Revista Brasileira de Enfermagem
REBEn

Night Admission at a Psychosocial Care Center III

Acolhimento noturno em um Centro de Atenção Psicossocial III

Acogimineto Nocturno en un Centro de Atención Psicosocial III

Thuany Cristine Santos da Silva[I]
ORCID: 0000-0001-8152-0056

Tatiana Marques dos Santos[I]
ORCID: 0000-0003-0811-6174

Izabella de Góes Maciel Tavares Campelo[I]
ORCID: 0000-0002-6801-6768

Maria Manuela Vila Nova Cardoso[I]
ORCID: 0000-0003-4231-1766

Adriana Dias Silva[I]
ORCID: 0000-0002-1353-6723

Maria Angélica de Almeida Peres[I]
ORCID: 0000-0002-6430-3540

[I] *Universidade Federal do Rio de Janeiro. Rio de Janeiro, Rio de Janeiro, Brazil.*

How to cite this article:
Silva TCS, Santos TM, Campelo IGMT, Cardoso MMVN, Silva AD, Peres MAA. Night Admission at a Psychosocial Care Center III. Rev Bras Enferm. 2020;73(1):e20170964. doi: http://dx.doi.org/10.1590/0034-7167-2017-0964

Corresponding Author:
Maria Angélica de Almeida Peres
E-mail: angelica.ufrj@uol.com.br

Submission: 01-27-2018 **Approval:** 07-17-2018

ABSTRACT

Objective: to analyze night admission characteristics at a Psychosocial Care Center III (CAPS III - *Centro de Atenção Psicossocial*). **Method:** a qualitative research, whose data were collected with 15 nursing professionals from November to April 2016, through a semi-structured interview. **Results:** it was verified that night admission is provided by the nursing team in different dynamics from the day care. This team has strategies of care during crisis, avoiding search for other network services and maintaining the CAPS in its function within the psychosocial model. **Final considerations: s**ervice operation depends on the nursing team for its permanence condition in all shifts, which leads to the need to think about the legislation reformulation that structures the CAPS III team, in order to guarantee the interdisciplinary care provided by the Brazilian Psychiatric Reform in this device, which should replace hospitalization in a specialized institution.

Descriptors: User Embracement; Night Care; Mental Health; Mental Health Services; Psychiatric Nursing.

RESUMO

Objetivo: analisar as características do acolhimento noturno de um Centro de Atenção Psicossocial III (CAPS III). **Método**: pesquisa qualitativa, cujos dados foram coletados com 15 profissionais de enfermagem, de novembro a abril de 2016, por meio de entrevista semiestruturada. **Resultados**: verificou-se que o acolhimento noturno se dá pela equipe de enfermagem em dinâmica diferenciada do acolhimento diurno, e que esta equipe possui estratégias de atendimento durante a crise, evitando a busca por outros serviços da rede e mantendo o CAPS em sua função dentro do modelo psicossocial. **Considerações finais**: o funcionamento do serviço depende da equipe de enfermagem pela sua condição de permanência em todos os turnos, o que leva à necessidade de se pensar na reformulação da legislação que estrutura a equipe mínima do CAPS III, de forma a garantir o cuidado interdisciplinar previsto pela Reforma Psiquiátrica brasileira neste dispositivo, que deve substituir a internação em instituição especializada.

Descritores: Acolhimento; Assistência Noturna; Saúde Mental; Serviços de Saúde Mental; Enfermagem Psiquiátrica.

RESUMEN

Objetivo: analizar las características de la recepción nocturna de un Centro de Atención Psicosocial III (CAPS III - *Centro de Atenção Psicossocial*). **Método:** investigación cualitativa, cuyos datos se recopilaron con 15 profesionales de enfermería, de noviembre a abril de 2016, a través de una entrevista semiestructurada. **Resultados:** Se verificó que el equipo de enfermería administra el host nocturno en una dinámica diferenciada del anfitrión diurno, y que este equipo tiene estrategias de asistencia durante la crisis, evitando la búsqueda de otros servicios de red y manteniendo el CAPS en su función dentro del modelo psicosocial. **Consideraciones finales:** el funcionamiento del servicio depende del equipo de enfermería por su condición de permanencia en todos los turnos, lo que lleva a la necesidad de pensar en la reformulación de la legislación que estructura al equipo mínimo de CAPS III, para garantizar la atención interdisciplinaria provista por la Reforma. Psiquiatra brasileño en este dispositivo, que debe reemplazar la hospitalización en una institución especializada.

Descriptores: Acogimiento; Cuidados Nocturnos; Salud Mental; Servicios de Salud Mental; Enfermería Psiquiátrica.

INTRODUCTION

The 66th World Health Assembly, composed of Ministers of Health of 194 Member States, adopted in May 2013 the World Health Organization (WHO)'s Comprehensive Mental Health Action Plan 2013-2020. Among the objectives established in this Plan are provision of comprehensive and integrated services of mental health and social assistance in community contexts, implementation of promotion strategies, as well as prevention and strengthening of information systems, evidence and research[1]. In Brazil, with the approval of Law 10.216, in 2001, known as the Psychiatric Reform Law, there have been performed changes in the characteristics of population's mental health care. These characteristics are promulgation of subsequent legislation that provided the necessary support for the construction of a network of substitute community services to implement and support the psychosocial care model[2-3].

Since then, the substitution of the asylum model in Brazil has been gradual, through the closure of psychiatric hospitals and the strengthening of the Psychosocial Care Network (RAPS – *Rede de Atenção à Saúde*); with the development of a policy of integration among territorial community devices, such as Psychosocial Care Centers (CAPS – *Centros de Atenção Psicossocial*), Day Hospitals, Coexistence Centers, Emergency and Psychiatric Emergency Services in General Emergency, Psychiatric Nurses in General Hospital, Community Centers, and Schools[4-5].

With regard to the CAPS, there are several modalities defined by increasing size/complexity and population coverage (I, II, III) and by the public to be cared for: adult (CAPS), users of alcohol and other drugs (CAPS AD) and children and adolescents (CAPS I). The CAPS III differs from the others because it has the operational capacity for care in municipalities with a population of more than 200,000 inhabitants, providing ambulatory service of continuous care for 24 hours daily, with night admission and stay, including holidays and weekends[6-7].

Recently, Resolution 32 of 2017, of the Ministry of Health, included in the RAPS specialized psychiatric hospitals, among other guidelines for its strengthening. This fact is dividing opinions, because it offers a risk of return to the asylum, if there is not an intense inspection on institutionalization aspects in hospitalization settings and does not maintain interlocution with the other services that compose this Network, in which the CAPS places central place. Thus, the CAPS III has an important role in changing care models in the area and must be kept within the reformist propositions of a psychosocial nature.

Recognizing the specificities of care that must support the mental health care to keep the person in mental suffering in services that replace the hospitalization in the psychiatric institution, contributions to nursing are related to the knowledge produced about the functioning of a CAPS during night admission, allowing the understanding of the issues that permeate this service within the scope of the Brazilian Unified Health System (*Sistema Único de Saúde*). These issues involve the staff of any CAPS III of Brazil, and should be solved to better assist people in psychological distress and their families. The same contributes to foment the discussion that arises on the recent resolution of the Ministry of Health, which revives the hospitalization in psychiatric hospitals. It is therefore necessary to strengthen the CAPS III substitution service to repress the opening of new psychiatric beds.

OBJECTIVE

To analyze night admission characteristics at CAPS III.

METHOD

Ethical aspects

This article is the result of a master's dissertation, whose project was approved by a Research Ethics Committee on 08/25/2015. All recommendations for the development of human research contained in Resolution 466/2012 of the Brazilian National Health Board (*Conselho Nacional de Saúde*) were respected.

Methodological route

This is a descriptive study of a qualitative nature. The research setting was a CAPS III located in the city of Rio de Janeiro, chosen for being in a programmatic area that includes neighborhoods with many poor communities, besides the service itself being inserted in a community considered very violent, with the worst Development Index Human (DIH). DIH has a strong impact on the mental health of people living there. The unit has 6 beds for night admission, distributed in 3 dormitories, counting on a total of 46 professionals of different categories. Study participants were members of the nursing team who, at the time of data collection, comprised a total of 20 professionals, 8 nurses and 12 nursing technicians. This study included professionals with night shift experience, with 15 (75%) nursing professionals, of which 7 (87.5%) were nurses and 8 (66.7%) were nursing technicians.

The data were collected from November to April 2016, through a semi-structured interview about the team and the work routine at CAPS at night. After data collection, interviews recorded on digital media were transcribed in full. The results were analyzed by thematic analysis of content subsidized by the available scientific literature, arriving at the following categories: *night admission professional staff* and *nursing night admission service*.

To maintain participant anonymity, they were identified with capital letters corresponding to the initial letter of the profession (N - Nurse and NT - Nursing Technician), followed by the ordinal number related to the interview.

RESULTS

The first category of analysis deals with an important situation that has been occurring in many CAPS III: night multidisciplinary staff absence. This absence limits care by the rupture of the interdisciplinary dialogue in part of the service schedule, overloading the nursing team.

Night admission staff

From the interviews, it was possible to perceive professional team organization of night admissions at CAPS III:

> *At night admission, the staff is reduced. It's always the role of a nurse with two technicians. This is the night team.* (NT06)

> […] *here at CAPS, as service is at night, there are only parts of the nursing staff, who is a nurse and two or three nursing technicians. This is the CAPS III night team.* (NT08)

According to one participant's report, on Thursdays there is a psychologist working at night:

> *At night there is only the nurse and the nursing technician. There's a day in the week but there's a psychologist on Thursdays. Only.* (N02)

Most participants report that in the night service there are only nursing professionals in the unit. Participants do not mention the day the psychologist is present, which demonstrates the low influence of this participation in the work developed in this period:

> *It is not difficult; it is the model. The model brings with it nursing only that it is here. I even think they should have other professionals.* (N03)

> *There is only nursing at night work,* […] *being specific to nursing. So the demand is very low at night, but it happens! And it is nursing that is here to make this embracement. The only category that works at night is nursing.* (NT 06)

Reports show that, at the CAPS III studied, nursing team is responsible for the existence and maintenance of night admission at CAPS. However, the almost exclusive permanence of the nursing team in the night admission contrasts with the work developed during day at CAPS:

> […] *it is a multidisciplinary team* [...]. *So, everyone performs pretty much the same activities.* (N03)

In this CAPS, the need for overnight accommodation is mostly assessed by the entire technical staff during shift meetings, during the day. However, there are cases that arise in the night shift. These are evaluated only by the night team, only nursing and a psychologist (once a week).

When the interviewees were asked about the presence of nursing professionals in other CAPS III during the night service, the following reports were obtained:

> *Yes, in all* [there are nursing professionals]. *In AD* [CAPS Alcohol and Drugs]*, in CAPS X* [cites another CAPS III]*, in all, it is only nursing that stays at night. I think this model should be different for everyone, not just here.* (N03)

> *It also works that way, but I know there are other CAPS that at night is a multidisciplinary team. And in the other CAPS that I work, this is a discussion, that there will be other professionals, such as psychologists, occupational therapists who will also compose this team of the night.* (NT06)

It can be observed from the reports that, because professionals are staying at night, nursing professionals are responsible for all the behaviors taken during this period, which differs from the multidisciplinary performance of the proposal of the psychosocial model:

> *We do not have a physician here tonight. So it is up to us, from the* [nursing] *team to know whether the patient has to stay or not, whether we're going to be support or whether we have to take him to some emergency room.* (NT08)

> […] *only nursing stays. So there's no plan B. It's nursing and nursing. So everything that goes on here at night* […] *in the evening, embracement is treated directly with us. We will only really ask for help if it is the case of very serious a patient crisis entry.* (NT01)

It was observed that this solitary practice, instead of an interdisciplinary practice, leaves nursing professionals in charge of night admission:

> *It's just nursing. Nursing is very much the target of everything. So it is nursing that says yes and says no, that it leads to smoking or that it does not, can or cannot. This exists. There is no way out of this.* (N02)

> *You do not have the backing of a present physician and you end up getting a bit unsure of maybe referring that patient to another service.* (NT06)

Regarding the insertion of other categories in the CAPS night service, the survey revealed the following:

> […] *I also do not know if a physician would make a difference. I do not know if it's supposed to be this way, do you understand? I have many issues, because I think if I had a 24-hour physician here, it would be very much an emergency, which is not the function of the night or extended embracement, which we talk about: weekend and night. However, I think if you had other* [professions]*, you would be adding to care. I think it would be important for each one with his knowledge, bringing new elements to care.* (N02)

The nursing team's settings are based on night service characteristics at CAPS III. It represents the availability of these professionals to qualify care at night, seeking to maintain the therapeutic relationship with users and guarantee extra-hospital care as much as possible, as presented in the second category below.

Nursing night admission service

Regarding the main care during the night period, participants evidenced the real need to have the CAPS III functioning to assist users in different moments in which they need care:

> *Night admissions as we have here is more for already known patients, rather than* […] *the fireman brings. It is patient that we already know. It's hard to have new cases at night.* (NT06)

> *References address that situation at the moment of crisis or at the moment of a certain vulnerability that it presents, and then it stays in the embracement here.* (N08)

> *It is also embraced that the patient will do a blood test the next day, that he needs to be fasted, and he, at home, alone will not do this fast, so the team thinks that it would be interesting to be embraced. There is the embracement really to the crisis, that the person or the family contacts CAPS, informing that the patient is agitated, is aggressive and does not accept going to emergency. Sometimes we*

> *can go to that patient's house and bring him here, just as we have a patient from the TR* [Therapeutic Residency] *that always gives a problem there and we go to TR and search to be accepted.* (NT07)

According to participants, following up the person suffering from psychic suffering in the night admission makes possible a greater interaction with the team and other ways of managing the crises as reported below:

> *In the night, we have a different management than in a hospital. Here you can listen to the patient better, he can walk in a healthier way, you can offer other spaces so that you can help something in his crisis.* (N08)

> *So at night it is usually a space that users may feel better about, because the nursing team is more present and can get a better listening of this user because that is when he feels better to talk. Then, food is offered, television, coexistence, a magazine, something to watch on the computer, anyway, over time we will see that it is super important. Because it seems that at some point he is not in crisis, that's fine.* (N02)

DISCUSSION

The data presented show that it is the nursing team that is responsible for the night admission, bringing with it the responsibility for the characterization of the device as the CAPS III, which contains, in its classification, night admission as an activity. It was also observed that, on a day-to-day basis, the multidisciplinary team is present, and nursing transits in the two shifts adapted to the different forms of team organization.

These findings corroborate findings from other studies that reveal that the night-care service in CAPS III is mostly made up only by professionals of the nursing team, while in the day service there are several professional categories[8-10].

This situation is reinforced by the literature on Mental Health. This literature states that, in the Brazilian Psychiatric Reform, it is still possible to perceive in the dynamics of mental health services some points that seem to lead to the repetition of old and inadequate practices. This occurs dichotomically with significant advances in the theoretical-clinical construction of care, especially with regard to the CAPS management model and in strengthening the ties between health teams in different care units[11].

However, according to Ordinance 336/Minister's Office, February 19 2002, which provides for the particularities of the CAPS III, for the night admission period, the team must be composed of 3 nursing technicians/assistants under the supervision of the nurse of the service and 1 (one) professional mid-level support area. Moreover, practice discussed here in the CAPS setting of the study is in accordance with the one recommended in the aforementioned Ordinance[6].

Night admission is a tool used to meet users demands in a comprehensive way, functioning as a strategy to avoid a psychiatric hospitalization. It is not new that the nursing team is first activated during the crisis of a person with mental disorder in any device. In the asylum, it was also nursing that first cared for during crisis. There are many studies that reveal the absence of other professionals in psychiatric institutions, which contributed to the ineffectiveness of the treatment offered to inpatients, since it is in crisis the greater need of support of multidisciplinary team to users[12]. Therefore, there is a need to rethink the legislation and dynamics of night admission at CAPS III.

On the other hand, facilities growth and the required assignments complexity imply re-adjustment of the number of professionals allocated in CAPS III. Considering that the implementation of legislation was fundamental to the consolidation of the Brazilian Psychiatric Reform, it is necessary to follow the evolution of services and establish new legal frameworks, not only to implant but also to improve the quality of the services offered in Mental Health[13].

Therefore, the discussion here points to an issue that arises in daily practice and was not foreseen when planning the organization and functioning of CAPS III, and should be inserted in the guidelines below.

However, intense psychic suffering produces organic and psychic symptoms that end up triggering 'crises'. It is often from the crisis that people establish their first contact with the mental health services network, mainly through hospital admission. This care, to a certain extent, is reduced to containment practices centered on drug administration. From the time of hospital admission, the majority of users are referred to other services of the mental health care network and, in particular, to CAPS[11].

However, regarding crises management, although the CAPS constitute specialized/strategic points of the RAPS, its professionals find it difficult to recognize the responsibility of their role in the embracement and management of crisis situations, even if they are frequent and even expected. Therefore, it is expected that this condition will be met by other devices, while at CAPS, "compensated" individuals will be the ones assisted[14].

When acting in these situations, the mental health professional should facilitate the conditions that may represent the safe harbor that the person needs to begin the necessary repair work according to their demands. Thus, the professional team's practical work should be focused on facilitating a sense of security at the time of crisis[15-16].

Among the tools used for this purpose, we highlight the embracement in Mental Health. Embracing is a process that depends not only on the structure or physical aspects of access, but on the clinical resources of the team, such as answering, listening, evaluating and discriminating demands. Embracement requires, on the one hand, immediate action (urgency) and, on the other hand, an interval of time for the response (tracing the route)[17].

Embracement is an activity in which, from the first contact with users, it demands evaluation and decision-making, not always the only responsibility of nursing, generating the need for other professionals, at the moment, for better decision-making and case management[8].

Night admission in crisis management is seen as indispensable by professionals and families, because it ends up reducing some of the difficulties encountered in care, by providing an alternative to serve the users crisis who often suffered with the refusal and resistance of care of health professionals and services not specialized in Mental Health[18].

Because it is a current treatment device, CAPS night admission is part of contemporary Mental Health care, which has holistic treatment as its value, whose objective is to enable people to be participants in their care and recovery. In this perspective, the Tidal Model relational model enriches the discussion, described as a way of thinking about how people can reclaim their personal history as a first step towards regaining their lives[19].

An effective nursing team involves providing care to people, other than simply treating or caring about them. This has implications not only for what goes on within the therapeutic relationship but also for the kind of support the professional helper may need to maintain the integrity of the caring process[15-16].

Therefore, all categories develop care for psychosocial care (individual and group consultations, home visit, matrix, etc.) during the day. Some care, such as hygiene, feeding, medication administration, among others, and the night admission, a central feature of CAPS III, are restricted to nursing professionals, validating their competence to assist people suffering from psychosis in the psychosocial model.

Study limitations

The objective was served through the data gathered for this research. However, impossibility of including as a participant the psychologist scheduled for night care once a week is considered a limitation of the study, since here was not voice given to this important professional to know his activities and difficulties in the service.

Contributions to Nursing, Health and Public Policy

It is highlighted, as a contribution of this research, the discussion about care in the psychosocial context. Thus, there is permission for reflections and survey of research questions about new perspectives and care mechanisms for nursing and other professionals who work at CAPS III. The results also offer the invitation to reflect on the night admission in CAPS III, in order to show in this practice, the motivations and strategies of the professionals to interact with the RAPS. This brings new questions and results that can qualify the service to users in the psychosocial model and subsidize discussions about the norms of operation of this fundamental service to prevent hospitalization in psychiatric hospital strengthens as a therapeutic resource.

FINAL CONSIDERATIONS

The research findings point to a nursing team that cares about performing a good care in Mental Health in night admission at CAPS III. These issues make these professionals people who fight for dignity in the treatment and care of people in psychological distress, since they are responsible for asserting a change in care logic, that is, the change from the exclusionary to the inclusive model.

It was possible to show that the nursing team is, in the setting under study, responsible for the night admission and, therefore, it is placed as main agent of maintenance of the CAPS-III, since this embracement is the differential of this service. Thus, all nursing care practices are necessary at CAPS and should not be placed separately. Since this is the only professional category present at nighttime, this team sometimes experiences a feeling of insecurity and discomfort, since at night there are demands that would have more satisfactory results if answered by an interdisciplinary team, as well as in day care.

The multidisciplinary team absence in night admission is foreseen in the Brazilian legislation that rules mental health public policies. However, services can move forward along the path towards the psychosocial care model that requires integrated teamwork for psychosocial care. Thus, reflection is raised on how much the legislation itself prompts the assistance to disciplinary practices, denying the Brazilian Psychiatric Reform's proposal.

According to the results of this study, only the nursing team is present at night admission at other CAPS III across Brazil. Thus, more research needs to be done to enrich these findings and to advance in this discussion, since a range of questions about the absence of other professionals at CAPS III at night, which refer to the issues of health work distribution as legally established in the model that has been implemented. Practices are configured in specific contexts, and professionals play their roles totally influenced by the peculiarities that make the service to be as it is.

Carrying out studies with the nursing professionals who act directly in the night admission can provide subsidies so that this space is still more resolving before a conscious and prepared multidisciplinary team.

It is necessary to mention that nursing surpasses each day its historical inheritances referring to the asylum characteristics to which users and itself were subject due to the precarious conditions of infrastructure, overcrowding, unattended shifts, little or no preparation to work in the area, among others already registered in research on the subject[12]. In the current context of reform, a nursing team is revealed that overcame such adversities and dedicates itself to psychosocial care, supporting the functioning of the community-based service, which centralizes RAPS, such as CAPS III.

The view placed here on the nursing team of a CAPS III allows to perceive this team with values of a profession of great social relevance, mainly for following with users' different moments of life. Moreover, team follows the comings and goings of psychic suffering characterized as unpredictable and distant from the conception that after treatment comes the cure. At different times of care, the nursing team has shown participation with deinstitutionalising actions, although its historical trajectory conventionally treats it with emphasis in asylums. This situation has been changed thanks to the Brazilian Psychiatric Reform, which allows us to say that nursing is a profession that follows the health model in its transformations.

FUNDING

This study was funded by the Coordination of Improvement of Higher Education Personnel (CAPES - *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*), through a master's degree scholarship.

REFERENCES

1. Organización Mundial de la Salud (OMS). Plan de acción sobre salud mental 2013-2020 [Internet]. Ginebra: OMS; 2013 [cited 2016 Mar 15]. Available from: https://apps.who.int/iris/bitstream/handle/10665/97488/9789243506029_spa.pdf?sequence=1
2. Ribeiro MC. Psychosocial care center workers in Alagoas, Brazil: interstices of new practices. Interface (Botucatu). 2015;19(52):95-107. doi:

10.1590/1807-57622014.0151

3. Azevedo DM, Silva AC. A Reforma Psiquiátrica e o Modelo de Atenção Substitutivo: implicações contemporâneas. Rev Bras Pesqui Saúde. 2013;15(2):1-2. doi: 10.21722/rbps.v0i0.5668
4. Ministério da Saúde (BR). Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2013 [cited 2016 Mar 15]. http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html
5. Weber CAT, Juruena MF. Day hospital and psychosocial care Center: expanding the discussion of partial hospitalization in mental health. Rev Assoc Med Bras. 2016;62(4):361-7. doi: 10.1590/1806-9282.62.04.361
6. Ministério da Saúde (BR). Portaria nº 2391/GM, de 26 de dezembro de 2002. Regulamenta o controle das internações psiquiátricas involuntárias (IPI) e voluntárias (IPV) de acordo com o disposto na Lei 10.216, de 6 de abril de 2002, e os procedimentos de notificação da Comunicação das IPI e IPV ao Ministério Público pelos estabelecimentos de saúde, integrantes ou não do SUS. [Internet]. Brasília: Ministério da Saúde; 2002 [cited 2016 Mar 15]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/MatrizesConsolidacao/comum/15791.html
7. Silva SN, Lima MG. Avaliação da estrutura dos Centros de Atenção Psicossocial da região do Médio Paraopeba, Minas Gerais. Epidemiol Serv Saúde. 2017;26(1):149-60. doi: 10.5123/s1679-49742017000100016
8. Anjos MA, Carvalho PAL, Sena ELS, Ribeiro RMC. Acolhimento da pessoa em sofrimento mental na atenção básica para além do encaminhamento. Cad Bras Saúde Mental [Internet]. 2015 [cited 2018 Jan 19];7(16):27-40. Avaiable from: http://incubadora.periodicos.ufsc.br/index.php/cbsm/article/view/1936
9. Okazaki C, Oliveira MAF, Claro HG, Paglione HB, Soares R. User embracement: expectations of the mental health professionals. Rev Ter Ocup Univ São Paulo. 2010;21(2):166-73. doi: 10.11606/issn.2238-6149.v21i2p166-173
10. Silva NS, Esperidião E, Cavalcante ACG, Souza ACS, Silva KKC. Development of human resources for work in mental health services. Texto Contexto Enferm. 2013; 22(4):1142-51. doi: 10.1590/S0104-07072013000400033
11. Cardoso MRO, Oliveira PTR, Piani PPF. Práticas de cuidado em saúde mental na voz dos usuários de um Centro de Atenção Psicossocial do estado do Pará. Saúde Debate. 2016;40(109):86-99. doi: 10.1590/0103-1104201610907
12. Bandeira PM, Souza CHP, Guimarães JCS, Almeida Filho AJ, Peres MAA. Psychiatric Nursing in Integrated Wards Accommodating Both Female and Male Patients: A Historic Pioneering Reform Initiative Implemented by the Institute of Psychiatry, a Unit of the Federal University of Rio De Janeiro, Brazil. Issues Ment Health Nurs. 2015;36(10):791-8. doi: 10.3109/01612840.2015.1043674
13. Conselho Nacional de Secretários de Saúde (CONASS). A atenção primária e as redes de atenção à saúde [Internet]. Brasília: CONASS; 2015 [cited 2018 Jan 19]. Available from: https://portal.tcu.gov.br/biblioteca-digital/a-atencao-primaria-e-as-redes-de-atencao-a-saude.htm
14. Zeferino MT, Cartana MHF, Fialho MB, Huber MZ, Bertoncello KCG. Health workers' perception on crisis care in the Psychosocial Care Network. Esc Anna Nery Rev Enferm. 2016;20(3):e20160059. doi: 10.5935/1414-8145.20160059
15. Barker PJ. The Tidal Model: Theory and Practice. Newcastle: University of Newcastle; 2000.
16. Barker PJ, Buchanan-Barker P. The Tidal Model: a guide for mental health professionals. London: Routledge; 2004.
17. Schmidt MB, Figueiredo AC. Acesso, acolhimento e acompanhamento: três desafios para o cotidiano da clínica em saúde mental. Rev Latinoam Psicopatol Fundam. 2009;12(1):130-40. doi: 10.1590/S1415-47142009000100009
18. Lima M, Jucá VJS, Nunes MO, Ottoni VE. Signos, significados e práticas de manejo da crise em Centros de Atenção Psicossocial. Interface (Botucatu). 2012;16(41):423-34. doi: 10.1590/S1414-32832012000200011
19. Ramage D, Ellis S, Marks-Maran D. Self-management, compassion and recovery: the Tidal Model in mental health practice. Br J Ment Health Nurs. 2015;4(4):178-84. doi: 10.12968/bjmh.2015.4.4.178