

SCHIZOPHRENIA AND NETWORKED CARE: DIAGNOSTIC AND THERAPEUTIC CHALLENGES AND THE ROLE OF THE MULTIDISCIPLINARY TEAM IN URGENT AND EMERGENCY CARE SERVICES

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Abstract

Schizophrenia is a severe psychiatric disorder with a predominantly chronic course and multifactorial etiology, characterized by positive, negative, and cognitive symptoms that substantially impair the functioning and quality of life of affected individuals. Although advances in neuroscience have broadened our understanding of the neurobiological mechanisms involved, diagnosis remains primarily clinical, and treatment continues to require an individualized and sustained approach. This study aims to analyze, in light of the contemporary scientific literature, the main historical, epidemiological, etiological, clinical, and therapeutic aspects of schizophrenia, with particular emphasis on the management of patients experiencing a psychotic crisis in urgent and emergency care services, as well as the role played by the multidisciplinary team in this setting. This is a narrative and integrative literature review based on publications indexed in national and international databases, with priority given to studies published in recent years. The findings show that effective care for individuals with schizophrenia depends on a coordinated care network in which physicians, nurses, psychologists, social workers, occupational therapists, and other professionals work in an integrated and complementary manner. However, these

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teams are often institutionally undervalued, whether because of precarious working conditions or fragmented care pathways, thereby compromising comprehensive care. It is concluded that addressing schizophrenia, particularly in urgent care settings, requires investment in continuing education, the strengthening of multidisciplinary teams, and efforts to overcome the historical stigma that still surrounds this condition, thereby ensuring care that is more humane, effective, and socially relevant.

Keywords: Emergency care, Mental health, Multidisciplinary team, Psychotic disorders, Schizophrenia.

INTRODUCTION

Schizophrenia is one of the psychiatric conditions with the greatest clinical complexity and social impact, ranking among the mental disorders that cause the most functional disability worldwide. It is characterized by a heterogeneous set of manifestations involving disturbances in thought, perception, cognition, affect, and behavior, resulting, in many cases, in a significant disconnection from shared reality.

Unlike other chronic illnesses with well-defined etiologies, schizophrenia still lacks a single biological marker that would enable its unequivocal identification. Diagnosis is therefore an essentially clinical process, based on careful history-taking, longitudinal observation, and the exclusion of other conditions associated with psychotic symptoms.

Historically, the understanding of psychotic disorders evolved slowly and was permeated by prejudice. In ancient societies, individuals displaying psychotic manifestations were often segregated, regarded as possessed, or simply classified under the generic label of “madness,” without any nosological distinction. It was only in the late nineteenth century that Emil Kraepelin systematized the concept of dementia praecox, describing a condition characterized by progressive deterioration that occurred predominantly in young individuals and distinguishing it from bipolar affective disorder, then known as manic-depressive psychosis (Dalgalarondo, 2019). Subsequently, in the early twentieth century, Eugen

Bleuler proposed the term “schizophrenia,” which literally conveys the idea of a “split mind,” emphasizing not the inevitability of cognitive deterioration, but rather the dissociation among thought, affect, and behavior as the fundamental core of the disorder (Dalgarrondo, 2019; Shorter, 2020).

More than a century after these initial conceptualizations, schizophrenia continues to challenge researchers, clinicians, and healthcare administrators. According to estimates by the World Health Organization, the disorder affects approximately 24 million people worldwide, corresponding to a global prevalence of roughly one in every three hundred people (WHO, 2023). The figures are also significant in Brazil, and recent epidemiological studies indicate an upward trend in morbidity and mortality indicators associated with the disorder over the past decade, followed by a relative decline in more recent years as a result of more structured, albeit still insufficient, psychosocial care policies (Ministry of Health, 2023; Chaves et al., 2023).

One of the most concerning aspects of schizophrenia is the so-called “treatment gap,” a phenomenon widely discussed in the international literature whereby more than two-thirds of people experiencing psychotic symptoms do not receive appropriate specialized care, whether because of barriers to access, social stigma, or structural weaknesses in healthcare systems (Correll et al., 2022). This gap manifests itself particularly starkly in urgent and emergency care services, where many patients arrive in the midst of a full-blown psychotic episode, without previous follow-up or an established diagnosis and, not infrequently, in situations of extreme social vulnerability.

It is precisely in this urgent care setting that the multidisciplinary team becomes indispensable while, at the same time, remaining historically undervalued. The management of patients experiencing a psychotic crisis cannot be confined to isolated medical intervention. On the contrary, it requires the coordination of knowledge and practices from different professional disciplines, including nursing, psychology, social work, occupational therapy, and clinical pharmacy. Together, these professionals form an essential care mechanism for clinical stabilization, ensuring the safety of both patients and staff, and

providing appropriate referral for continuity of care within the network (Silva; Oliveira, 2021; Fontanella et al., 2022).

Despite their unquestionable importance, these professionals remain persistently undervalued in the day-to-day practice of healthcare services, as reflected in precarious working conditions, inadequate staffing levels, a lack of specific continuing education in the management of psychiatric emergencies, and insufficient institutional and financial recognition (Campos et al., 2023).

Against this background, the general objective of this study is to analyze, based on current scientific literature, the main conceptual, epidemiological, etiological, clinical, and therapeutic aspects of schizophrenia, with particular attention to the management of patients experiencing a psychotic episode in urgent and emergency care services and to the strategic, yet frequently overlooked, role of the multidisciplinary team in this context. The specific objectives were to: (i) revisit the historical development of the concept of schizophrenia and its relevance to the contemporary understanding of the disorder; (ii) discuss the main etiological models and risk factors recognized in the current literature; (iii) describe the clinical presentation and current diagnostic criteria; (iv) present the pharmacological and psychosocial therapeutic approaches recommended by contemporary guidelines; (v) analyze the specific characteristics of caring for patients with schizophrenia who are experiencing an acute psychotic episode in urgent and emergency care services; and (vi) critically discuss the work and undervaluation of the multidisciplinary team in this setting, proposing possible avenues for strengthening it.

The social and academic relevance of this study lies in the urgent need to advance the discussion of one of the most stigmatized psychiatric conditions of the present day, thereby contributing to the education of healthcare professionals who are more sensitive, technically prepared, and committed to humane care. Furthermore, by highlighting the multidisciplinary team as an indispensable pillar of care, this study seeks to foster reflection capable of informing institutional policies that recognize and value these workers, who are essential to the effectiveness of the Brazilian Psychiatric Reform and to the

consolidation of a Psychosocial Care Network (Rede de Atenção Psicossocial - RAPS) that is truly effective and committed to the dignity of people experiencing psychological distress.

METHODOLOGY

This is a narrative and integrative literature review intended to gather, systematize, and critically analyze the available scientific evidence on schizophrenia, focusing on clinical management in urgent and emergency care settings and the work of the multidisciplinary team. The methodological choice of an integrative review is justified by its capacity to incorporate studies with different methodological designs, including quantitative and qualitative research, systematic reviews, clinical guidelines, and technical and institutional documents. This enables a broader and more multidimensional understanding of the phenomenon under investigation (Souza; Silva; Carvalho, 2021).

The literature search was conducted in the Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences Literature (Literatura Latino-Americana e do Caribe em Ciências da Saúde - LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE/PubMed), and Virtual Health Library (Biblioteca Virtual em Saúde - BVS) electronic databases, as well as in technical documents published by official bodies such as the World Health Organization (WHO) and the Brazilian Ministry of Health. The following Health Sciences Descriptors (DeCS/MeSH) were used separately and in combination, in Portuguese and English: “esquizofrenia” (schizophrenia), “transtornos psicóticos” (psychotic disorders), “psiquiatria” (psychiatry), “emergência psiquiátrica” (psychiatric emergency), “equipe multiprofissional” (multidisciplinary team; patient care team), “saúde mental” (mental health), and “reforma psiquiátrica” (psychiatric reform). The Boolean operators “AND” and “OR” were used to refine the searches.

The inclusion criteria comprised scientific articles, book chapters, clinical guidelines, and institutional documents published primarily between 2018 and 2024, available in full text, written in Portuguese, English, or Spanish, and directly or indirectly addressing the central themes of this study. As

an exception, classic works from the psychiatric literature considered essential to the historical and conceptual understanding of schizophrenia were included even when published before the specified period because of their indispensable theoretical relevance to the field. Duplicate studies, publications that had not undergone peer review, conference abstracts for which the full text was unavailable, and materials not directly related to the proposed objectives were excluded.

The selected material was analyzed using a qualitative, descriptive-analytical approach organized around the thematic axes that structure the development of this article: (i) the historical and conceptual development of schizophrenia; (ii) contemporary epidemiology; (iii) etiology and risk factors; (iv) clinical presentation and diagnosis; (v) current therapeutic approaches; (vi) management of psychotic crises in urgent and emergency care services; and (vii) the work and professional recognition of the multidisciplinary team. This thematic organization enabled the construction of a broad and integrated overview of the object of study, facilitating the triangulation of the different theoretical and empirical perspectives identified in the literature reviewed.

Because this is a review study based exclusively on publicly available secondary sources, submission to a research ethics committee was not required, in accordance with the guidelines applicable to this type of scientific research. This study also underscores its ethical commitment to the accuracy of the information presented by duly attributing authorship to all sources consulted.

DEVELOPMENT

HISTORICAL AND CONCEPTUAL DEVELOPMENT OF SCHIZOPHRENIA

The contemporary understanding of schizophrenia is the product of a lengthy historical process of conceptual development, marked by scientific advances but also by ethical setbacks that resulted in segregationist and dehumanizing practices. For centuries, individuals who displayed behaviors considered “bizarre” or incomprehensible were treated as social outcasts, and their suffering was frequently attributed to supernatural or moral causes (Shorter, 2020).

The scientific turning point effectively occurred in the late nineteenth century, when Emil Kraepelin systematized psychiatric nosology and coined the term *dementia praecox* to describe a clinical condition characterized by early onset and a deteriorating course, distinguishing it from manic-depressive psychosis on the basis of its poorer prognosis. Kraepelin also proposed subdividing the disorder into hebephrenic, catatonic, and paranoid forms. Although the rigidity of this classification has since been superseded, it continues to influence some of the clinical terminology used today (Dalgarrondo, 2019).

A few decades later, Eugen Bleuler critically revised the Kraepelinian concept, arguing that not all patients necessarily progressed to complete cognitive deterioration. He proposed the term “schizophrenia” to emphasize fragmentation and dissociation among psychic functions, namely thought, affect, volition, and behavior, as the fundamental core of the disorder. Bleuler described the so-called “four As” as its fundamental symptoms: loosening of associations, ambivalence, autism, and affective disturbance. These elements were subsequently reclassified, to a large extent, as negative symptoms of schizophrenia (Dalgarrondo, 2019; Shorter, 2020).

Throughout the twentieth century, other significant contributions were added to this conceptual framework. Particularly noteworthy were the works of Kurt Schneider, who described the so-called “first-rank symptoms,” such as thought echo, voices that comment or converse with one another, experiences of bodily influence, and thought insertion or withdrawal. At the time, these symptoms were considered highly suggestive, although not pathognomonic, of schizophrenia (Kaplan; Sadock; Grebb, 2017).

These classic descriptions continue to serve as reference points for contemporary classification systems, such as the International Classification of Diseases (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), both of which are widely used in current clinical practice (American Psychiatric Association, 2022; World Health Organization, 2023).

It is important to emphasize that the history of schizophrenia is also marked by episodes involving serious violations of human rights, including compulsory institutionalization in psychiatric hospitals, the indiscriminate performance of lobotomies, and the exposure of patients to experimental treatments

without consent. These practices, now widely condemned, contributed significantly to the construction of the stigma that continues to shape social perceptions of the disorder, erroneously associating it with dangerousness and absolute incapacity (Amarante; Nunes, 2018).

The Psychiatric Reform movement, which began in several countries during the second half of the twentieth century and was consolidated in Brazil following the enactment of Law No. 10,216/2001, represented a major milestone in reframing mental healthcare. It proposed the gradual replacement of the hospital-centered model with a community-based psychosocial care network guided by the principles of deinstitutionalization, psychosocial rehabilitation, and the protection of the civil rights of people experiencing psychological distress (Amarante; Nunes, 2018; Brazil, 2001).

This process, which remains ongoing and is permeated by political and financial tensions, is essential to understanding the current landscape of care for people with schizophrenia, including in urgent and emergency care services, which are now integrated, or should be integrated, into a broader network designed to provide alternatives to the asylum-based model.

CONTEMPORARY EPIDEMIOLOGY

Schizophrenia has a relatively uniform distribution across different cultures and geographic regions, although recent studies indicate significant variations related to socioeconomic, environmental, and migration-related factors. According to data from the World Health Organization, the global prevalence of the disorder is approximately 0.3% to 0.7% of the general population, affecting roughly 24 million people worldwide (WHO, 2023).

Incidence is generally slightly higher among men, with earlier onset, usually between late adolescence and early adulthood. Among women, onset tends to occur later, and the clinical course is, to some extent, less deteriorating (Kaplan; Sadock; Grebb, 2017; Chaves et al., 2023).

In Brazil, epidemiological studies indicate that schizophrenia ranks among the leading causes of years lived with disability (DALYs) in the young adult population, representing a significant challenge for

public healthcare systems (Ministry of Health, 2023). Data from the Hospital Information System of the Brazilian Unified Health System (Sistema Único de Saúde - SUS) show that schizophrenia-spectrum disorders remain among the leading causes of psychiatric hospitalization in the country. Nevertheless, a trend toward a gradual reduction in long-term hospitalizations has been observed in recent decades, attributed to the expansion of the Psychosocial Care Network (RAPS) and the strengthening of services such as the Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPS) (Ministry of Health, 2023).

Also noteworthy is the high prevalence of comorbidities associated with schizophrenia, particularly substance use disorders, metabolic syndrome, cardiovascular diseases, and an increased risk of suicide. Together, these factors contribute to a reduction in life expectancy of approximately fifteen to twenty years compared with the general population (Correll et al., 2022).

These data reinforce the need for a comprehensive, multidisciplinary approach that extends beyond the exclusively pharmacological management of psychotic symptoms and addresses the multiple dimensions of patients' physical, mental, and social health.

ETIOLOGY AND RISK FACTORS

The etiology of schizophrenia is recognized as multifactorial, resulting from a complex interaction among genetic vulnerability, neurodevelopmental alterations, and environmental exposures throughout life, as described by the vulnerability-stress model (Kaplan; Sadock; Grebb, 2017). Family aggregation, twin, and adoption studies consistently demonstrate the high heritability of the disorder, estimated at between 70% and 80%, although no single gene is sufficient to determine its onset. Genome-wide association studies (GWAS) have identified multiple risk loci, each contributing a small individual effect, thereby reinforcing the polygenic nature of the disorder (Correll et al., 2022).

From a neurobiological perspective, the dopamine hypothesis remains central to the understanding of the pathophysiology of schizophrenia. It proposes dopaminergic hyperactivity in the mesolimbic

pathways, which is associated with positive symptoms, and hypoactivity in the mesocortical pathways, which is associated with negative and cognitive symptoms. More recently, models incorporating glutamatergic dysfunction, particularly involving NMDA receptors, as well as abnormalities in the GABAergic system, have broadened the understanding of the neural circuits involved (Dalgarrondo, 2019).

The environmental risk factors most consistently associated with schizophrenia include obstetric and perinatal complications, maternal infections during pregnancy, intrauterine malnutrition, psychoactive substance use, especially cannabis use at an early age, migration, urbanization, and exposure to traumatic events or psychosocial adversity during childhood (Correll et al., 2022; Chaves et al., 2023).

These findings support the contemporary understanding of schizophrenia as a neurodevelopmental syndrome whose full clinical manifestations generally emerge only in late adolescence or early adulthood, although subtle and nonspecific signs may already be present during childhood, constituting what the literature refers to as “prodromal symptoms” or an “at-risk mental state” (Fontanella et al., 2022).

CLINICAL PRESENTATION AND DIAGNOSIS

The clinical presentation of schizophrenia is traditionally organized into three broad symptom dimensions: positive, negative, and cognitive symptoms, which are also frequently accompanied by mood disturbances. Positive symptoms involve distortions of normal functions and include delusions, particularly persecutory delusions, delusions of reference, and delusions of control; hallucinations, predominantly auditory, in the form of voices commenting on or commanding the patient’s behavior; disorganized speech; and grossly disorganized or catatonic behavior (American Psychiatric Association, 2022).

Negative symptoms, in turn, reflect a reduction or loss of normal functions and manifest as blunted affect, alogia, or poverty of speech, avolition, anhedonia, and social withdrawal. These symptoms tend to be more persistent throughout the course of the disorder, respond less satisfactorily to

conventional pharmacological treatment, and are strongly associated with long-term functional impairment (Kaplan; Sadock; Grebb, 2017; Correll et al., 2022).

Cognitive symptoms, which include deficits in attention, working memory, processing speed, and executive functions, have received increasing attention in the scientific literature because they are among the main determinants of patients' functional disability and often have a greater impact on daily life than the positive symptoms themselves (Fontanella et al., 2022).

The diagnosis of schizophrenia remains essentially clinical, based on the criteria established by the DSM-5-TR and ICD-11. These criteria require the presence of at least two characteristic symptoms, namely delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms, persisting for at least six months and causing significant functional impairment. They also require the exclusion of other clinical or neurological conditions, as well as substance-related conditions, that could produce a similar presentation (American Psychiatric Association, 2022; World Health Organization, 2023).

The absence of specific imaging or laboratory tests capable of independently confirming the diagnosis reinforces the central importance of careful clinical interviewing, longitudinal observation of the course of the disorder, and information obtained from family members or other people close to the patient. Such tests are used primarily to exclude organic differential diagnoses.

CURRENT THERAPEUTIC APPROACHES

The treatment of schizophrenia is necessarily multimodal, combining pharmacological and psychosocial interventions in a complementary and individualized manner. Antipsychotics form the basis of pharmacological treatment and act primarily on positive symptoms through the blockade of dopamine D2 receptors. The literature distinguishes between first-generation, or typical, antipsychotics, such as haloperidol, and second-generation, or atypical, antipsychotics, such as risperidone, olanzapine, quetiapine, and clozapine. Clozapine is reserved for cases of treatment-resistant schizophrenia because of

its superior efficacy and, at the same time, its more severe adverse-effect profile, which requires continuous hematological monitoring because of the risk of agranulocytosis (Correll et al., 2022).

Beyond medication management, contemporary guidelines, such as the recommendations issued by the National Institute for Health and Care Excellence (NICE) and the World Health Organization, emphasize that psychosocial interventions are indispensable and inseparable components of treatment. These include cognitive behavioral therapy for psychosis, family psychoeducation, social skills training, psychosocial rehabilitation, and programs supporting reintegration into employment and education (Fontanella et al., 2022). In Brazil, the Psychosocial Care Centers (CAPS) play a strategic role in this process by providing community-based, continuous care integrated into the broader network, in accordance with the principles of the Psychiatric Reform (Ministry of Health, 2023).

It is worth emphasizing that treatment adherence is one of the greatest therapeutic challenges in schizophrenia and is frequently compromised by a lack of insight into the condition itself, or anosognosia, adverse medication effects, and fragile therapeutic relationships. In this regard, the use of long-acting injectable, or depot, antipsychotics has proven to be an effective strategy for reducing relapse and rehospitalization rates, especially among patients with a history of frequently discontinuing oral treatment (Correll et al., 2022).

MANAGEMENT OF PSYCHOTIC CRISES IN URGENT AND EMERGENCY CARE SERVICES

Urgent and emergency care services are frequently the point of entry into the healthcare system for patients with schizophrenia who are experiencing a crisis, creating a clinical setting of considerable complexity and high technical and human demands. An acute psychotic crisis may manifest as intense psychomotor agitation, aggression, behavioral disorganization, incoherent speech, and, in some cases, an imminent risk of harm to self or others. These situations require a response from the care team that is rapid, safe, and, above all, humane (Silva; Oliveira, 2021).

The first step in managing these situations is a careful assessment of the patient's overall clinical condition to exclude organic causes that may mimic or exacerbate the psychotic presentation, such as exogenous intoxication, infectious conditions, metabolic disorders, or acute neurological abnormalities. This is a critical step that is not infrequently neglected in settings affected by overcrowding and resource shortages (Fontanella et al., 2022).

Only after this initial assessment should the most appropriate therapeutic approach be determined. This may range from verbal de-escalation and environmental management, with priority given to calm environments and reduced sensory stimulation, to mechanical restraint and pharmacological sedation when strictly necessary. Such measures must always be governed by the principles of proportionality, the least restrictive intervention possible, and respect for the patient's dignity (Silva; Oliveira, 2021).

Recent literature reinforces the importance of "verbal de-escalation" as the first-line intervention for psychomotor agitation. This technique prioritizes empathic communication, a calm tone of voice, nonthreatening body language, and offering the patient choices, significantly reducing the need for coercive measures (Campos et al., 2023).

When pharmacological restraint is necessary, antipsychotics combined with benzodiazepines should preferably be administered orally or intramuscularly. Intravenous administration and combinations with greater sedative potency should be reserved for situations involving imminent risk and must always be accompanied by rigorous monitoring of vital signs (Correll et al., 2022).

A critical and frequently neglected aspect of urgent care for patients with schizophrenia is the continuity of care following stabilization of the acute presentation. Discharging patients from the emergency service without effective coordination with the psychosocial care network is one of the main shortcomings in care identified in the literature and is associated with high short-term rehospitalization rates and treatment discontinuity (Ministry of Health, 2023).

Accordingly, urgent and emergency care services must establish clear and effective referral and counter-referral pathways with CAPS, primary healthcare units, and other RAPS services. This ensures

that the patient is not simply treated as a problem “resolved” during the acute episode, but is instead effectively welcomed into a continuous care network.

THE WORK AND UNDERVALUATION OF THE MULTIDISCIPLINARY TEAM

The effective management of psychotic crises and the longitudinal follow-up of patients with schizophrenia depend fundamentally on the coordinated work of a multidisciplinary team. The psychiatrist is responsible for diagnostic assessment and for prescribing and adjusting medication. Nurses play a central role in the initial assessment, the safe administration of medication, the monitoring of vital signs, and the implementation of restraint interventions when necessary. Psychologists contribute to psychological assessment, provide emotional support to patients and their families, and subsequently deliver psychotherapeutic interventions. Social workers identify social vulnerabilities, coordinate care with the social assistance network, and help ensure that patients’ rights are protected. Occupational therapists, in turn, play an important role in psychosocial rehabilitation and in helping patients regain functioning and autonomy (Silva; Oliveira, 2021; Campos et al., 2023).

Despite their recognized indispensability, the literature reveals a persistent pattern of institutional undervaluation of these teams, particularly within urgent and emergency care services. This undervaluation takes multiple forms: staffing levels that are insufficient to meet demand, a lack of specific continuing education in psychiatric emergency management, precarious employment arrangements, excessive workloads, exposure to workplace violence, and a shortage of institutional spaces in which workers themselves can be heard and receive support for their mental health needs (Campos et al., 2023).

This situation contributes not only to the teams’ physical and emotional exhaustion, resulting in occupational stress and burnout syndrome, but also to the fragmentation of care, directly compromising the quality and safety of the services provided to patients.

Compounding this situation is the stigma that has historically affected not only patients with schizophrenia, but also, indirectly, professionals dedicated to mental healthcare. These professionals are often institutionally perceived as working in an area of lower technical prestige compared with other medical specialties (Amarante; Nunes, 2018).

Reversing this situation requires concrete investment in continuing professional education, appropriate human-resource staffing levels, stronger institutional protocols for managing psychiatric crises, and, above all, effective recognition, both symbolic and material, of multidisciplinary work as a foundational and irreplaceable element of the mental healthcare network.

FINAL CONSIDERATIONS

This literature review has shown that, more than a century after its initial conceptualization, schizophrenia remains one of the greatest challenges facing contemporary psychiatry, from both clinical and social perspectives. It is a disorder with a multifactorial etiology whose diagnosis remains primarily clinical and whose treatment requires an individualized, sustained, and necessarily multidimensional approach capable of integrating pharmacological and psychosocial interventions within a comprehensive care framework.

The study also demonstrated that urgent and emergency care services occupy a strategic, yet simultaneously critical, position in the care pathway of patients with schizophrenia, frequently serving as the point of entry during periods of acute crisis.

In this context, the appropriate management of psychomotor agitation and behavioral disorganization, guided by verbal de-escalation and the least restrictive intervention possible, is crucial both to patient safety and to the protection of patients' rights and dignity. Equally important is the assurance of continuity of care following stabilization of the acute presentation through effective coordination with the Psychosocial Care Network. Without such coordination, a cycle of rehospitalization and treatment discontinuity may be perpetuated.

Finally, the effectiveness of this care depends substantially on the work of a cohesive, technically prepared, and institutionally valued multidisciplinary team. However, as demonstrated throughout this study, these teams continue to face precarious working conditions, inadequate staffing, and insufficient institutional recognition, all of which directly compromise the quality of care provided.

Future research should therefore investigate concrete strategies for strengthening multidisciplinary mental healthcare teams, as well as continuing education models specifically designed for the management of psychiatric emergencies.

From a public policy perspective, there is an urgent need for investment that ensures not only the quantitative expansion of the Psychosocial Care Network, but also the professional development and recognition of those who sustain mental healthcare in Brazil on a daily basis. This is an indispensable condition for building psychiatric care that is truly humane, effective, and socially committed to overcoming the historical stigma that continues to surround schizophrenia.

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