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EXPERIENCES OF EMBRACEMENT ACCORDING TO PROFESSIONALS OF A PSYCHOSOCIAL ATTENTION CENTER

EXPERIÊNCIAS DE ACOLHIMENTO SEGUNDO PROFISSIONAIS DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL

ACOGIMIENTO SEGUNDO PROFESIONALES DE UN CENTRO DE ATENCIÓN PSICOSOCIAL

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ABSTRACT

Objectives: This article aims to identify the conceptions of the embracement procedure performed in a Psychosocial Care Center according to its professionals. **Method**: The research was qualitative, descriptive, and made use of a set of interviews, applied to four professionals on the functioning of the CAPS and the care provided in addition to participant observation. The interviews were transcribed and subjected to content analysis. **Results**: The participants highlighted changes in the way of carrying out the host from changes in demand CAPS and showed strengths and difficulties of performing a host group. **Conclusion**: The study highlights the approach of family-members-team from the host group, the development of listening and bonding, as well as the operation of this group in order to minimize difficulties arising from flaws in the local mental health system.

Keywords: User Embracement, Mental Health, Health Services.

RESUMO

Objetivos: Este artigo teve como objetivo identificar as concepções sobre o processo de acolhimento realizado em um Centro de Atenção Psicossocial segundo seus profissionais. **Método**: A pesquisa realizada foi qualitativa, de natureza descritiva, e fez uso de um roteiro de entrevistas, aplicado em quatro profissionais, sobre o funcionamento do CAPS e os cuidados prestados, além de observação participante. As entrevistas foram transcritas e submetidas à análise de conteúdo. **Resultados**: Os participantes destacaram mudanças na forma de realizar o acolhimento a partir de mudanças na demanda do CAPS, bem como apresentaram pontos positivos e dificuldades da realização de um grupo de acolhimento. **Conclusão**: Destaca-se a aproximação de familiares-usuários-equipe a partir do grupo de acolhimento, pelo desenvolvimento de escuta e vínculo, bem como o funcionamento deste grupo como forma de minimizar dificuldades advindas de falhas na rede de saúde mental local.

Palavras chaves: Acolhimento, Saúde Mental, Serviços de Saúde.

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RESUMEN
Objetivos: Este artículo tiene como objetivo identificar las concepciones del procedimiento de recepción realizado en un Centro de Atención Psicosocial de acuerdo a sus profesionales. **Método**: La investigación fue cualitativa, descriptiva, e hizo uso de una serie de entrevistas, aplicado a cuatro profesionales sobre el funcionamiento de los CAPS y la atención recibida, además de la observación participante. Las entrevistas fueron transcritas y sometidas a análisis de contenido. **Resultados**: Los participantes destacaron los cambios en la forma de llevar a cabo la acogida de los cambios en la demanda y CAPS mostraron fortalezas y dificultades de la realización de un grupo de hosts. **Conclusión**: El estudio pone de relieve el enfoque de la familia-miembros-equipo del grupo de acogida, el desarrollo de la escucha y la unión, así como la operación de este grupo con el fin de reducir al mínimo las dificultades derivadas de fallas en el sistema de salud mental local.
Palavras clave: Acogimiento, Salud Mental, Servicios de Salud.

INTRODUCTION

The Psychosocial Attention Center (CAPS) is a mental health service that offers counseling to people in severe psychic suffering and/or due to the use of substances and aims social and cultural insertion of users and their families on the territory. Currently, CAPS integrates the Psychosocial Attention System and in addition, offers daily counseling to users. It is also responsible for managing therapeutical projects personalized for each user, to organize the mental health network on the territory and giving support to professionals of the mental health basic network.[1]

In addition to clinical monitoring, CAPS offers other activities that promotes social reinsertion and psychosocial rehabilitation, such as therapeutical workshops, community and artistic activities, individual and group activities as well, orientation and the monitoring of medication use, visits and home care.[1]

Besides all those activities, embracement is also an important tool adopted by CAPS' teams, daily accomplished by the team. In the embracement process, the team prioritizes the qualified hearing, which provides the establishment of the bond between the users with the health service, as the individual is seen as a person and not his sickness.[2] Embracement is not defined as a space or a place, with time or specific professional to accomplish it, but a welcoming attitude from all the professionals that "listen and welcome" those that search assistance for their demands.[3] And for this reason, it can be understood as an action that must occur in all sites and in moments of service. Besides, the embracement is a technology for reorganizing the services that aims to guarantee humanized universal access to

health equipment, the reorganization of work process and the access with responsibility and resolution.[4-5]

Even though the literature[4] points to a daily welcoming attitude, guided by the team to users, a Brazilian study performed from interviews with professionals, allowed the delineation of different comprehensions about the tool "Embracement", to know: (a) Embracement as a triage-interview, at the service entrance; (b) Embracement as an action in healthcare, a synonym of the "host act", that can occur in different spaces and moments of CAPS' routine and allow more humane relationships between users and workers; (c) Embracement as an analytical device of the process of working in health, that is, as a concept used in order to problematize the given assistance to users; (d) Embracement as a space of listening, process that allows to visualize the establishment of the user's trust towards the technical team, approximating to the *Winnicottian* concept of holding, thus, an environment sufficiently good, capable of sustaining the personal development by team action.

From the recognition of the importance of Embracement under the scope of SUS' network[6] and its use on CAPS, being pointed as a guideline by the Ministry of Health, as well as the diversity of points of view over this strategy among professionals of the network, as research problems were pointed: in which way is performed the embracement in CAPS[1] currently? Is there a single way adopted by the team? Is there a necessity of changes in the way the embracement has been performed? Which positive aspects and difficulties this tool generates?

From these questions, the objective of the present research was to identify the conceptions of professionals of a Psychosocial Attention Center about the embracement.

METHOD

The study was developed as a qualitative research of descriptive nature. An interview-based script was used, initially semi-structured composed by the following social demographic data: age, sex, civil status, professional formation (graduation, specialization) and time performing on healthcare. It was investigated the following guiding questions: previous work experience on healthcare and mental healthcare; activities developed in CAPS' present time; conceptions on Embracement; evaluation on CAPS' users (main diagnostics,

advances and difficulties found on the daily execution of work). Beside the interviews, a participant observation of the referred activities was performed on users' embracement. It was performed four visits to CAPS with this goal, 3 hours period each.

Four professionals participated in the study of a CAPS II unit at the city of Goiânia, which attended users with severe and persisting mental disorders. The following inclusion criteria were used: work in CAPS for over six years, older than 18 years old, having availability to give a recorded interview and perform the embracement to users in the period in which the embracement occurred.

All the participants of the study received an Informed Consent Form which assured them total secrecy of declared information and the preservation of the identity of the interviewed, compatible with the approval of the Ethics Committee in Research with Human Beings of PUC Goiás (Sentence CEP/SGC 1840/2011). In order to ensure anonymity, it was used E1, E2, E3 and E4 as denominations to identify the surveyed.

The surveys occurred at CAPS itself, in the year of 2012, in a reserved room and in a time selected by each participant. Each interview was fully transcribed and the amount of transcriptions was submitted to content analysis.[7]

RESULTS

All the professionals interviewed were female, between 20 and 50 years old and approved by a public examination from the city office; two of them had a partner and the other ones were single. The surveyed professionals worked at CAPS for 5 to 10 years and all of them had performed an educational specialization (healthcare or in other areas).

Category 1 – Different Embracement formats in CAPS' history

According to the professionals, Embracement was initially taken care of during all week by CAPS' professionals alongside the user, that for the first time arrived at the service, with the gathering of some information about his history and the motives on which made him visit the site. The Embracement occurred without the necessity of a schedule and it was performed by a single professional each shift (one worker by the morning and another on the afternoon, according to the established schedule) and all the cases were discussed on the general team

meeting (weekly) for the elaboration of the user's therapy project:

The embracement was performed during the week… on Friday it was brought into the team meeting… for the people to decide which therapy project would be applied for each person. (E4)

CAPS' demand was growing and the number of professionals that integrated the team as well. According to reports, the Embracement was transformed into an activity that caused overload, because of the gravity of some cases and the necessity of a "second look" directed by the user and his history before defining whether the user should or should not be inserted on CAPS' routine. From these difficulties, the Embracement started to be made in pairs by professionals:

By time, CAPS was getting a bigger demand… and at the same instant, it had to develop a way to do the Embracement in pairs as well. (E4)

According to those that were interviewed, in a third moment, there was an alteration in the way Embracement was performed. Besides, the individual Embracement to the user that searched for CAPS, it was created by the team the "Embracement Group" with the intent of knowing the users better, their demands, and search to clarify the questions that those brought.

At the moment data collection occurred, by searching CAPS, according to the interviewed, the person could do it spontaneously or by some referral.

This person would be received by one of the professionals that would make a hearing, would give orientations regarding the service and CAPS' functionality, and would fill a form with user's life and clinic history. From this moment on, the user was invited to participate in the "Embracement Group", where activities occurred twice a week. This group of embracement allowed attending the necessity of major clarifications about CAPS' functionality to users and provides an environment that would enable them to know them better:

Sometimes [the user] started to attend [CAPS' activities] and saw that it wasn't that, or sometimes that you were proposing it wasn't relating to that person or sometimes wouldn't come at all, only for the embracement… then it was thought… let's form a group so the person would have time to know the service and the team starts to know the person in order to make a more relevant project…and that is why we created this embracement group. (E2)

Category 2 – Function of Embracement and Embracement Group

Two distinguished moments were established at CAPS, the Embracement and

the Embracement Group. One of the interviewed workers highlighted that:

It is in the embracementthat we get various data, since the person's pregnancy, what brought her to that sickness, the amount of hospitalizations, every single thing… Then it is the first moment the person comes to the unit […] From this embracement, the professional that is part of the [Embracement Group] also makes a small evaluation if this person will benefit from CAPS or at the ambulatory. (E2)

After the embracement, the user was invited to participate in the group. The professionals pointed that the Embracement Group had, as its function, to evaluate the user, allowing the user-team link, filtrates users with or without the profile for CAPS, promote hearing and increase adhesion to CAPS' treatment. In the Embracement Group the professionals would have a bigger opportunity to know the user, his story, so in that away, assess whether he had or did not have the profile for the service. Therefore, the function of "filtrating" was very important, as noted by one interviewed:

[…] It is in the embracement group that we are going to evaluate if it really is a [psychiatric] ambulatory case or for CAPS… (E1)

Most of users that attended the group remained for a period of 2 to 3 months, even though it did not have a minimum or maximum time, since the demand was always evaluated of each one. In this period, the user attended just this group (meeting with other users under a professional coordination and medical evaluation). If the user had the profile to be assisted at CAPS, the professionals responsible for the group would forward the user to a mini team of reference from the service in order to give continuity to the attendance and conduct of the personalized medical therapy plan. In case the user did not have the profile, the guidance of the individual was made to a different network service:

But at first… we will get to know you, you will bring your story to the group, who you are, the coordinators will be observing who is the one that is in the group. And from there, from each situation, each story, we can direct you in the following week to a mini team or in the following week for a network service contact…(E1)

Among the users that attended the Embracement Group at the moment of the interviews, it was found those that came during a crisis, with a moderate depression to a light one, a schizophrenia picture, bipolar disorder, anxiety, certain types of phobia, chronic patients, or even with an organic disorder, mild or severe:

But we must understand that this Embracement Group covers users that are in crisis, some moderate depression, mild, serious, people that are chronic, that sometimes is not even here,

we have this profile… so there are people with a more mild disorder, a phobia, an anxiety disorder. (E4)

An interviewed professional illustrated the functionality of the Embracement Group, which final function would be to forward the user to one of the mini teams of reference or to another network service.

Category 3 – Positive aspects and difficulties of the Embracement Group

Despite the denomination "Embracement Group", adopted by the interviewed and other CAPS' professionals, two groups worked: one directed to users, and another to users' families. On Tuesdays and Thursdays, on the afternoon, for 2 hours, a professional coordinated the "Embracement Group for users" and another worker simultaneously coordinated the "Embracement Group for families". Altogether, there were four professionals responsible for these groups and took turns in coordinating during the month. Besides that, an evaluation of the user was programmed with one of the psychiatrics of the unit.

When arriving at CAPS, people were accompanied by their families, with the intent to bond the families with the service and help in the treatment. The meetings with users and families of the Embracement Group happened on the same day and time:

So we started to realize that there were people that were brought by family members, they stood waiting … so let's use that to link the family members to the service… it was when we started the family group as well. (E4)

The weekly inclusion of families in CAPS' services was evaluated positively by the interviewed workers. The Embracement Group was pointed as one of the most important spaces among the service, because it was through the service that the link between CAPS, users and families was formed. From the moment in which the user got to know deeply the functionality of the service, it would have a bigger adhesion, therefore, more quality on his treatment.

On this Embracement Group, we try to talk of anything that moves around this individual's life for us to know, his day-to-day reality… for us to search activities that he will get this adhesion. (E3)

This way, it is understandable that the Embracement Group nurtured the professionals with information for the elaboration of the user's Individual Therapy Project, in a second moment, when they no longer were part of this group and were forwarded to a mini team

of reference, integrated to CAPS' "routine".

Despite the highlighted positive points, according to the interviewed workers, part of the users of the Embracement Group did not have the profile to be at CAPS and they remained there for difficulty in articulating the care in another network point. Thereby, the Embracement Group also supplied a necessity of taking care of the users that were suffering, which profile was not suited for CAPS. According to the professionals, the forwarding of a user for a city ambulatory demanded a three month-period to a year until he was able to leave, making CAPS crowded.

There was a time that forwarding to an ambulatory was critical, for example… to send to an ambulatory. Then, the service was getting bigger, bloated… we couldn't keep up… (E4)

For the delay on forwarding the user, and the fact that there were no other options for service on the network that could support these users, CAPS ended up supporting an excessive demand, without the profile for the care in this equipment and under these conditions:

But we have some trouble that is connected with our network… so; sometimes people come in search of a service like this because there are no others on the basic health care system… so this person comes to be hosted by CAPS… the individual does not have the CAPS' profile… she does not have the necessity of this particular service…but I don't have a basic service on the network that can assist him. (E4)

This situation, according to the interviewed workers, demanded exhaustive work, stressful and made the monitoring of users among service more difficult:

It's a little bit wearing. In a function like this, where "n" situations that occur on a list like that… but there will be those that we know really well, that is everything ok, straightforward on a month, two, you already make the project [individualized therapeutical], there are those that you know that, that is an ambulatory case, that are those that comes only one time and never came back again. (E3)

If on one hand, there was the concern of keeping the user on CAPS until a space would open at the city ambulatory, on the other, there was the knowledge that many have not attended the embracement group. The list of users of the embracement group was approximately of 150 users, but those that attended CAPS were only 12 to 15. Many did not participate the group effectively and that generated, with a certain difficulty, the functionality of the service. One interviewed exemplifies:

It's not a CAPS' case, but it needs psychiatric monitoring. But it doesn't qualify as CAPS. So this spots, that delays, when I send her

there, it takes three months… so she end up staying [at the embracement group]… (E2)

Besides the questions above, the interviewed workers also pointed out the difficulties of the professionals at the Embracement Group of gathering, discussing cases, performing the correct forwarding and to work collectively. Different of the other mini-teams that worked at CAPS, the technicians of the embracement group did not have a specific day in the week to meet and discuss cases, making the forwarding and therapeutical projects individually made, and not always with the consensus of others on the team:

But you do not have all the people sitting down to discuss… very rare, you know! There are people that are at the embracement group since it was created that cannot find a time to seat down… all of those people… The barrier maybe is people's organization of time… sometimes people have difficulty on working collectively… (E4)

By the end of the research, in the evaluation of data, in the following year after the collection, the team informed that the embracement group was extinct, it was evaluated as unproductive. The individual embracement remained and the team was investing on the capacitation of basic attention as a way to amplify the care points of users on psychic suffering, but which profile did not point out the necessity of remaining at CAPS.

DISCUSSION

At CAPS, where the study was performed, the embracement was made in a first moment by a group of professionals who attended users who looked for the service. A hearing was performed, where the professional searched for understanding the user's needs and to fill a form with his life and clinical history, right after, it was evaluated by the professional whether this person would benefit of CAPS' activities, or not. At this moment, the embracement was the entrance door[4,] that is, it had the triage function and also the *listening space* of the user, for further discussion and therapeutic project elaboration with the participation of the team. By fulfilling the function of guiding the construction of the singular therapeutic project, the embracement is assumed as a tool that allows the dialogue between professionals and family for the user's care that, at the first moment attending CAPS, finds himself/herself in a crisis or in an intense psychic suffering.[6,14]

In a second moment, it was formed the Embracement Group with part of the professionals (a mini team) of CAPS responsible for the accomplishment of group activities with the users (User's group) and family members (Family

Group). In other words, after the embracement, the user was invited to participate in the Embracement Group. There wasn't a minimum period, or a maximum, for the remaining of the users in this group and its main purpose was to evaluate if the user would or wouldn't be a case to be attended at CAPS.

At this moment, the Embracement Group assumed the character of an *analytical engine of the work process in healthcare* as for *listening space*. The embracement as for listening space[4] can provide a sufficiently good environment (holding) to the user and assist him in the therapeutic process. The embracement must be effective, and for such, it is necessary to qualify the hearing and build, alongside the team, an assistance model that is centered on the user[8,] and that search for giving positive answers to the problems that those bring, even though the answer is the act of embracing.

The analytical character of the process of working in healthcare settles[4] on the embracement as a problematic perspective of the given assistance to users, thus, it generates data, for example, regarding the necessity of suspending the embracement when it becomes impossible to serve everyone.[4] By promoting care for users that wisely don't require intensive attention and could benefit from ambulatory treatment, but can't get a spot immediately for such, CAPS assumes that this portion of users would be unassisted and, at the same time, centers the demand when taking responsibility for people which would make the level of attention different.[4] Here it is necessary to point out that the creation of this kind of support occurs due to a failure in the psychosocial care center, because without taking care of the user without a severe psychiatric situation or intense situation of psychic suffering immediately for the care, CAPS takes responsibility for the demand without having, until the moment of the collection, articulated with other points of the center to offer different modalities of attention in mental health.

Some authors argues that the concept of embracement is not restricted to the user's first contact with the service, since it unfolds in other stages: include the person in the service and do follow-up or guide the person to a more adequate service for care to take place.[9] In this way, there is a responsibility of the welcoming team for the trajectory of the user in the center. The embracement serves as a bridge between the users and the services, and it is from this embracement that the user will form a connection with the institution or not, so

the importance of thinking about this strategy.[9-12] This view corroborates with the results of the current study, starting from the change in how the embracement was made to what has been accomplished.

The interviewees considered as essencial a good bond with the users and also the families. According to the interviewees' view, it is through support to families that a better user adherence to treatment is achieved. This view corroborates with literature[12,] which highlights that CAPS have family members as treatment partners. With this, the family has the important role to encourage them in the involvement with the therapeutic Project, as well as providing assistance to the users. And by noticing the importance of the family, CAPS had as proposal the creation of the embracement group for the family. However, it should be noted that family can not be solely seen as a link between the user and the service, since it must also be taken care of by mental health teams.[1]

The results of the research showed that the professionals saw teamwork as positive in the service, once it provides a greater exchange of experience, sharing of decisions and a different look on the same goal.[6] This sharing of decisions and the exchanges among professionals from different areas, from the technicians to the support staff of the service, allow opportunity for listening and embracing these professionals, which causes some improvement in the acceptance of the population's demand.

It is necessary to point out the lack of articulation among network services, since the rationale of referral to psychiatric outpatient clinic was mentioned in the interviews, without articulation with primary care being present. At the end of the data collection, at the time of returning to service, the team reported that the Embracement Group had been disabled in CAPS for greater adherence to the rationale of mental health matricity in the basic network.

Embracement is essential for integral health care[13] and for practices related to humanization policy, which should be fundamental in the qualified listening and in the accountability of users and professionals for the health of population. Such accountability only occurs through the narrowing of the professional-user relation, the work in reference teams with interdisciplinary characteristics and actions of matrix support.

The practice of embracement[6] as an operational guideline requires a change in

health care, implying appreciation of the individuals involved as protagonists in health production; reorganization of work processes from the problematization of daily practices with critical and constructive discussions among professionals, users and managers, available for change; social network approach; elaboration and monitoring of the Unique Therapeutic Projects (UTP); listening posture that shows commitment to the needs of users, respecting their culture, knowledge and ability to assess risks and collective construction with the Integral Care Center.

As with the data in this article, the area literature[4] also found services in which several users who arrived at CAPS were not in demand for this type of service, and the municipality did not have another mental health service that absorbed them. For example, users who might have been accommodated in primary care and not in a specialized service could run the risk of being "disqualified".[4] By taking care of people who can not be referred, CAPS centralizes the demand, which should be distributed in primary care services, as the interviews highlighted, because they do not have a profile for psychosocial care.

Another important point regarding embracement[14-15] is its role in relation to crises, because with the expansion of community-based services it is increasingly urgent to strengthen practices based on construction of bond and integral care, perceiving the subject in suffering and create attention strategies that are dissociated from the hospital-centered model based on the remission of symptoms.

FINAL CONSIDERATIONS

The study aimed to understand what CAPS professionals understood by embracement and how it was performed in the service. With the implementation of this article, it is considered that the goal has been achieved. Initially because it was possible to identify the conceptions of CAPS professionals on the embracement tool. Secondly, because it was possible to perceive the embracement transformation process over time, triggered by team reflections from a process done in pairs to a group practice coordinated by one of the team members, in system of rotating with others.

It was possible to perceive the meaning and importance that the professionals interviewed add to

embracement, the difficulties found and the concern with the existence of a team-user-family bond in the care of people in psychological distress. In addition, the study also pointed to the need for articulation among services, at the moment when the embracement was maintained as a group practice to ensure that the user was in care while a vacancy in another mental health service in the city was not obtained. Yet it is necessary to emphasize that there is a need for creating network effective care, not only for the expansion of existing services, but especially for the implementation of action of specialist orientation in mental health with primary care, so that people are cared for and CAPS can fulfill its role of articulator of the territory and of attention to people in more intense situation of suffering.

It is worth noticing the need for new studies in the area, in different places around the country to discuss the theme, as well as the investigation of embracement from the perspective of users and family.

REFERENCES

1. Ministério da Saúde (Brasil), Secretaria de Atenção à Saúde. Saúde Mental no SUS: os centros de atenção psicossocial. Brasília: Ministério da Saúde; 2004. [citado em 21 jan 2015]. 86p. Disponível em: http://www.ccs.saude.gov.br/saude_mental/pdf/sm_sus.pdf.
2. Franco TB, Bueno WS, Merhy EE. O acolhimento e os processos de trabalho em saúde: o caso de Betim, Minas Gerais, Brasil. Cad. de Saúde Pública. 1999; 15(2):345-353.
3. Silva LG, Alves MS. O Acolhimento como Ferramenta de Práticas Inclusivas de Saúde. Rev. APS. 2008; 11(1):74-84.
4. Scheibel A, Ferreira LH. Acolhimento no CAPS: Reflexões Acerca da Assistência em Saúde Mental. Rev. Bahiana de Saúde Pública. 2011; 35(4):966-983.
5. Coimbra VCC, Kantorski LP. O Acolhimento num Centro de Atenção Psicossocial. Rev. Enferm. UERJ. 2005; 13:57-62.
6. Ministério da Saúde (Brasil), Secretaria de Atenção à Saúde,. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas Práticas de Produção de Saúde. Brasília (DF): Ministério da Saúde; 2006. [citado em 19 jan 2015]. 44p. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/acolhimento_praticas_producao_saude.pdf.
7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2006. 281p.
8. Mendes EV. Editorial. REAS [internet]. 2013 [acesso em: 20 jan 2015]; 2 ESp2:1-3. Disponível em: http://www.uftm.edu.br/revistaeletronica/index.php/enfer/article/download/552/416.
9. Schmidt MB, Figueiredo AN. Acesso, Acolhimento e Acompanhamento: Três Desafios para o Cotidiano as Clínica em Saúde Mental. Rev. Latinoam. Psicopat. Fund. 2009; 12(1): 130-140.
10. Gomes MCPA, Pinheiro R. Acolhimento e vínculo: práticas de integralidade na gestão do cuidado em saúde em grandes centros urbanos. Interface - Comunic, Saúde, Educ. 2005; 9 (17):287-301.
11. Jorge MSB, Pinto DM, Quinderé PHD, Pinto AGA, Sousa FSP, Cavalcante CM. Promoção da Saúde Mental – Tecnologias do Cuidado: vínculo,

acolhimento, co-responsabilização e autonomia. Ciência & Saúde Coletiva. 2011, 16(7):3051-3060.
12. Silva L, Moreno V. A religião e a experiência do sofrimento psíquico: escutando a família. Ciência, Cuidado e Saúde. 2004; 3(2):161-168.
13. Ballarin MLGS, Carvalho FB, Ferigato SH, Miranda IMS, Magaldi CC. Centro de atenção psicossocial: convergência entre saúde mental e coletiva. Psic. em Estudo. 2011; 16(4):603-611.
14. Zeferino MT, Cartana MHF, Fialho MB, Huber MZ, Bertoncello KCG. Percepção dos trabalhadores de saúde sobre o cuidado às crises na Rede de Atenção Psicossocial. Esc. Anna Nery. 2016; 20(3):e20160059.
15. Silva MD. O cuidado na saúde pública: potencialidades de uma clínica em movimento. Est. Contemp. Subjetividade. 2016; 6(1):64-76.

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