CRITERIA FOR NIGHT RECEPTION ACCORDING TO THE PSYCHOSOCIAL CARE CENTER TEAM

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ABSTRACT. Night care is one of the resources offered by Type III Psychosocial Care Centers in the care of subjects in severe psychological distress. This study aimed to identify the perceptions of professionals in a Psychosocial Care Center type III on the criteria for insertion and discharge of users in night care. It is a qualitative research in which nine professionals participated, responding to a semi-structured interview script about socidemographic data and questions about the functioning and criteria for night reception at the referred service. Thematic content analysis was performed with the data obtained. Thematic content analysis that the stabilization of the crisis and the protection of life are central criteria for insertion in the night reception, which can assume both a sense of vigilance about the user's behavior and an opportunity to develop a bond with the patient. team. In view of this, it is concluded that night care has a strategic role in managing crisis situations in mental health and that there are many challenges faced by the team when talking about the different points of the psychosocial care network in caring for its users.

Keywords: Publica health services; crisis intervention; mental health.

CRITÉRIOS PARA ACOLHIMENTO NOTURNO, SEGUNDO A EQUIPE DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL

RESUMO. O acolhimento noturno configura-se como um dos recursos oferecidos pelos Centros de Atenção Psicossociais de tipo III no cuidado aos sujeitos em sofrimento psíquico grave. Este estudo teve como objetivo identificar as percepões de profissionais de um Centro de Atenção Psicossocial tipo III sobre os critérios para inserção e alta de usuários em acolhimento noturno. Trata-se de uma pesquisa qualitativa da qual participaram nove profissionais respondendo a um roteiro semiestruturado de entrevista sobre dados socidemográficos e questões sobre o funcionamento e os critérios para o acolhimento noturno no referido serviço.e realizada análise de conteúdo temática com os dados obtidos. A análise de conteúdo temática que a estabilização da crise e a proteção à vida configuram-se como critérios centrais para a inserção no acolhimento noturno, ao qual pode assumir tanto o sentido de vigilância sobre o comportamento do usuário quanto de oportunidade para desenvolver vínculo com a equipe. Diante disso, conclui-se que o acolhimento noturno tem função estratégica no manejo às situações de crise em saúde mental e que muitos são os desafios enfrentados pela equipe na interlocução dos diversos pontos da rede de atenção psicossocial no cuidado aos seus usuários.

Palavras-chave: Serviços de saúde pública; intervenção na crise; saúde mental.

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CRITERIOS DE RECEPCIÓN NOCTURNA SEGÚN EL EQUIPO DEL CENTRO DE ATENCIÓN PSICOSOCIAL

RESUMEN. La recepción nocturna está configurada como uno de los recursos ofrecidos por los Centros de Atención Psicosocial Tipo III en la atención de sujetos con angustia psicológica severa. Este estudio tuvo como objetivo identificar las percepciones de los profesionales en un Centro de Atención Psicosocial tipo III sobre los criterios de inserción y alta de los usuarios en la atención nocturna. Es una investigación cualitativa en la que participaron nueve profesionales, que respondieron a un guión de entrevista semiestructurada sobre datos socidemográficos y preguntas sobre el funcionamiento y los criterios para la recepción nocturna en el servicio referido. El análisis del contenido temático se realizó con los datos obtenidos. El análisis de contenido temático de que la estabilización de la crisis y la protección de la vida son criterios centrales para la inserción en la recepción nocturna, que puede asumir tanto un sentido de vigilancia sobre el comportamiento del usuario como una oportunidad para desarrollar un vínculo con el paciente. equipo En vista de esto, se concluye que la atención nocturna tiene un papel estratégico en el manejo de situaciones de crisis en salud mental y que el equipo enfrenta muchos desafíos al hablar sobre los diferentes puntos de la red de atención psicosocial en el cuidado de sus usuarios.

Palabras clave: Servicios de salud publica; intervención en la crisis; salud mental.

Introduction

The theme of this research is the night care offered in a Type III Psychosocial Care Center (CAPS). CAPSs are equipment that emerged for the care of people in psychological distress, replacing the model of psychiatric care based on long-term hospitalization, hypermedicalization of the subject, and violent practices in the psychiatric hospital with actions that seek to provide the subject in psychological distress with humanized care. Strategies of psychosocial care, as opposed to asylum practices, seek to preserve the permanence of subjects in the family and community context, and operate from the perspective of establishing bonds, of caring for the needs of each subject in search of (re)building their relational field, thus promoting their autonomy (Portaria nº 366, 2002; Dimenstein & Silva, 2014). With the support of Ordinances MS 224/1992 and later 336/2002, CAPSs established themselves as a point of access to mental health care and, from 2011, became part of the Psychosocial Care Network (RAPS), formed by care points for people in psychological distress and/or with needs resulting from the use of alcohol and other drugs, such as Basic Health Units, Street Clinic Teams, Coexistence, and Culture Centers, in addition to therapeutic residences, CAPSs and hospital units with beds for hospitalization (Portaria nº 366, 2002; Ministério da Saúde, 2017b).

In type III CAPSs, which operate in municipalities with a population of over 200,000 inhabitants, night care is one of the functions for caring for individuals in psychological distress who require emergency and comprehensive mental health care (Dimenstein et al., 2012), as an alternative for crisis care and management. For the authors, CAPS III and general hospitals would be essential devices in the constitution of the crisis care network, since they provide the night care service to users. Within the context of RAPS, care, and management of crises emerge as some of the greatest difficulties for health professionals who work there (Dimenstein & Silva, 2014). Campos et al., (2009), in one of their qualitative

studies with different groups linked to a CAPS III, such as workers, users, and family members of users, indicate the appearance, in the reports, of two antagonistic conceptions about the crisis: (1) the one that relates to the emergence of symptoms to be contained by the team and (2) another linked to the perception of the situation as extremely fragile, but also an opportunity for reconstruction.

In another study (Zandoná, 2016), the notion of crisis is discussed based on the definition of the Caderno de Assistência Básica 34 de Saúde Mental (Ministério da Saúde, 2013), which addresses the situation of psychic crisis as an expression of an attempt to the reorganization of a suffering subject, whose disorders must be received and supported. It requires thinking about it in its relational dimension, considering the various elements that make up the subjects' unique stories and the resources available in their social and family context. The perception of the crisis has to involve not only symptoms but also relational, community, social, and political dimensions, among other aspects (Louzada & Castro, 2021). Crisis care in the logic of psychosocial care requires, according to Cruz, Guerrero, Scafuto and Vieira (2019), type III CAPS, which offers long-term support to users; emergency services that receive people in psychological distress and dialogue with the CAPS; psychiatric beds in general hospitals, which must be accessed when territorial and community-based resources run out when the CAPS has a prominent role in assessing demands and regulating access.

In this study, we adopt the concept of crisis proposed by Dell'Acqua and Mezzina (2005). 'Crisis situations' in the context of psychiatric services can be recognized when there is the prevalence of at least three of the following specifications: (a) severe psychiatric symptoms; b) serious rupture in the family and/or social context; (c) refusal of treatment; (d) obstinate refusal of contact; (e) inability to confront alarm situations in their life context. In addition to this definition, we agree with Ferigato, Campos and Ballarin (2007), who argue that the crisis should not be seen as a negative situation, which should be controlled as quickly as possible. On the contrary, the person in crisis must have their situation examined, explored, and received in all its potential and with all the resources available by the teams. As resources used in the management of crises by CAPS workers are: reception of users, extended service hours, drug intervention, physical restraint, intensive care, reintegration and psychosocial rehabilitation, home care, referral, and psychiatric hospitalization (Dimenstein & Silva, 2014).

Campos et al. (2009) also point out that the lack of CAPS III opens up gaps for the day/night fragmentation of the service, a common movement in psychiatric hospitals, and that the existence of beds for night care is a differential factor in care, as it allows users to be with the same team integrally in times of crisis. The Ministry of Health (Portaria nº 854, 2012) defines night care as hospitality actions offered as one of the resources of the unique therapeutic project of users who are being followed up at the CAPS, which occurs from the removal of the user from 'conflicting situations' in which they are involved and "[…] management of crises motivated by suffering resulting from mental disorders - including those due to the use of alcohol and other drugs". "Relational conflicts characterized by family and community breakdowns, limits of communication and/or impossibilities of coexistence […]" may be present, and the insertion in night care aims to build possibilities for "[…] the resumption, rescue and resizing of interpersonal relationships, family and/or community life […]", in which the maximum duration of use of this resource is 14 days.

Night care is mentioned in the specialized literature (Nilo et al., 2008; Silva, 2014; Gonzaga & Nakamura, 2015; Moura, 2015; Vainer, 2016; Brandão, Breda, Santos &

Albuquerque, 2018; Silva et al., 2020) as a device that guarantees accessibility, integral reception, team autonomy, and individualized assistance that does not agree with asylum logics, requiring articulation with the other care points in the network. In the municipalities with this type of service, this device fills a serious gap in mental health care, since "[…] suffering is not guided by the clock […]" and most of the existing CAPS are type I and II, organized for care "[…] only under daylight" (Nilo et al., 2008, p. 131). From this, the night care of users would be, for these authors: "[...] a way of dealing with and enabling exits for a subject breaking with their social bond" (Nilo et al., 2008, p. 118), that is, "[…] who became a foreigner in their own home, who broke out of speaking another language, who does not have a document or visa".

With regard to CAPS III as a modality of service and care in mental health, there is scarce scientific literature about its strategic function of night care, a fact that can be understood as a consequence of its low implementation in the country (Vainer, 2016). According to the Ministry of Health, in 2017, 100 CAPS III and 106 CAPS ad III were operating in Brazil (Ministério da Saúde, 2017a), for a total of 2,462 registered CAPS. The same document highlights that the number of CAPS with at least 12 crisis assistance records in 2016 was 561, which corresponded to about 23% of the total CAPS in the country. The newsletter *Mental Health in Data*, published by the Ministry of Health (Ministério da Saúde, 2015), states that in December 2014 only 85 CAPS III were registered throughout the Brazilian territory and 69 CAPS Ad III, of which 12 CAPS III and 10 CAPS Ad III were located in the state of Minas Gerais, in which this research was carried out. Given the considerations raised here, it is important to understand how CAPS type III teams perceive night care in user assistance, its limits, and its contributions. Therefore, the objective of this research was to identify the criteria used by professionals of a type III CAPS for the insertion and discharge of users in night care.

Method

A qualitative study was developed, characterized by the researcher's interest in apprehending the meaning of phenomena, experiences, events, ideas, and what these represent for the individual. In the health field, particularly, understanding such meanings becomes fundamental for strengthening the relationships between professional, patient, family, and institution (Turato, 2005). Participants were nine professionals from the team of a Type III Psychosocial Care Center in the state of Minas Gerais. The number was determined by theoretical saturation. Professionals who worked both at night – in which hospitality effectively takes place – and during the day were invited, as both are involved in the care process. The inclusion criteria were: working at the CAPS for at least three months at the time of data collection and being available to provide an audio-recorded interview. The exclusion criteria were: being on vacation or leave at the time of collection. CAPS III, the research scenario, had been operating for ten years, had 200 active users in the service and its team consisted of about 40 professionals from Psychology, Social Assistance, Nursing (graduates and technicians), Physicians (Psychiatrist and Clinician), receptionist, general services and doorman. The municipal network also had, at the time, a CAPS ij, a CAPS Ad type II, a CAPS Ad type III, two CAPS type II, a Child Care Unit, a Coexistence and Culture Center, 25 mental health beds in a university general hospital, in addition to traditional Basic Health Units and Basic Family Health Units (a team from the Support Center for Family Health supporting two primary care teams). The population of the municipality was over 500 thousand inhabitants at the time. It is important to highlight that the CAPS III, research setting, receives, for night care, in the six available beds users whose unique

therapeutic projects are developed in the unit and also users of CAPS II in the municipality, considering that they do not have rear beds. In these cases, the user remains at the CAPS II of origin during the day and at the end of the afternoon is taken to CAPS III by transport from the municipality, remaining there until the morning of the following day, when is taken to the CAPS II of origin.

As a data collection instrument, an individual and semi-structured interview script was developed. According to Duarte (2004), this type of instrument is essential when intending to map values, beliefs, and practices of certain social universes, allowing the researcher to delve deeply into the way each participant perceives and means the investigated phenomenon. The script initially encompassed the general characterization of the interviewee (age, profession, whether he/she has a partner, time working at SUS and at CAPS, among others) and guiding questions about the theme under study (the purpose of night care; the criteria for insertion and discharge in night care; advantages of night care).

After approval of the research project by a Human Research Ethics Committee (CAAE 80394017.5.0000.5152) and the issuance of authorization for contact with the manager by the Municipal Health Department, initial contact was made with the unit manager and one of the researchers attended a team meeting to explain the research objectives and deliver a copy of the project. The contacts of the professionals who were willing to participate in the research were noted for scheduling the interview, which took place on a date and time indicated by each professional, after signing the IC, using one of the CAPS rooms reserved for this purpose. A number was assigned to each interview, also as a way of preserving the participant's anonymity (for example, the first interview was assigned the initials E1, the second E2, and so on). To help preserve the identity of respondents, the specialties of each professional will not be disclosed.

The analysis of the transcribed material was inspired by the steps suggested by Bardin (1977) for thematic content analysis (pre-analysis; material exploration; treatment of results, inference, and interpretation). Each interview was read successively, independently by two different researchers, and after discussion, the identified subtopics were grouped and presented in the following section in the form of two categories and their subcategories.

Results and discussion

Characterization of participants

Among the nine interviewees, seven were women and two were men, aged between 25 and 41 years (mean age 31 years). Regarding the level of education, all are graduates, and five completed a graduate degree (two master's and three specializations). The minimum and maximum time of work in the health area of the interviewees was, respectively, one year and three months, and 16 years (mean of 5.3 years).

Category 1 - Criteria for inserting users in night care

Acute crisis: a manifestation of psychopathological signs and symptoms

One of the criteria for inserting the user in night care is the manifestation of signs and symptoms, characterizing a crisis in the classic molds of psychiatric manuals: "[...] the general crisis criterion that is linked to an exacerbation of the symptom, a psychic and emotional disorganization" (E1); "[...] the person has an intensification of the symptoms that they cannot manage on their own" (E2); "[...] when the patient is very agitated, very accelerated, complaining a lot about the family, threatening the family [...]" (E5); "A patient in crisis is showing symptoms, hearing voices, seeing things that other people cannot see,

is more irritable, aggressive [...]" (E6). The intensification of symptoms appears as an indication for insertion in night care, guaranteeing a period of observation by the team: "[...] the acute crisis is that state where the patient enters [...] into a disorganization, and needs help, listening, or if possible a referral to a place to [...] have a more effective, more intensive observation" (E3); "[…] a crisis that we believe that, with normal medication, he/she [user] will not be able to get out [...] when it is more acute, then these are already criteria for entering hospitality" (E9). The explanations listed here are in line with the definition of crisis named by Ferigato, Campos and Ballarin (2007) as an 'aggravation of psychiatric symptoms', something destructive that must be stabilized. This simplified reading of the moment of crisis, in addition to disregarding the potential for the subject's transformation, also disregards several other aspects understood by Dell'Acqua and Mezzina (2005) as important when thinking about the concept of crisis, such as the complexity of relationships established by the subject and the current historical context, in addition to the possibility of reorganizing the suffering subject (Zandoná, 2016; Ministério da Saúde, 2013).

Preventive overnight stay

In addition to the exacerbation of symptoms, the notion of 'preventive hospitality' appears, which justifies the indication for night care and occurs in three situations. The first concerns behavior changes that indicate to the team that a crisis may soon occur, that is when the team identifies prodromes:

> There are some cases in which we insert hospitality in a more preventive way. The person is not in crisis, they still [emphasis] are not in crisis, but we think they are having a behavior change that can evolve into a crisis or because of a stressful event in their life, there was some very big change [...] Then we insert them into hospitality to control this, regulate, and prevent the crisis from appearing and getting worse (E1).

The concept of prodrome, explained by McGorry and Edwards (2002 cited by Carvalho & Costa, 2008), describes a situation where, before the outbreak of a psychotic crisis, it would be possible for those who live with the subject to observe changes in their behavior such as social isolation, lower body hygiene, lack of initiative, changes in speech and affection. According to the authors, recognizing such changes - prodromes - could help the person in psychological distress insofar as changes in their treatment can be organized, adapting it to the needs of the moment (Carvalho & Costa, 2008; Freitas & Costa, 2017). The recognition of prodromes by the team that participated in this study, on the one hand, signals professionals who are attentive and close to the user and, on the other hand, leads us to question the need for isolation of the subject through night care, to the detriment of other possible changes in their unique therapeutic project.

The second situation refers to the need to observe the user more closely to clarify a diagnosis, that is, "[…] a way of understanding a condition... sometimes to set a diagnosis that the team is in doubt, which is named by the family as a crisis [...] and inserts [in the night care] in a preventive way as well" (E2). This need to insert in night care to clarify a diagnosis brings the service closer to a traditional clinic than to an expanded clinic, which should guide assistance in psychosocial care (Campos, 2001). Finally, the third situation occurs when the family requests hospitalization, but the team does not assess this need: [The family] is not thinking about hospitality, they want hospitalization. So, we offer hospitality sometimes even to prevent [...] hospitalization" (E8). This third situation signals the support of the CAPS team to the user in an attempt to sustain the crisis itself, "[…]

transforming the outbreak into a passage" (Campos, 2001, p. 105), which places the CAPS effectively as a substitute for hospitalization.

Social Crisis: failures of the family in relational aspects with the user

Participants used the expression 'social crisis' to describe situations in which there is not just or primarily an exacerbation of psychopathological signs and symptoms, disconnected from their relationships: "[…] it could be a social crisis, when the individual is not well at home, with family members, with whom the person lives with, right? And they need [...] some time [...] away from home [...] but then they will come back soon" (E7). In the interviews, the family appears as a central character in scenes of 'social crises' in which three paths emerge. In the first case, according to the interviewees, the user-family relationship is characterized by low support for the user, when the family is unable to offer care to the subject who is in crisis within their own home, either due to the severity of the symptoms or the family's difficulty of handling with the user, requiring assistance with specialized support. In this case, professionals claim that night care offers the necessary support to avoid hospitalization and to manage the case, which implies the possibility that the CAPS becomes a substitute service (Campos, 2001). The period in night care allows the family to reorganize itself and receive the user at the end of the hospitality period:

> In the end, we see that those cases in which the family is not able to stay with the patient at home are left in hospitality [...] because they are aggressive or because they are very depressed [...], so the family is no longer able to deal with that situation at home [...] (E8).

There are also cases in which many intra-family conflicts are present in the home environment, making the subject's stay in that place quite stressful. Night care would emerge as support for the subject in crisis and their family in this period of conflict, offering them specialized care and support for the family to restructure the family bond: "In other cases [...] home is a very big focus of conflict, the family cannot [...] So, being here at the CAPS, right? We manage to remove the individual from the stressful environment for [...] a few moments and offer the care they need" (E1). The need to offer care to families, including them in treatment, highlights the partnership relationship with the CAPS, both being co-participants in user care, with the possibility that the family, being seen as an ally of the team, has valued its subjectivity and protagonism (Pinho, Hernández & Kantorski, 2010; Rodovalho & Pegoraro, 2020).

The second way in which the 'social crisis' appears in the participants' speeches points to the night care only for the overnight stay of users and reveals difficulties in partnerships with equipment outside the health area. These are cases in which the family has difficulties receiving the user at home due to the breaking of the subject-family bond and the team cannot, for example, obtain a place for the subject in institutions that offer temporary shelter: "It's not that the person is in crisis, but they are in a social crisis if you think about it because the family does not want to receive. Where are they going?" The interviews indicate that, at certain times, the night hospitality beds have been used to meet demands that could be covered by other services that are part of the RAPS, but which do not exist in the researched scenario, such as the Reception Units (Ministério da Saúde, 2017b) or hostels accredited to the municipality. These are situations perceived by the team as 'exceptions', but present in the interviews:

> For example, a person that the family does not accept at home for 'n' reasons and there are no devices that accept the person as they are, for example, hostels, right? [...] There is nowhere to go...

and sometimes they appear here with this demand. [...] sometimes it happens to appear and it is necessary to insert them, right? They are exceptions (E2.)

The social issue is very important here because sometimes the patient does not have any family support outside, there is nothing that can help [...] and sometimes there are also no other sectors to turn to, and then we are ourselves. The municipality charges this from us, right? [...] There are also cases of homeless patients who are brought in, who have no one, we cannot find anyone from the family and they stay here for a long time (E9).

Finally, the so-called social crisis also suggests night care due to the need to readjust the medication. It is understood that medication administration should be accompanied or supported by a family member, which does not always occur:

[...] sometimes the patient does not take it right at home, they say they take it and we realize that they are not taking it, the family does not administer it, does not take care of it properly. And then we insert them to see how they will be doing the appropriate drug treatment here (E2).

Usually, patients who do not have very good family support [...] to help administer these drugs at home, the patient ends up cycling, right? [...] cycles and comes into crisis again [...] We propose hospitality exactly for people to see if the medication is simply not... [...] they are not taking it, or if they need a medication readjustment (E3).

The linking of family responsibility in the administration of prescribed medications places the family nucleus sometimes as co-responsible for the treatment of the user together with the CAPS, serving the night care as an aid to the family in the management of the subject's crisis, sometimes as blamed for the stressful environment that it provides and the negligence of user care, as pointed out by Pinho, Hernández and Kantorski (2010).

Protection x surveillance

The protection of the lives of users who are at risk of suicide or those who have drug debts and are in danger in the territory where they live is one of the criteria for insertion in night care. Users who have persistent suicidal ideas or who have already attempted self-extermination are indicated for night care due to the protected environment and the presence of the team: "There are also cases of patients of attempted self-extermination [...] patients who maintain the ideation, who want to die [...], so we keep them here to have an environment where there is someone who is always looking after them" (E8).

This patient will be observed the whole time, away from sharp objects, away from risky situations such as ropes or an attempt to intoxicate with excessive medication [...]. This service we do precisely to not let this patient [...] provoke these situations [...] (E3).

The lack of objects/instruments that allow the user to make a suicide attempt is one of the justifications for night care. Heck et al. (2012) point out that, in cases of suicide attempts, taking action must be done with agility and responsibility, intervening in a humane and empathetic way, since building a bond with the user at this time of great psychic suffering becomes essential.

According to the interviewees, many service users are in a situation of vulnerability and risk in the territory, mainly due to debts resulting from the purchase of psychoactive substances for personal use. CAPS professionals stated that night care would also offer protection to life in cases where these users are threatened with death due to debts to drug dealers in the territory:

Many patients [...] especially patients who use psychoactive substances [...] tend to have conflicts in the territory precisely because of the lack of money, not being able to maintain the addiction [...] some

problems with the local police in the neighborhood, so we try to provide [...] this protected environment [...] (E3).

[...] a patient of ours who maybe is a drug user, [...] he/she bought the drug and didn't pay and is being threatened [...] And also if he/she's not well, it's not just the threat, but he/she is not well psychologically and he/she is also at risk in the territory, it is another option for us to offer hospitality [...] (E6).

Night care, justified by the need for a closer look by the team for 24 hours and care for the life of those who are threatened by debts to drug dealers, point to a contradiction in the assistance, which both protects and watches over: "It is an environment that we talk about protected, but it is also a monitored environment, where there is always someone so that, until the treatment has some effect, the person does not make a new attempt [suicide]" (E8) Not only the team's commitment to life can be perceived, but in situations involving suicide attempts and debts to drug dealers, also a surveillance situation over the bodies that must be kept alive, suggesting tension installed in the team.

Opportunity to bond with the user

Night care is also justified, according to the participants, as a resource that favors the creation of bonds between the team and the user in two situations, which is confirmed by the literature (Silva et al., 2020; Campos, 2001; Campos et al., 2009). The first refers to the insertion of 'users who do not adhere' to CAPS therapeutic proposals and who do not attend the unit. The second situation that, according to the interviewees, makes night care a possibility for building bonds, refers to a user who is not known by the team, was attended by an emergency service, and was referred to the first care at CAPS. Examples of these two situations are:

For several reasons, they do not come to the CAPS: the family does not bring them, or cannot come alone and there is no one to bring them, or they do not want to come, or they refuse to leave the house to come [...] Then we do a search [...] at home, we take the ambulance there, talk and stuff, and then we bring this person [...] or the family managed to bring them [...] then we propose to the patient 'Let's stay a few days, that you stay there, we get to know each other better'. After that, we realize that it has a good result. The patient starts to come and starts to attend most of the time (E7).

We receive the patient and if we know them, we already know if they are in crisis or not. If we don't know, in providing care, we can also see if they are well or not and offer hospitality, depending on the severity (E6).

Contraindications of night care

When narrating situations in which night care was a practice adopted by the CAPS team, the interviewees also pointed out situations in which care would be contraindicated. The first situation involves users with clinical complications that require hospital support:

When the patient [...] starts to have clinical issues, for example, they don't eat anything, they don't even drink water [...] and then they start to have a clinical imbalance too, and here we don't even have the condition to administer saline. So when it gets worse, we assess the need for hospitalization, so that ends here, but it goes to another level [...] of follow-up (E7).

The second situation occurs in cases where the user's family is not located by the team so that they can return to the residence and there is a need for care, attention, and housing for mental health treatment. The user remains in night care and, when the municipal network requests the vacancy, the team can negotiate the transfer to another location: "[...] if it is a social issue if it is sometimes a case of going to a transitional bed at [name of a clinic]" (E5).

The third factor that contraindicates night care and, in addition, highlights the referral to other services is the high level of aggressiveness of the user in crisis for which the management of the team is insufficient, either due to the impossibility of increasing the dosage of medication in the CAPS or because there is no hospital apparatus to deal with serious clinical issues resulting from the use of a large amount of medication. In these cases, there is an indication of going to the emergency service with a view, often, to hospitalization. This last factor exposes the need for articulation between CAPS and emergency services and the central role that CAPS must play in assessing demand (Cruz et al., 2019):

> [...] when the management of the team is not enough to take care of the patient here, in terms of aggressiveness, or terms of response to treatment, [...] it has been there for a long time and does not get better [...] when you already have a medication dosage that you can no longer increase at the CAPS and you need to have hospital support because the patient runs the risk of having an arrest, a lowering of the level of consciousness (E7).

Category 2 - Criteria for discharge of users in night care

Requests made by users and family members

Interruption of the user's period in night care does not always occur due to the team's indication. Four factors were mentioned as justification for discharge: (1) requested by the user, who identifies improvement and stabilization of the crisis; (2) requested by the user together with the family, after identifying improvement and stabilization of the crisis; (3) requested by the user, who refuses to continue in night care and (4) requested by the family, who does not accept that the user continues in night care. If the team considers that the user is not able to be discharged and there is a request by the user or his family, 'discharge at request' occurs upon the signature of a term of responsibility by the family member or by the user for the end of night care: "It is very common for the patient to put this end to us. [...] when they are well, they will ask to leave" (E7); "If the team does not agree that they are fine with discharge, we ask that a relative, or they, to sign a term of responsibility" (E6).

This discharge request made by the user or their family is related to the difference that the team makes between night care and hospitalization. For night care, the user must accept/agree with their insertion in this procedure "[...] the patient needs to accept to stay here, because if they do not accept it, we do not oblige, it is not the same as hospitalization [...]" (E7). Likewise, at discharge there is a counterpoint between night care and hospitalization, requiring the consent of the user: "Hospitality is not a hospitalization, so the person has autonomy, freedom to say 'Oh, I don't want anymore, I want to go home', which also applies to family members 'I don't want my father/my son/my husband to stay here anymore, I want to take him home, I'm going to take him somewhere else', so we discharge him" (E1). This understanding disregards the voluntary character that some short-term hospitalizations for mental health cases have today in Brazil.

Crisis stabilization

The stabilization or attenuation of signs and symptoms that led to the inclusion of the subject in night care is another criterion for discharge (Ferigato et al., 2007). The organization of the flow of thoughts, the coherence of speech, and the regularization of sleep are indicative of stabilization, with remission of symptoms: "If the patient slept well or not, if they have a regular sleep, the question of organization, both of the flow of thoughts and verbalization [...]" (E3); "We observe if those criteria that we used to insert [...] [that is] what was generating conflicts, the crisis [...] or whatever it was if there has already been

improvement. We observe whether the patient is already more organized [...]" (E7). "When we realize [...] that they have reduced the intensity of the symptoms, they can talk about themselves [...] regardless of the disorder. So that's when we determine the discharge" (E5).

Restoration of family support

According to the professionals interviewed, the family has to be able to receive the user back in the family environment so that the discharge can be carried out, thus being able to offer the necessary care and support to this subject who is returning to the family: "[...] we discharge when the family already feels safer for that person to return home, there will be someone with them longer because of the threats they may have" (E1); "[...] when you can articulate with the family or with someone who can receive that person into the family, where they receive the protection they need, in the way they need it" (E4).

The withdrawal of the individual from their social environment, either to 'set a diagnosis', or to offer the family a middle ground for what they ask for, regularize the medication when the family fails in this task, or to protect them from conflicts arising from debts to drug dealers takes us back to Phillipe Pinel's initial psychiatry project and not to the care developed by the psychosocial care method. In the words of Oda and Dalgalarrondo (2004, p. 135), for Pinel, "[…] the confinement and isolation of the patient were fundamental and aimed at, at the same time, distancing them from their usual environment, offering safe measures to society and the alienated themselves and better observe them, to better treat them". The authors point out that, at the time of Pinel, the hospice should lead "[…] to reason through discipline and fair repression, in a calm, regulated environment, away from turmoil and passions" (Oda & Dalgalarrondo, 2004, p. 135).

Dimenstein et al. (2012) warn of the risk that some CAPS III function as structures attached to the psychiatric hospital, as they reaffirm their need when they fail to establish themselves as effective substitutive services. Concerning the CAPS that served as the setting for the present study, it offers support with night hospitality beds for other CAPS in the municipality that do not have this resource. Therefore, many of the users who arrive referred to the night hospitality and who have been regularly accompanied by the team from another unit, start to receive assistance from a new team, with, therefore, a certain fragmentation of the bond between the user and the team of the CAPS of origin, contrary to the perspective of Campos et al. (2009), who emphasize that the differential of night hospitality is to allow patients to be fully with the same team in the service in times of crisis. In this sense, the advantage present in the logic of the authors would only exist in cases of users who are received and monitored in the CAPS III.

In addition, noting the need for coverage of the other CAPS in the municipality in relation to night hospitality by the CAPS III in question, the data provided by Vainer (2016) and the Ministry of Health (Ministério da Saúde (2017a) are confirmed, which affirm the existence of a low implementation of CAPS III in the country and the consequent scarce scientific production on the subject.

The concept of territory in mental health has to be highlighted, as this has direct implications for the practices of the different network services. The gap that opens up when considering night care as an alternative protective measure for the user at risk in the territory is vast, as it makes us reflect on the (in)existence of team practices in the care of the user in the territory, considering its possibilities in the face of the conflicts experienced in this place and the social relationships it establishes. Furtado, Oda, Borysow and Kapp (2016) address the existence of an instrumentalization of the concept of territory, understood most

of the time only as an administrative organizer of the coverage area of health services of the network, disregarding the inclusion of the subject in mental suffering in its relational scope. Given this, they affirm the need to distinguish the simple insertion of the user in the RAPS from their true inclusion in the physical, social, and relational spaces that make up the notion of territory.

Final considerations

This research investigated the criteria for inserting users in night care in a 24-hour Psychosocial Care Center. Its relevance lies in the low number of publications on CAPS care resources and the importance of night care for assistance during crises and outside the hospital, making CAPS a truly substitutive service. Understandings of the team that participated in the research about night care only as an overnight space, difficulties in dialogue with equipment outside the field of health, and the aspect of care that brings it closer to a body surveillance instrument, observed in this study, do not reduce the night care. On the contrary, they point to the arduous task of the team in providing care in a territorial-based service and reveal, in our view, the need for mechanisms such as clinical-institutional supervision to be activated to allow spaces for reflection for the CAPS teams, especially those with more ability to establish themselves as effectively substitutive services, which is only possible with the operation of the 24-hour service. Another space for reflection can be opened with feedback on the research. In this sense, a reprint of the research report was delivered to the mental health coordination of the municipality and the CAPS in question, but the meeting with the team to discuss the material with the service has not yet taken place.

Once it was carried out in a single CAPS III and only professionals from this service participated, one of the limitations of the research is the impossibility of investigating the understanding of the functioning of this resource in other CAPS and points of the network, as well as the perspective of other subjects involved in the night care process (such as users and their families). From this, we point out the importance of continuing to investigate the strategic role of night care beyond the municipal level, considering the interlocution of the various points of the network, as well as providing listening to users and family members about their understanding of this resource.

References

Bardin, L. (1977). *Análise de conteúdo*. Lisboa, PT: Edições 70.

Brandão, T. M., Breda, M. Z., Santos, D. S., & Albuquerque, M. C. S. (2018). A necessidade pelo acolhimento noturno em centro de atenção psicossocial: percepções da pessoa que usa drogas. *SMAD, Revista Eletrônica Saúde Mental Álcool e Drogas, 14*(2), 84-91.

Campos, R. O. (2001). Clínica a palavra negada - sobre as práticas clínicas nos serviços substitutivos de Saúde Mental. *Saúde em Debate, 25*(58), 98-111.

Campos, R. T. O., Furtado, J. P., Passos, E., Ferrer, A. L., Miranda, L., & Gama, C. A. P.

(2009) Avaliação da rede de centros de atenção psicossocial: entre a saúde coletiva e a saúde mental. *Rev. Saúde Pública*, *43* (Suppl. 1), 16-22.

Carvalho, N. R., & Costa, I. I. (2008). Primeiras crises psicóticas: identificação de pródromos por pacientes e familiares. *Psicologia Clínica*, *20*(1), 153-164.

Cruz, K. D. F., Guerrero, A. V. P., Scafuto, J., & Vieira, N. (2019). Atenção à crise em saúde mental: um desafio para a reforma psiquiátrica brasileira. *Revista do NUFEN*, *11*(2), 117-132. https://dx.doi.org/10.26823/RevistadoNUFEN.vol11.n02ensaio51

Dell´Acqua, G., & Mezzina, R. (2005). Resposta à crise: estratégia e intencionalidade da intervenção no serviço psiquiátrico territorial. In P. Amarante (Coord.), *Archivos de saúde mental e atenção psicossocial 2* (p.161-194). Rio de Janeiro, RJ: Nau.

Dimenstein, M. D. B. et al. (2012). O atendimento da crise nos diversos componentes da rede de atenção psicossocial em Natal/RN. *Polis e Psique, 2*, 95-127.

Dimenstein, M. D. B., & Silva, M. L. B. (2014) Manejo da crise: encaminhamento e internação psiquiátrica em questão. *Arquivos Brasileiros de Psicologia*, *66* (3), 31-46.

Duarte, R. (2004). Entrevistas em pesquisas qualitativas. *Educar, 24*, 213-225.

Ferigato, S. H., Campos, R. T. O., & Ballarin, M. L. G. S. (2007) O atendimento à crise em saúde mental: ampliando conceitos. *Revista de Psicologia da UNESP, 6*(1), 31-44.

Freitas, M. M., & Costa, I. I. (2017). Grupo de intervenção precoce nas primeiras crises do tipo psicóticas (gipsi): acolhendo o sofrimento humano. *Pluralidades em Saúde Mental, 6* (2), 7-14.

Furtado, J. P., Oda, W. Y., Borysow, I. C., & Kapp, S. (2016). A concepção de território na saúde mental. *Cadernos de Saúde Pública, 32*(9)*,* 1-17*.*

Gonzaga, N., & Nakamura, E. (2015). Os significados dos encaminhamentos feitos aos CAPS III de Santos: a visão dos profissionais. *Saúde Sociedade, 24*(1), 232-243.

Heck, R. M., Kantorski, L. P., Borges, A. M., Lopes, C. V., Santos, M. C., & Pinho, L. B.

(2012). Ação dos profissionais de um centro de atenção psicossocial diante de usuários com tentativa e risco de suicídio. *Texto Contexto Enfermagem*, *21*(1), 26-33.

Louzada, A. P. F., & Castro, M. D. C. (2021) Crise no cotidiano: o cuidado nos Caps. *Mnemosine*, *17*(1), 163-183.

Ministério da Saúde. (2013). *Cadernos de atenção básica, n. 34 (saúde mental)*. Recuperado de: https://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_34_saude_mental.pdf

Ministério da Saúde. (2015). Informativo eletrônico de dados sobre a Política Nacional de Saúde Mental. *Saúde Mental em Dados, 10*(12). Recuperado de: www.saude.gov.br e www.saude.gov.br/bvs/saudemental

Ministério da Saúde. (2017a). *Panorama e diagnóstico da Política Nacional de Saúde Mental*. Recuperado de: http://portalarquivos2.saude.gov.br/images/pdf/2017/setembro/04/2a-Apresentacao-CIT-Final.pdf

Ministério da Saúde. (2017b). *Portaria nº 3.588, de 21 de dezembro de 2017. Altera as Portarias de Consolidação nº 3 e nº 6, de 28 de setembro de 2017, para dispor sobre a Rede de Atenção Psicossocial, e dá outras providências*. Recuperado de: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588_22_12_2017.html

Moura, A. F. (2015). *Estudo sobre o uso do dispositivo leito de acolhimento noturno em Centro de Atenção Psicossocial Álcool e Drogas – CAPS AD* (Dissertação de Mestrado). Universidade Federal de São Carlos, São Carlos.

Nilo, K., Morais, M. A. B., Guimarães, M. B. L., Vasconcelos, M. E., Nogueira, M. T. G., & Abou-Yd, M. (2008). Resposta à crise: a experiência de Belo Horizonte. In Secretaria Municipal de Saúde de Belo Horizonte. *Política de Saúde Mental de Belo Horizonte: o cotidiano de uma utopia* (p. 11-128). Belo Horizonte, MG.

Oda, A. M. G. R., & Dalgalarrondo, P. (2004). O início da assistência aos alienados no Brasil ou importância e necessidade de estudar a história da psiquiatria. *Revista Latinoamericana Psicopatologia Fundamental, VII* (1), 128-141. Recuperado de: http://www.scielo.br/pdf/rlpf/v7n1/1415-4714-rlpf-7-1-0128.pdf

Pinho, L. B., Bañon Hernández, A. M., & Kantorski, L. P. (2010). Serviços substitutivos de saúde mental e inclusão no território: contradições e potencialidades. *Ciência, Cuidado E Saúde*, *9*(1), 28-35. https://doi.org/10.4025/ciencuidsaude.v9i1.6824

Portaria nº 336/2002, de 19 de fevereiro de 2002. (2002). Recuperado de: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt0336_19_02_2002.html

Portaria nº 854/2012, de 22 de agosto de 2012. (2012). Recuperado de: http://bvsms.saude.gov.br/bvs/saudelegis/sas/2012/prt0854_22_08_2012.html

Rodovalho, A. L. P., & Pegoraro R. F. (2020). O Centro de Atenção Psicossocial segundo familiares de usuários: um estudo a partir dos itinerários terapêuticos. *SMAD, Revista Eletrônica Saúde Mental Álcool e Drogas, 16*, 1-8.

Silva, E. O. (2014). *Hospitalidade noturna: subsídios para atenção psicossocial no Cersam Ad Pampulha/MG* (Monografia). Universidade Federal de Santa Catarina, Florianópolis.

Silva, T. C. S., Santos, T. M., Campelo, I. G. M. T., Cardoso, M. M. V. N., Silva, A. D., & Peres, M. A. A. (2020). Acolhimento noturno em um Centro de Atenção Psicossocial III. *Revista Brasileira de Enfermagem, 73*(1), e20170964. http://dx.doi.org/10.1590/0034-7167-2017-0964

Turato, E. R. (2005). Métodos qualitativos e quantitativos na área da saúde: definições, diferenças e seus objetos de pesquisa. *Saúde Pública*, *39*(3), 507-514.

Vainer, A. A. (2016). *Demanda e utilização do acolhimento noturno em Centro de Atenção Psicossocial III na cidade do Rio de Janeiro* (Dissertação de Mestrado). Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz, Rio de Janeiro.

Zandoná, L. B. (2016). Manejando a crise: uma proposta ético-inventiva. *ECOS – Estudos Contemporâneos da Subjetividade,* 6(2), 197-210. http://www.periodicoshumanas.uff.br/ecos/article/view/1856