disproportionately impacting the lives of already vulnerable people and resonating with Mbembe's concept of the death of bodies[8].

The program's visualization tool was used, which made it possible to highlight the links between the categories in an understandable way using the frequency map in Figure 1. The program used the initial documents and automatically showed the relationship between the categories.

The research was approved by the Research Ethics Committee under opinion number 5.057.047 in 2021. The information was coded to preserve confidentiality, identifying the professionals and services (Professional 1 - UPA, Professional 1 - CAPS) and the crises monitored (Family member - crisis 1, Family member - situation 2), as well as the medical records (MR) and the researcher's notes (RN).

## RESULTS

### Scrapping of Psychosocial Care Network services

During the interviews, it became clear that mental health in the municipality is in a precarious situation, with reports of a lack of medication and the absence of essential services in the care network. This situation has a significant impact on the RAPS(in Portuguese), which is weakened by the scrapping of mental health services, favoring admission to psychiatric hospitals.

*(on the insufficient services in the RAPS) I think it's the CAPS themselves because when these patients arrive here, they're already in crisis because sometimes they haven't had adequate follow-up at the outpatient level (...) either because they don't have the unit, or because they don't have the medication, or because they don't have an outcome.* (Professional 1 - UPA)

*CAPS 3 has yet to open. These patients who come here, who sometimes even end up going to the psychiatric hospital, if there was a CAPS 3, we could take them there, to one that worked 24 hours, and we wouldn't even need to send these patients to the psychiatric hospital. It's necessary, it's necessary for yesterday."* (Professional 5 - CAPS)

In addition to the need for a CAPS III, which is non-existent in the capital, the professionals are also concerned about the number of people treated at the CAPS, who, according to them, shouldn't remain there.

*Upon arriving at the CAPS, the professionals reported that during the most difficult phase of COVID-19, care was provided using a work schedule, suspending care for a fortnight and then limiting the number of new cases per day. At this point in the collection, appointments are made on an individual basis, which seems to contribute to professional overload.* (RN)

Another factor concerns the logistical component of the RAPS, which is scrapped in many ways and generates discontinuity in follow-up. There is no computerization of medical records at the CAPS, there is a lack of folders and a suitable place for them to be stored. Another problem is the lack of a car in the unit to carry out home visits, active searches, and matrix support, among others, limiting professionals to using the landline.

*Let's suppose that in six months they are discharged and have a crisis again; they come here, and their past is recorded in our medical records, but now we don't know what happened in those six months, what follow-up they had.* (Professional 1 - UPA)

*Group activities and home visits were suspended and had not been resumed at this service until the end of the survey. A landline telephone was used for active searches. The unavailability of a car for matrix support and home visits occurred even before the pandemic. In the past, professionals had to make appointments with the town hall vehicle, but now this is no longer possible.* (RN)

It was possible to identify that the physical structure of the CAPS is dilapidated. The facilities are old, and sometimes unsanitary, in the case of the only bathroom available to the professionals, with no specific rooms for applying medication and no stocks of equipment and medication. Basic supplies for care are lacking.

*A ceiling fan fell on top of the table in the cafeteria, scaring everyone at the CAPS. There are several broken benches on site; the bathroom for professionals is unsanitary, and there is no soap for washing hands.* (RN)

*As far as the patient is concerned, we usually arrange them here on the stretcher. We lay them out, but we don't even have a sheet. We put a TNT, sometimes we cover them up, and we lay them down until they stabilize. Now, if it's late, we arrange for the patient to go home, with their family, with their mother.* (Professional 5 - CAPS)

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This disregard also applies to the employment relationships of health professionals, since, due to the type of employment relationship, the contract needs to be renewed every two years, generating a feeling of insecurity for them.

*This week, I heard professionals talking about job insecurity due to the type of employment relationship, since contracts are renewed or not at the end of each year. This makes me think that, of the eight professionals interviewed, only one is a civil servant.* (RP)

*My relationship with the town hall is a contract. Now, at the end of the year, on December 31, 2021, my contract ends. It can be renewed or not. We're left feeling insecure."* (Professional 1 - CAPS)

## The outpatient logic of CAPS

The statements show that, before the COVID-19 pandemic, CAPS faced problems such as an outpatient approach to care, irregular working hours, a lack of case discussions and home visits, as well as a lack of institutional supervision. There were also difficulties in accessing medical professionals and a lack of singular therapeutic projects.

*People think that CAPS is an outpatient clinic, even though it works as an outpatient clinic. This is because we don't have supervision (institutional supervision) and a case study with the whole team; working hours are fragmented; some people work eight hours and others six.* (Professional 2 - CAPS).

*I heard one professional comment to another that the CAPS needed to be dis ambulate as if it had undergone a process of scrapping. This seems to me to be consistent with the medical records, since I didn't find any PTS in the records, even before the pandemic.* (NP)

*You see [medical professionals] in the corridor. It's something that should be more natural. He's a doctor and we're professionals just like him at CAPS. It should be an exchange. Like the exchange with other professionals, an exchange. Doctors should also be like that, meeting and discussing.* (Professional 1 - CAPS)

This fragmentation of care can also be seen in the medical records. The professionals stop at recording stories (sometimes the same event with reports from different professionals), changes in mental functions, descriptions of behavior at the time of the consultation, calls made, and dispensing prescriptions by a member of the team.

*23/07/2021 - The grandmother, Mrs. Flor, called CAPS to request a prescription. 30/07/2021 - The aunt withdrew the prescription.* (MR)

*22/11/2021 - The patient came to his appointment alone, showing stable behavior now, but a somewhat logorrheic dialogue was noticeable. He reported that he had been without his medication for 15 days. Prescriptions for risperidone 2 mg and escitalopram were handed in* (MR)

The professionals take turns providing individual care to each other, but there is no sense of a continuation of actions with specific interventions and goals, much less the construction of the STP, which is indispensable in situations of serious psychological crises. The above observation shows that the case discussion is not attended by the whole team and its focus is on medication.

## Serious mental health crisis care

The three crises monitored at CAPS involved two men and one woman. They all went to the Mobile Emergency Care Service (SAMU) and the UPA during their first psychic crises and were later referred to the CAPS. The 19-year-old started being monitored by the mental health service in 2021 when he was 18. Black, living in a lower-middle-class neighborhood, lives with his mother, stepfather, and three brothers. The other young man, aged 23, started attending CAPS in 2020 when he was 21. Black, lives with his grandmother, also in a lower-middle-class neighborhood, and was admitted to a psychiatric hospital for about two months. The woman, 29, brown, began to be seen by the team at the time of data collection in 2021, in her first psychic crisis, and lives with her partner and stepson.

The three crises encountered at the UPA involved two women and one man. The first woman, 32, brown, lives with her mother, son and two sisters. Her symptoms began around four years ago but have intensified in the last two years. The second young woman, 23, black, started having symptoms when she was 19 and currently lives with her sister but has been homeless. The young man, 31, white, lives alone with the support of his ex-stepmother and father. At the time, all situations were referred for admission to a psychiatric hospital.

The conduct adopted by the team, even before the pandemic, for crises that lead to more disorganized behavior, was to call the SAMU center and/or refer the person to the UPA. When they contacted SAMU, they were asked about the occurrence of aggressive behavior, so that in these cases the Military Police could be called.

*After the pandemic started, it became more difficult because the SAMU no longer takes people. Before the pandemic, it was a bit difficult with the SAMU, but then it got worse because they had nowhere else to go at the time. The SAMU would be called, they'd give medication on the spot, and the person would stay at home, or sometimes they'd even give medication here at CAPS.* (Professional 4 - CAPS)

Conducts such as taking medication and leaving, and the fact that the family itself had to take the person to the UPA, is evidence of care that lacks continuity and is centered on medication. Thus, in the context of the pandemic, the SAMU began to carry out the triage to ascertain the seriousness of the case and the medication at the person's home.

*The SAMU was called. Then, as he had already taken this medicine, they gave him two injections. Then he slept, slept... since then he hasn't improved, has he? (...) SAMU came and left.* (Family member - crisis 2)

In other cases, the UPA started denying care for a serious psychic crisis, even when taken by the SAMU, claiming a lack of beds.

*For God's sake, I'm begging you, I'm not eating, I'm not sleeping, for Christ's sake. "You can't take her". No, the SAMU can. No, only if you have, I don't know what, I don't know what.* (Family member - crisis 2)

CAPS advises that, during a crisis, family members contact the SAMU or take the person to the UPA and, only after the person has stabilized, call CAPS. As a result, family members do not consider CAPS support during crises. Professionals also report a lack of knowledge of official protocols or flows in the service.

*05/11/2020 - At around 4:10 pm, the grandmother came to the unit unaccompanied, reporting that her grandson was unwell, wandering the streets, and not taking his medication properly. She was advised to take him to the UPA in the event of a crisis.* (MR)

*When the professionals were asked if they knew where such a flow might have come from or if a protocol had been established for these cases, they were unable to answer. At the time of this collection and observation, I had no access to any care flow or protocol.* (RN)

The professionals mention the social issues present in CAPS care. In addition, of the six situations monitored in the research, five of them involved black and/or brown people. During the in-service observation, some notes were made about the race of the people being cared for.

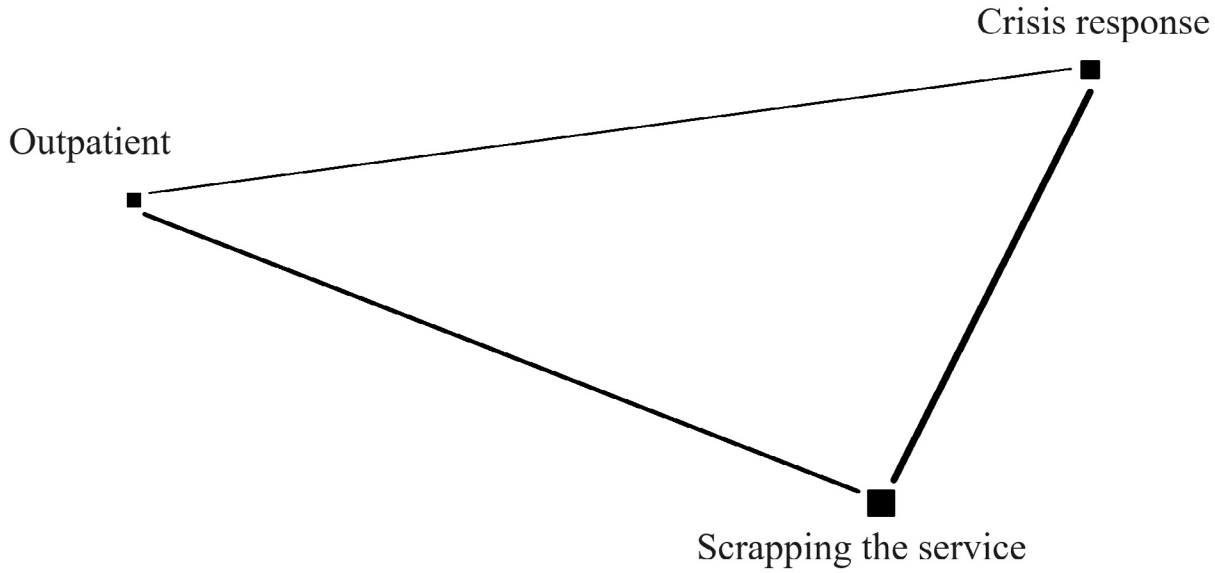
*Most of the people seen here are black and from a low social status* (Professional 4 - CAPS).

*But we know, it's clear, especially here at CAPS, that our public is very much from lower social classes.* (Professional 5 - CAPS)

*It struck me that the medical records I had access to at the CAPS have a cover that asks for various pieces of information about the person, yet one of the only blank fields is race.* (RN)

In addition, the following figure shows the relationship between the categories analyzed. The more often the categories are attributed together, the closer they appear on the map. The scrapping category is more strongly linked to what was discussed in the crisis response.

**Figure 1 -** Analytical map showing the relationship between the categories analyzed. Cuiabá, MT, Brazil, 2023.




Source: MAXQDA (2023)

The thicker line shows that there is a greater link between the scrapping of the service and crisis care, followed by the link between scrapping and CAPS outpatient care.

## DISCUSSION

In recent years, environments have been created in health services, especially in mental health, that do not promote life, but rather prolong death, especially in serious mental health crises. There have been decades of reduced infrastructure, limited facilities and professionals, and a significant decrease in public investment in health. Mental health has historically been underfunded, as has the Unified Health System[15].

The concept of necropolitics and its project of subjugating life to the power of death should be reflected in state structures, not just governmental ones. We can see the degradation of social policies due to austerity policies, disguised by the state's financial crisis and the underfunding of services not aligned with capital[16]. However, to say that we have only been living a necropolitics since 2019 is fragile, as the struggle to ensure the rights of the Brazilian constitution and those won by the Anti-asylum Struggle is constant[17].

Scientists point out that deaths caused by COVID-19 in Brazil have had different impacts according to race, gender, territory, and economic situation, affecting infections, deaths, and vaccination[18-20]. One study revealed that the black Brazilian population faced more hospitalizations and deaths from severe acute respiratory syndrome, while there was a reduction among white people[21]. This same black population impacted by the virus has historically been excluded from hospices. The lack of consistent racial data in health services reinforces this exclusion, with professionals hesitating to ask about racial self-declaration, considering it bureaucratic rather than analytical[18].

Racialized and unproductive bodies for capitalist logic are more vulnerable during the pandemic, as prevention policies prioritize socially valued bodies, while devalued ones are neglected, as in psychic crises during COVID-19[16]. The place given to life, death, and the human body is questioned, especially during a severe psychic crisis[8].

In the municipality studied during the pandemic, the lack of remote care flows for mental health resulted in the discontinuity of services and the neglect of serious cases of mental health crises[16]. Mental health care is crucial during the pandemic, as the context can cause crises or aggravate mental suffering. Health restrictions have limited face-to-face activities, but local and international experiences indicate virtual alternatives and highlight the importance of face-to-face care in urgent situations.

In Brazil, experiences such as online listening chats, social networks with accessible scientific material, booklets, mental health telematics, and the restructuring of face-to-face care[10-12] have been led by universities, professional councils, and professionals from each service. The Ministry of Health did not lead mental health during the pandemic, resulting in a lack of management and decisions for the country's governance.

In contrast, governments such as Italy have recognized mental health as a priority, implementing remote interventions and telemedicine. In basic care, face-to-face care was maintained for serious cases, and telephone triage was carried out for new cases and emergencies[20]. In France, face-to-face consultations and home visits were maintained in necessary cases, representing 20% of cases[22]. In China, unified management policies were established with widely adopted online services, mobile applications, and collaboration between the academic community and health authorities[23].

About crisis care, when it is accompanied by psychomotor agitation, there is a misconception that the CAPS is not a service for these cases. It should be emphasized that the CAPS is the place for crisis care, as it must consider serious and persistent cases[24]. The presence of necropolitics in mental health work makes it difficult for professionals to reflect on this and interferes with the provision of care. This can lead to the reproduction of the asylum model and the prioritization of psychiatric hospitalization.

The outpatient logic of the CAPS does not promote the autonomy and social reintegration of people in crisis, jeopardizing continuous access to care, especially during the pandemic, and weakening the logic of territorial care. It is essential to implement co-responsibility between care networks for comprehensive care for people in crisis[2].

In addition to online care and clear information about the pandemic, it is crucial to have a territorially based multi-professional team that offers care and support, with solid government management guidelines in the Brazilian territory. Ensuring adequate funding and structure for RAPS is fundamental, including stable working conditions, with public tenders and decent salaries.

Thus, in the discourses analyzed, there is little criticism of this necropolitics, which began long before the pandemic. This finding corroborates a study that discussed the logic present in the organization and provision of remote psychological services in Brazil during the COVID-19 pandemic. In this study, it was concluded that for most of the discourses analyzed, it was as if the situation - political, social, economic, health, environmental, climatic, and ethical - in which the pandemic merges and spreads was not critical, even before its arrival[25].

In addition, as can be seen in Figure 1, the scrapping of services threatens the principle of equity in the SUS and contributes to increasing the social exclusion that already exists, especially in the case of care for the most serious mental illnesses, such as psychic crises. In addition to online care and clear information about the pandemic, it is crucial to maintain a territorially based multi-professional team to provide mental health care with support and bonds. This requires strong government management, adequate funding, and a minimum structure for the RAPS, as well as stable working conditions and decent salaries.

In addition, the pandemic has exacerbated symptoms such as guilt and anxiety due to the need for social isolation, impacting people with pre-existing mental disorders[26]. This situation highlights the paradoxes faced by the state, which at the same time demands isolation of the population to contain the spread of the virus and faces the challenge of dealing with the worsening of mental suffering resulting from this prolonged isolation.

Necropolitics, with its structures of underfunding and negligence in health care, also generates daily deaths due to inequalities, especially in severe psychic crises. These conditions are permitted due to a chronic state of acceptance, creating zones of exposure to conditions that are not life, but a "slow death"[18].

The limitations of the study include the time taken to follow up on the cases, influenced by the availability of financial resources and the researcher's schedule for completing her thesis. In addition, the lack of a pilot test and the absence of external evaluation of the data collection protocol by judges are also limitations. However, the instruments contained in the protocol were analyzed by the examining board, as they were developed specifically to meet the objectives of the thesis.

## FINAL CONSIDERATIONS

The categories analyzed show how necropolitics negatively affects black people suffering from mental illness. The lack of specialized services and precarious infrastructure hinder crisis care, leading CAPS to refer cases to SAMU and UPA. During COVID-19, the lack of technical support and protocols has aggravated the denial of care by municipal, state and federal authorities.

The dismantling of mental health, with limited infrastructure and reduced public investment, was already taking place before the pandemic. It is noteworthy that necropolitics

runs through mental health, highlighting the urgent need to debate this issue. It is essential to include the participation of vulnerable people, especially the black population who use mental health services, to confront racism and reaffirm territorial and community care.

To adapt our mental health services to future pandemics, it is important to carry out research into the experiences of managers and health professionals in different contexts, with ongoing evaluations of the care provided.

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