MENTAL HEALTH INTERVENTIONS TO TREATMENT OF DRUGS' ABUSERS PATIENTS: POLICIES, PRACTICES AND DOCUMENTATION[1]

Jacqueline de Souza[2], Luciane Prado Kantorski[3], Margarita Antonia Villar Luis[4], Nunila Ferreira de Oliveira[5]

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[2] PhD in Science. Professor of the Department of Psychiatric Nursing and Human Sciences of EERP/USP. São Paulo, Brazil. E-mail: jacsouza2003@yahoo.com.br

[3] PhD in Nursing. Adjunct Professor of the Faculty of Nursing and Obstetrics of the Federal University of Pelotas. São Paulo, Brazil. E-mail: kantorski@uol.com

[4] PhD in Nursing. Full professor of the Department of Psychiatric Nursing and Human Sciences of EERP/USP. São Paulo, Brazil. E-mail: margarit@eerp.usp.br

[5] Doctoral student in Sciences of the Postgraduate Program of the Department of Maternal-Child Nursing and Public Health of EERP/USP. São Paulo, Brazil. E-mail: nunilaferreira@gmail.com

ABSTRACT: Currently the major day treatment services for people with problems related alcohol and other drugs are in accordance with the principles of the Brazilian Health System and guided by recent mental health politics. Aimed to know the interventions provided by documents, to observe these interventions in practical context of a these services and to problematize possible weaknesses. The parameters of analyze were the National Policies of Drugs, the Health Ministry's Policy to Integral Attention of the Alcohol and Drugs Users and the recommendation of the WHO to prevent of drugs abuse. The methodological techniques were the documentary analysis and participant-observation. Were seen important advances like: recommendation to intersectoral actions, integrality and actions focused in social context. About the fragilities were highlighted some difficulty in the consolidation of the some actions, as: active search, leisure activity, work and harm reduction.

DESCRIPTORS: Mental health. Substance related-disorders. Health policy. Deinstitutionalization. Nursing.

INTERVENÇÕES DE SAÚDE MENTAL PARA DEPENDENTES DE ÁLCOOL E OUTRAS DROGAS: DAS POLÍTICAS À PRÁTICA COTIDIANA

RESUMO: Atualmente os principais serviços de tratamento para pessoas com problemas relacionados ao álcool e outras drogas seguem os princípios do Sistema Único de Saúde Brasileiro e são orientados pelas atuais políticas de saúde mental. Objetivou-se conhecer as intervenções previstas pelos documentos, observar estas intervenções no dia-a-dia e problematizar possíveis fragilidades destas práticas num destes serviços. Os parâmetros para análise foram a Política Nacional sobre Drogas, a Política do Ministério da Saúde para Atenção Integral dos Usuários de álcool e drogas e preconizações da Organização Mundial da Saúde com relação à prevenção e controle do uso abusivo de drogas. As técnicas metodológicas foram a análise documental e a observação-participante. Evidenciaram-se importantes avanços como: preconização de intersetorialidade, integralidade e ações focadas no ambiente social. Como fragilidade destaca-se certa dificuldade na consolidação das seguintes ações: busca ativa, atividades de lazer, trabalho e redução de danos.

DESCRITORES: Saúde mental. Transtornos relacionados ao uso de substâncias. Política de saúde. Desinstitucionalização. Enfermagem.

INTERVENCIONES DE SALUD MENTAL PARA USUARIOS DE DROGAS: DE LAS POLÍTICAS Y DOCUMENTACIÓN A LA PRÁCTICA COTIDIANA

RESUMEN: En la actualidad los servicios principales de tratamiento para las personas con problemas relacionados con el alcohol y otras drogas están en conformidad con los principios del Sistema Único de Salud brasileño y las actuales políticas de salud mental. Este estudio tuvo el objetivo de aprender acerca de las intervenciones recomendadas por los documentos, teniendo en cuenta estas intervenciones en el día a día y discutir las posibles deficiencias en las prácticas de uno de estos servicios. Se adoptó como parámetros para el análisis, las Política Nacional sobre Drogas, y Política del Ministerio de la Salud para Atención Integral de los Usuarios de alcohol y drogas bien como orientaciones de la Organización Mundial de la Salud con relación a la prevención del uso abusivo de drogas. Fueron utilizadas las técnicas de análisis documental y observación-participante. Importantes avances se evidenciaron como la preconización de la acción intersectorial, integral y centrada en el entorno social. Se destaca como debilidad, la dificultad en la consolidación de las siguientes acciones: búsqueda activa, actividades de ocio, trabajo y reducción de daños.

DESCRIPTORES: Salud mental. Trastornos relacionados con sustancias. Políticas de salud. Desinstitucionalización. Enfermería.

INTRODUCTION

The complexity of the problems related to alcohol and other drugs demands different treatment options. Currently, the main approaches used mix cognitive-behavioral type interventions (e.g., relapse prevention, motivational interviewing), self-help and pharmacological treatment, with similar, very low rates of abstinence after the treatment.[1] The cognitive-behavioral theory assumes that negative reinforcement decreases the frequency of undesired behavior and proposes brief psychotherapy to modify distorted ideas and dysfunctional behavior through the sensitization of individuals to think about themselves and their performance in the world.[2-4] Relapse Prevention (RP) mixes behavioral skills training, cognitive interventions and lifestyle changes. It is understood that the individual can return to using drugs in high-risk situations and, once this risk is identified, it is possible to develop effective coping strategies.[5] Motivational Interviewing, also based on cognitive principles, aims to assist the subject in the process of behavioral change through the modification of thought patterns, understanding of the emotional reactions and implementation of solutions.[6] Additionally, systematic intervention with the families and the mobilization of different resources of society in order to identify risk situations and construct coping strategies are important practices and should be linked to other approaches.[7]

The harm reduction model is an approach that has assumed importance in the drug scenario. According to the Program of Orientation and Assistance to Addicts of the Federal University of São Paulo (PROAD-UNIFESP), the aim is to minimize the harmful effects of the drugs in order to improve the physical and social well-being of the users. For this, field work is conducted in the streets, in hospitals and in prisons, to make the healthcare services more accessible, and to provide social rehabilitation opportunities. It is recommended that professionals working in this program assume a comprehensive and inclusive approach aiming to help the subject avoid the use of psychoactive substances or early involvement with them; to help individuals already involved to not become dependent; and to offer to those that are already dependent ways of abandoning the drug or guidance so that less harm is caused to them.[8]

Some services that specialize in addressing individuals with substance abuse or dependence problems are: day-hospitals, specialist clinics, recovery retreats (or residential services), self-help groups that follow the 12-step model (Alcoholics Anonymous-AA, Narcotics Anonymous-NA and other groups) and, specifically in Brazil, the Psychosocial Care Centers for alcohol and drugs (CAPSad).[9-12] The CAPSad are community-based mental health services recommended by the current mental healthcare policies as one of the component of the care network for the demands arising from the use of psychoactive substances.[9-10] In the CAPSad, attention to substance users and addicts includes therapeutic and preventive activities, such as: individual care (medication, psychotherapy, guidance), group care (psychotherapy, operative groups, social support activities), therapeutic workshops, home visits, attending families and community activities.[12] Despite the range of intervention possibilities in these services, some researchers of the area,[11,13-14] have indicated the need for improvements, aiming to increase the adherence and resolvability of the actions. In this context, there is a demand for studies that provide an overview of the practices of the CAPSads in a way that problematizes the knowledge and professional practices in these care provisions.

The aims of this study are: 1) to know what interventions are envisaged by the documents that support the functioning of the Centre for Chemical Dependent Care (CADEq) of the municipality of Alegrete-RS; 2) to highlight such actions in the practical context; and 3) to identify the weaknesses of these practices. Achieving these goals will allow some aspects, considered for the continued improvement of mental health care for alcohol and drug addicts, to be problematized.

METHODOLOGY

This study originates from an evaluative study of the CAPSs of southern Brazil, concentrating on the CADEq of the municipality of Alegrete-RS, a CAPSad registered service. The project was approved by the Research Ethics Committee of the Faculty of Medicine of the Federal University of Pelotas (protocol No. 058/06). The techniques used were participant-observation, a systematic observation technique in which the researcher/observer is part of the reality to be studied in order to understand it broadly and in detail,[15] and documentary analysis, the purpose of which is to perform scientific-informative extraction of information from documents, in order to obtain

an objective reflection on the original source as well as new messages implicit in the document.[16]

The participant-observation (682hs) was performed by three researchers previously trained for the collection of qualitative research data, with the observations recorded in the field diary, at the location, or later. Daily, after the working hours of the service, the researchers discussed the observations recorded in their respective field diaries, so that the maximum coverage of the actions of the service was achieved.

The documents selected for the data survey were: Multiyear Plan - Mental Health Service Project (DOC-1), Planning 2006 (DOC-2), Basis Document for a Psychosocial Care Policy for alcohol and other drugs in the municipality of Alegrete 2006 (DOC-3) and the CADEq Technical Project 2005 (DOC-4). The criterion for this selection was that the document made reference to the mental health actions offered, provided or instituted as the interventions. Thus, the documentary analysis was performed having as the parameter: the National Drug Policy,[17] the Policy of the Ministry of Health for Integral Attention for the Users of Alcohol and Drugs[12] and recommendations of the World Health Organization concerning the prevention and control of the abusive use of drugs.[18]

In the data analysis, the analysis of documents was performed first, extracting the main content of each document, and systematic reading for the identification of the convergence of the items with the mental health policies. After successive readings the interventions envisaged by the documents were highlighted. These were listed in a matrix according to the division proposed by the WHO[18] for the methods of prevention and control of the abusive use of drugs: direct methods (actions centered on the behavior of the drug user) and indirect methods (practices directed toward factors related to the use of drugs aiming to correct the "determinant" conditions of the use to reduce the consumption and its respective problems). The indirect methods include the following subdivision: a) the Mental Health Method – drug abuse is considered a consequence of psychological stress. The actions are aimed at eliminating the sources of emotional tension through early detection and care, and educational programs and training (self-confidence building, social communication of the individual, family relationships, etc.); b) Health Promotion Strategy – which considers that the improvement of the individual's perception of health can encourage the abandonment and non-adoption of harmful practices. The actions are focused on habits, lifestyles and individual responsibility (food, work, exercise, leisure); and c) Social Environment Method – which considers that social conditions are determinants or favor the abusive use of drugs; the actions, therefore, are intended to eliminate or correct negative social influences. "The programs of this type tackle problems such as poverty, inadequate living, unemployment, the lack of access to productive activities, dangerous leisure activities, social alienation and marginalization".[18:49] The interventions were compared with data from the participant observation to identify those who were or were not evidenced in the practices of the service during the study period, considering the parameters adopted for the analysis.

Figure 1 presents the organization of the data and the focus of the discussion of the results.

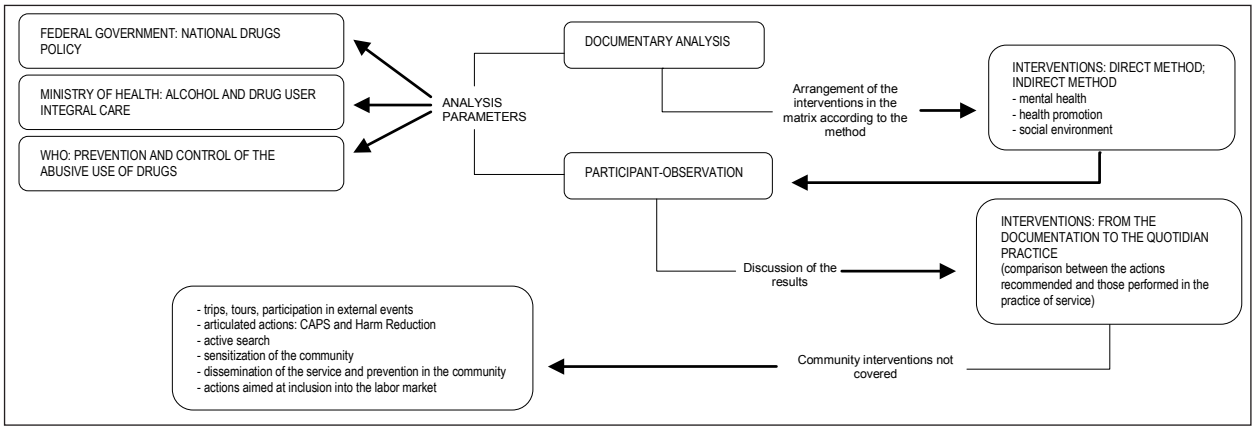

Figure 1 - Conceptual map of the organization of the study. Alegrete-RS, 2006 to 2008

RESULTS AND DISCUSSION

Table 1 presents the basic contents of the documents analyzed. As can be seen, each document possesses specific contents, however, all are aligned with the proposal of the current mental health policies.

Table 1 - Documents used in documentary analysis. Alegrete-RS, 2006 to 2008

Document/ year	Title	Content
DOC-1/2005	Multiyear Plan Mental Health Service Project	General aims and goals of the services that make up the mental health network of the municipality, deadlines and people responsible for the goals; the current diagnostic and the material resources necessary.
DOC-2/2006	Planning 2006	Needs survey in the areas of: reception, flow, services provided, training, coordination, professional development, resources.
DOC-3/2006	Basis Document for Psychosocial Care Policy for Alcohol and Other Drugs in Alegrete	Presents the guidelines and aims of the Policy of Integrated Mental Health Care in Alegrete; the attributes of the services and discusses aspects related to the finance. Presents the principles and guidelines of the Integral Mental Health Care Service.
DOC-4/2005	Technical Project of the Center for Psychosocial Care for Alcohol and Other Drugs of Alegrete	Presents the theoretical and technical concept that covers the drug phenomenon, the main guidelines and aims of the service, the care program, access to treatment criteria, discharge conditions, dynamics of the work and the human resources and necessary materials.

The DOC-1 document is a goal plan that presents as the key objectives, the social inclusion of people with mental disorders into society, the recovery of citizenship, and multiprofessional care. It presents actions to fulfill these aims and their respective deadlines. The general proposal is the continuous improvement of the quality of the services provided. The DOC-2 document indicates various improvement needs, among which is the qualification of the reception. This aspect has great relevance because the reception consists of a primary technique for establishing a bond with the user and consequently for their adherence to the treatment or referral to other services of the network, if necessary. The factors that deserve attention in DOC-2 are: The recommendation of continuous training for the professionals of the Primary Healthcare and the general hospital of the city, courses for the reception staff (receptionists) and study meetings with the participation of the entire team. The team meeting and training are presented as priorities. The valorization of the team and the dedication to qualify the professionals make up a human resources management policy consistent with the proposals of valorization of the human being and horizontalization of the relationships. This concern is consistent with the recommendation of the Ministry of Health regarding Continuing Education in Health.

The principles of the service are presented in DOC-3 and converge with the principles of the Brazilian National Health Service (SUS) and of the mental health policy, such as the integrality of the care, the equity in care, health as a right of all, the reception, the bond, and the work in intersectoral and interdisciplinary teams. The DOC-4 document presents, as the aims of the service, the search for integrality in the prevention, health promotion and rehabilitation actions for people vulnerable to alcohol and other drug abuse in the community, observing the principles of the SUS. The analysis of all the documents identified that the theory behind the practices predicts hierarchization of the actions in the different spaces of construction of the subjectivity of the subject: intimate-individual, group-personal, public-institutional and socio-community, striving for intersectoral actions and a focus on the integrality of the care, aspects that converge with the recommendations of the policies adopted as the parameter for the analysis in this study.

Interventions: from the documentation to the quotidian practice

The documentary data (Table 2) and participant observation highlighted that some recommended interventions were not put into effect during the study period.

Table 2 - Interventions recommended by the documents. Alegrete-RS, 2006 to 2008

Direct Method	Indirect method		
	Mental Health	Health Promotion Strategy	Social Environment
1. Medical care	9. Reception	19. Therapeutic workshops (crafts, floriculture, gardening, horticulture, music, painting, beauty, paper recycling)	27. Development of the skills of the users for coexistence in the world of work
2. Nursing care	10. Listening	20. Therapeutic groups	28. Social care: support for solving precarious living conditions (lack of house, income)
3. Medication	11. Family care	21. Self-help groups	29. Community Activities: - care and prevention sensitization (adults and elderly) - prevention especially together with schools and families - discussion about violence - dialogue about mental health - dissemination of the service (goals, functioning) - radio program on mental health/ campaigns to reduce prejudice
4. Multiprofessional Intensive care	12. Monthly meetings with family members	22. Leisure activities, trips and cultural tours	
5. Multiprofessional outpatient care	13. Multiprofessional individual interview	23. Participation in events and fairs for the exhibition of works	
6. Meeting with users	14. Team carries out hospital monitoring	24. Educational activities/ pedagogic activities	
7. Psychotherapy, psychological care	15. Preparation and review of the Individualized Therapy Project	25. Physical education	
8. Participation of team in crisis situations	16. Administrative meetings: users, family members and staff	26. Support and guidance on the proper use of retirement benefits: support in the management of resources	30. Intersectoral articulation: "Wheels of Knowledge"
	17. Active search for users		31. Actions linked with the Harm Reduction Service
	18. Home visits/monitoring: guidance and advice		

Interventions 1 to 16, 18 to 21, 23 to 26, 28 and 30 were evidenced during the participant-observation; of which, interventions 14, 26 and 30 were highlighted. Interventions 17, 22, 27, 29 and 31 were not evidenced during the participant-observation. The interventions, considering the set of documents, are distributed among the four methods proposed by WHO18 (Table 2). The predominance is visible of interventions belonging to the indirect method, which have characteristics of the psychosocial model of mental health care.

The interventions of the direct method (care centered on the behavior of the user) were cited in all the documents selected. Although such interventions belong to the traditional model of mental health care, the observation data allowed certain characteristics to be identified that, within the set of service proposals, also reflect the specificities of the psychosocial model. Of the indirect method actions (focused on the determinants of the drug use), some interventions stood out, namely those numbered 14, 26, and 30 (Table 2).

The monitoring of the users of CADEq when they are subjected to hospitalization (intervention 14) has great importance, as it enables the monitoring of the individual at a critical moment of their treatment, making it possible to strengthen the professional-user bond and the interaction between the workers of the different services: hospital and CADEq. This action expresses care and concern for the individual and meets the guidelines related to the reception, the referral and creating co-responsibility.

The support and guidance for the use and administration of retirement benefits (intervention 26), is a practice directed toward individuals with more severely psychologically compromised (e.g., those with psychiatric comorbidities) and is performed by different mid or higher level professionals. This intervention ranges from the monitoring of the user regarding banking procedures and the planning of monthly expenses (purchase of food, money for the weekend, leisure), to the organization of the budget, the search for and acquisition of furniture, electrical appliances or home improvements, according to the needs of the subject. The action is actually performed together with the user (and not for the user) and has

fundamental importance for enabling progressive learning focusing on the autonomy of the subject, contrasting with the tutelary character of the traditional care model practices.

The interdisciplinary character presupposes the participation of the professionals in specific activities regardless of their training, except for those activities defined by the respective councils. However, in the case of nurses of the service, it was observed that the involvement in activities focused on health education, guidance in the use of medicines and motivation to continue treatment, was tied only to the personal commitment, that is, such activities were not regarded as the body of specific skills of this professional. This question leads us to the discussion regarding the core and field of competency in mental health. The core is understood as the set of knowledge and responsibilities specific to each professional.[19] Regarding nursing, we could consider its core of competence to be centered in three dimensions: The nursing care; the monitoring of the conditions of individual and collective health (through individual consultation and/or group care); and the management actions directed towards the care.[20-21] The field is understood as the knowledge and responsibilities common or confluent to various professional or specialities.[19] For example, the knowledge that the entire work team should have about the basic principles of the SUS and about the directives that guide the current mental health policies. Thus, the fact that the nurses have no defined role in the context of psychosocial rehabilitation care is an issue related to the core and field of competences in mental health and needs to be problematized so that nursing is consolidated as a figure that acts in an interdisciplinary way, but also masters the competences that are specific to them. The "Wheel of Knowledge" project (action 30) involves the CADEq and other devices of the mental health network (Figure 2). Its execution takes place through regular meetings and has the form of "*Mateadas Culturais*" (a group that meets to drink *mate* tea, a drink typical of Rio Grande do Sul).

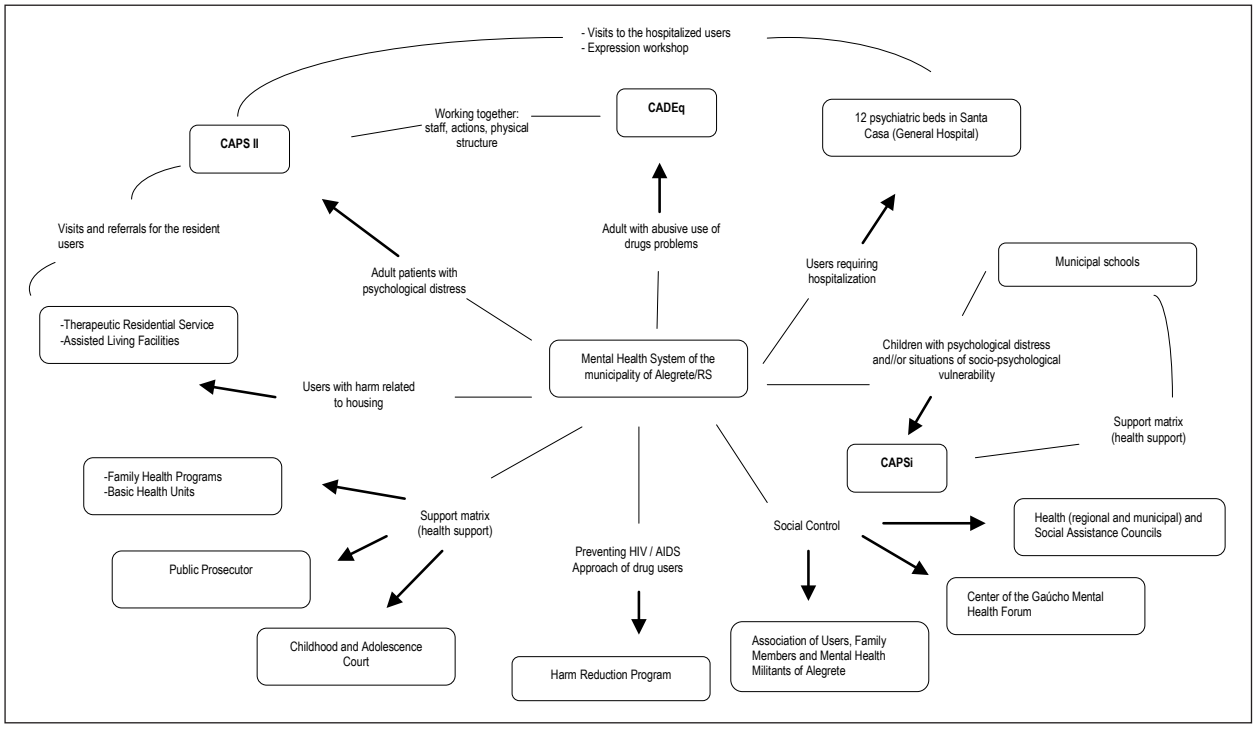

Figure 2 - Mental health system of Alegrete: a network of services linked to mental health of the municipality of Alegrete-RS, 2006 to 2008

They occur in the form of plenary meetings, panels, informative lectures and other techniques of knowledge production previously structured by the participants. There is pre-planning in relation to the subject to be discussed and the respective people responsible for the content, organization and dissemination for the next meetings. Such action may be identified as an important basis for the maintenance of intersectoral and integral care in the municipality, because the representatives of the various services that make up the mental health network carry out the strategic planning,

the organization of the services and direct the flow to other care spaces through the exchange of experiences, knowledge and information. These meetings encourage a critical view regarding the knowledge in collective mental health and the public policies and enable the organization of the system of reference and counter-reference in the light of the practices of the education, health, social welfare and justice systems.

Despite this possibility of intersectoral articulation, interventions do not exist that involve the CADEq and the team of the Harm Reduction Program (intervention 31), although DOC-4 provides for this type of articulation. This indicates a weakness in the realization of the principle of intersectorality between two services (CADEq and Harm Reduction Program) that focus on the same problem: the abusive use of psychoactive substances; and presuppose actions in the same context: in the social networks.

The tours and participation in events outside the service (Table 2, intervention 22) were not observed during the field work period, although there were photographs of tours, parties and trips made in moments preceding the study. Moreover, the CADEq did not perform the active search (intervention 17) - a practice recommended by the Ministry of Health Policy for Integral Attention for Users of Alcohol, and the World Health Organization.

The active search, in its traditional concept, consists of a specific technical procedure of epidemiological surveillance which means to go looking for certain individuals to identify certain early symptomatologies, aiming for the control of diseases in the vulnerable populations. The current health policies, when conceiving the territory as the organizing principle of the actions, assume the active search as a political posture that provides work technologies that operate in movement (home visits, community health workers, harm reduction workers, and therapeutic monitors). It is an active posture to access the users and their needs at the expense of the automatism of the spontaneous demand.[22]

The active help idea[6] transcends the "searching" action as it relates to maintaining an active, positive and interested posture, mediated by the different needs of the user. It includes: motivation for treatment, contact with the user when they miss appointments, co-responsible monitoring when the user is referred to another service and other attitudes that demonstrate care for the subject. It is understood that this type of intervention is essential with substance users and dependent people, as the active search, as an expression of help and care, will certainly have a major impact on the motivation and adherence to the treatment of these individuals. Also, no external articulations or actions directed towards the insertion of the users into the labor market were observed. This can be considered as another critical point, because the exclusion from the labor market is an issue that accentuates the influence of all the other determinants of the health-disease process (e.g., the self-esteem, the self-provision, the possibility of leisure activities, the autonomy, the social relationships, etc.).

In general, the set of actions not implemented by the service studied (Table 2, interventions 17, 22, 27, 29 and 31) denotes a certain difficulty on behalf of the professionals to "externalize" their mental health practices, i.e., to perform more actively and effectively in the community spaces not restricting their actions to the physical space of the service. This difficulty was also observed in another study conducted in a CAPSad of the Rio Grande do Sul region[7], which highlights a problem that merits increased attention, mainly because it was found in two community-based services.

Considerations for improving the community-based mental health care

The body of documents examined emphasized the constant concern with improving the quality of the care. From this, some proposals should be made with regard to the mental health practice in community-based services. Based on the previous discussions related to the interventions not performed in the service, the relevance is understood of a call for the "externalization of the practices", a term designed to put the institution into an interrogating movement: the power relationships, the various forms of crystallization of the actions and distancing, and the different ways of "closing doors" that are produced in the quotidian.[23]

When considering the reintroduction of patients with psychological distress into the social space as the fundamental principle that guides the practices in the new model of mental health care, it appears that the coexistence of the individual under treatment in different social spaces is the indicator regarding what is therapeutic in

the actions.[24] Thus, the circulation of the user is paramount and must be the primary purpose of any therapeutic action, especially through the expansion of bonds and by making inclusion opportunities possible for the subject in which they are not reduced to their psychiatric problem[25] and their power to effect social exchanges is increased. Such assumptions relate to the arguments in favor of the consolidation of a "peripatetic clinic", understood as a clinical practiced outside of the usual settings (spaces, scenarios, situations used for the realization of the therapeutic techniques), addressing the problems that have not received a response in the traditional protocols; i.e., a clinic that is practiced in movement and out of the conventional spaces enabling new practices and new connections. This proposal is presented as being the core of the anti-asylum clinic, the primarily aim of which is the interaction of the user with the city and people through various movements in the external context of the health unit.[26] The image of a "clinic in movement", that is, intervention practices in transit in the territory, refers directly to the Harm Reduction actions, with the approach of the user being performed in situ, on the streets, in homes, and in places where people meet.[6]

Based on the evidence from a study of the CAPSad and Harm Reduction (HR) in a municipality of Rio Grande do Sul[13], it is highlighted that the Psychosocial Care Centers would benefit greatly from interaction with the HR teams, which have the differential of transiting the community with greater ease, acting to ensure not only the right of entry, but also that of circulation and permanence in the most critical areas of the more peripheral neighborhoods of the municipalities in which they operate. This differential is directly related to the strategic aim of the actions of the HR: to approach the population in order to gain intervention opportunities and to propose techniques related to the intimate issues of the life of each person, such as sexuality and the use of drugs.[26]

The initiative on the part of professionals to circulate "uncompromisingly" through the coverage territory of the service could function as an exercise that favors knowing, being and passing through a space that is not theirs and, therefore, mitigates the idea of power that commonly defines the relationship between professionals and users. New intervention alternatives may emerge from this insertion of the professional into the community.[27]

CONCLUSION

From the three aims listed in this study, analysis was performed of the documentation and of the practice of the service comparing them with the current policies on alcohol and other drugs in Brazil. Additionally, the weaknesses indicated were problematized and this allowed some recommendations to be outlined.

In the analysis of the documents it was found that the theory behind the interventions is strongly aligned with the principles of the SUS and the current mental health policies. The principles adopted by CADEq are integrality, intersectorality and equity. The priorities, in agreement with the documents, are social inclusion, recovery of citizenship and health as a right. For the operationalization of the practices, qualification of the reception, strengthening of the bond, preventive approaches, health promotion and rehabilitation are anticipated. The observation of the practice showed that direct (individual care and medication) and indirect method actions are developed. The indirect method mental health actions observed were the reception, listening, meetings and assemblies, home visits, family care, and the individual therapeutic project. The health promotion strategies basically consisted of workshops and groups.

Interventions in the social environment were the least observed during the study period. Nevertheless, there was a predominance of indirect method actions, i.e., interventions focused on the determinants of the drug use. The actions that stood out positively relate to the interaction with other services (e.g., the "Wheels of Learning" project and monitoring of the patients when they are hospitalized). The support and guidance regarding the use of retirement benefits is also an important strategy for promoting the autonomy of the subjects. Considering the weaknesses, not having articulation with the Harm Reduction service, not engaging in activities related to leisure and work, and not conducting an active search indicate the need for increased practice in the community spaces. The lack of effective definition regarding the role of the nurse in the psychosocial care context was problematized, and it is suggested that the competences of the core and field of nursing are better defined and articulated. This can be a key strategy to fill the gaps that confer certain fragility to the practices of the service studied and possibly of the CAPSads in general.

A limitation of this study is that it considered only one institution. The inclusion of other services of this type could broaden the perspectives of the discussions. It would also be important to include the perceptions of different individuals involved in the care, namely professionals, users and family members, these aspects can be explored in future studies.

REFERENCES

1. Noto AR, Galduroz JCF. O uso de drogas psicotrópicas e a prevenção no Brasil. Ciênc Saúde Coletiva. 1999; 4(1):145-51.
2. Scott J, Williams JMG, Beck AT, organizadores. Terapia cognitiva na prática clínica – um manual prático. Porto Alegre (RS): Artes Médicas; 1994.
3. Beck JS. Terapia cognitiva: teoria e prática. Porto Alegre (RS): Artes Médicas; 1997.
4. Focchi GRA, Leite MC, Laranjeita R, Andrade AG. Dependência química: novos modelos de tratamento. São Paulo (SP): Roca; 2001.
5. Marlatt GA, Donavan DM. Prevenção de recaída: estratégias de manutenção no tratamento de comportamentos adictivos. 2ª ed. Porto Alegre (RS): Artmed; 2009.
6. Miller WR, Rollnick S. Entrevista motivacional: preparando as pessoas para a mudança de comportamentos adictivos. Porto Alegre (RS): Artmed; 2001.
7. Souza J, Kantorski LP, Mielke FB. Vínculos e redes sociais de indivíduos dependentes de substâncias psicoativas sob tratamento em CAPS ad. SMAD Rev Eletr Saúde Mental Álcool Drog [online]. 2006 fev [acesso 2008 Ago 27]; 2(1):1-17. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1806-69762006000100003
8. Programa de Orientação e Atendimento a Dependentes. O que é a "redução de danos" e a "redução de riscos" [online]. Universidade Federal de São Paulo, Escola Paulista de Medicina; 2004 [acesso 2004 Dez 01]. Disponível em: www.unifesp.br/dpsiq/proad/redução.htm
9. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os Centros de Atenção Psicossocial. Brasília (DF): MS; 2004.
10. Furegato ARF. Políticas de saúde mental do Brasil. Rev Esc Enferm USP. 2009 Jun; 43(2):258-9.
11. Pechansky F. Treatment for drug and alcohol problems in Brazil: a puzzlewith missing pieces. J Psychoactive Drugs. 1994 Jan-Mar; 27(1):117-23.
12. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, SVS/CN-DST/AIDS. A Política do Ministério da Saúde para Atenção Integral a usuários de álcool e outras Drogas. 2ª ed. Brasília (DF): MS; 2004.
13. Souza J, Kantorski LP, Gonçalves SE, Mielke FB, Guadalupe DB. Centro de Atenção Psicossocial Álcool e Drogas e Redução de Danos: novas propostas, novos desafios. Rev Enferm UERJ. 2007 Abr-Jun; 15(2):210-7.
14. Nascimento AB. Uma visão crítica das políticas de descriminalização e de patologização do usuário de drogas. Psicol. Estud. 2006 Jan-Abr; 11(1):185-90.
15. Queiroz DT, Vall J, Souza AMA, Vieira NFC. Observação participante na pesquisa qualitativa: conceitos e aplicações na área da saúde. Rev Enferm UERJ. 2007 Abr-Jun; 15(2):276-83.
16. Iglesias MED, Gómez AMM. Análisis documental y de información: dos componentes de un mismo proceso. ACIMED [online]. 2004 [acesso 2008 Jul 12]; 12(2). Disponible em: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S1024-94352004000200011&lng=es&nrm=iso
17. Conselho Nacional Antidrogas (BR). Resolução nº003/GSIPR/CH/CONAD, de 27 de outubro de 2005: aprova a Política Nacional sobre Drogas. Rev Jurídica Ministério da Defesa. 2006; (5):145-52.
18. Organización Mundial de la Salud. Prevención y control del abuso de drogas. Ginebra (SW): OMS, 1990.
19. Campos GWS. Subjetividade e administração de pessoal: considerações sobre modos de gerenciar o trabalho em equipes de saúde. In: Merhy EE, Onocko R, organizadores. Agir em saúde: um desafio para o público. 3ª ed. São Paulo (SP): Hucitec; 2007. p. 229-66.
20. Peduzzi M. A inserção do enfermeiro na equipe de saúde da família, na perspectiva da promoção da saúde. In: Secretaria do Estado da Saúde de São Paulo. Seminário: O enfermeiro no Programa de Saúde da Família. São Paulo (SP): Secretaria do Estado da Saúde de São Paulo; 2000.
21. Spricigo JS, Carraro TE, Cartana MHF, Reibnitz S. Atenção ao usuário de drogas - um espaço para o enfermeiro. Texto Contexto Enferm. 2004 Abr-Jun; 13(2):296-302.
22. Lemke RA, Silva RAN. A busca ativa como princípio político das práticas de cuidado no território. Estud Pesqui Psicol. 2010; 10(1):281-95.
23. Nicacio F, Campos GWS. Instituições de portas abertas: novas relações usuários-equipes-contextos na atenção em saúde mental de base comunitária/territorial. Rev Ter Ocup Univ. 2005 Jan-Mar; 16(1):40-6.
24. Scarcelli IR. Trabalhadores em saúde mental na construção de práticas antimanicomiais: a rede substitutiva no município de São Paulo. In: Vieira MCT, Vicentin MCG, Fernandes MIAC organizadores. Tecendo a rede: trajetórias da saúde mental em São Paulo. São Paulo (SP): Editora Universitária; 1999. p.297-320.

25. Stasevskas YO, Maximino VS. A rede e o sentido. In: Vieira MCT, Vicentin MCG, Fernandes MIAC, organizadores. Tecendo a rede: trajetórias da saúde mental em São Paulo. São Paulo (SP): Editora Universitária; 1999. p.155-67.

26. Lancetti A. Clínica peripatética. São Paulo (SP): HUCITEC; 2006.

27. More CLOO. As redes pessoais como instrumento de intervenção psicológica no contexto comunitário. Paidéia. 2005 Ago; 15(31):287-97.

Correspondence: Jacqueline de Souza
Av. Dos Bandeirantes, 3900
14040-902 – Campus USP, Ribeirão Preto, SP, Brazil
E-mail: jacsouza2003@yahoo.com.br

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