

Caring for crack users: strategies and work practices in the territory

O cuidado ao usuário de crack: estratégias e práticas de trabalho no território

Cuidado al usuario de crack: estrategias y prácticas de trabajo en el territorio



Aline Basso da Silva^a
Leandro Barbosa Pinho^a
Agnes Olschowsky^a
Débora Schlotfeldt Siniak^a
Cristiane Kenes Nunes^a

How to cite this article:

Silva AB, Pinho LB, Olschowsky A, Siniak DS, Nunes CK. Caring for crack users: strategies and work practices in the territory. Rev Gaúcha Enferm. 2016;37(spe):e68447. doi: <http://dx.doi.org/10.1590/1983-1447.2016.esp.68447>.

doi: <http://dx.doi.org/10.1590/1983-1447.2016.esp.68447>

ABSTRACT

Objective: To know the care strategies for crack users in Brazil from the perspective of the Centre of Psychosocial Care for Alcohol and Other Drugs (CAPS AD).

Method: This is a qualitative descriptive study. Data were collected by means of interviews conducted with eight professionals of a CAPS AD in the metropolitan region of Porto Alegre, between February and March 2013. Data were subjected to thematic analysis.

Results: The analysed data revealed the use of care strategies, such as itinerant teams, home visits, and the extended clinic, and that the work territory should essentially be the home of the professional.

Conclusion: Care in the territory is considered an innovation in the field of mental healthcare because it enables care that focuses on social, cultural, and historical context of users.

Keywords: Mental health. Healthcare reform. Nursing. Public policies. Drug users.

RESUMO

Objetivo: Conhecer estratégias de cuidado ao usuário de crack no território a partir da realidade de um Centro de Atenção Psicossocial para álcool e outras drogas (CAPS AD).

Método: Estudo qualitativo e descritivo. Os dados foram coletados por meio de entrevista, realizada com oito profissionais de um CAPS AD da região metropolitana de Porto Alegre, entre os meses de fevereiro e março de 2013. Para análise dos dados utilizou-se a análise temática.

Resultados: Foram apontadas, a partir dos dados analisados, estratégias de cuidado no território como: as equipes itinerantes, as visitas domiciliares, a clínica ampliada e a importância do território de trabalho ser o mesmo da residência do profissional.

Conclusão: O cuidado no território mostra-se como uma inovação para o campo da Saúde Mental, visto que permite uma atenção em saúde voltada para o contexto social, cultural e histórico dos usuários.

Palavras-chave: Saúde mental. Reforma dos serviços de saúde. Enfermagem. Políticas públicas. Usuários de drogas.

RESUMEN

Objetivo: Conocer las estrategias de atención al usuario grieta en el territorio de la realidad de un centro de atención psicossocial contra el alcohol y otras drogas (CAPS AD).

Método: Se trata de un estudio cualitativo y descriptivo. Los datos fueron obtenidos con entrevistas a ocho profesionales de un CAPS AD de la región metropolitana de Porto Alegre, entre los meses de febrero y marzo de 2013. Para el análisis de los datos se utilizó el análisis temático.

Resultados: Sugieren las siguientes estrategias de atención: equipos itinerantes, visitas domiciliarias, la clínica ampliada y la importancia del territorio de trabajo ser el mismo que el de la residencia del profesional.

Conclusión: El cuidado en el territorio se presenta como una innovación en el campo de la Salud Mental, ya que permite una atención a la salud centrada en el contexto social y cultural de los usuarios.

Palabras clave: Salud mental. Reforma de la atención en salud. Enfermería. Políticas públicas. Consumidores de drogas.

^a Universidade Federal do Rio Grande do Sul (UFRGS). Escola de Enfermagem. Programa de Pós-Graduação em Enfermagem. Porto Alegre, Rio Grande do Sul, Brasil.

■ INTRODUCTION

Drug abuse, especially the use of illicit substances like crack cocaine, has been the focus of significant international concern and is currently a serious public health problem⁽¹⁻²⁾. Chemical dependency can compromise the physical and mental health of users and it has serious implications on their social and family life⁽³⁾.

Despite the complexity and the magnitude of the abuse of psychoactive substances, users and their families are still facing significant gaps in the provided healthcare. The formulation of public policies, which historically emphasise repression of the supply and demand and a disease-oriented model, reveal the need to discuss these policies⁽⁴⁾.

The current public policies should be based on the assumptions of the mental health reform, in which care for the users of crack and other drugs is not hospital-oriented, and health services are provided in the territory. These services offer an innovative way of providing care, where social rehabilitation and care within the territory are also within the axes that guide the practice of psychosocial care workers, and transcend the purely biological aspects to focus on the contexts of people's lives.

The territory of which we speak is not only physical, a mapping of space to offer health services; it is a much broader concept, a territory-network, a complex web formed by social and power relations. This territory is also political, social, and cultural; it is the place where people build their life stories. Therefore, this space forms the various discontinued networks with the superposition of several territories and territorialities that complement or contradict each other⁽⁵⁾.

In practice, these territories are the networks formed by the relations of the population with the health services, with their life contexts, with their spaces of living, of drug use, and social relationships, that are mobile, autonomous, and are transformed according to these interpellations.

It is from this territory that the first responses to the demand of mental health-related issues occur. It is not merely considered a place for the practice of healthcare, but the place where all the resources meet, the basis of work, the place of residence, where material and subjective exchanges are made and influenced, and where relationships are established.

In addition to all the aspects presented above, it can still be identified by a tangle of multiple networks, such as the network of healthcare services and the network of mental health services, as well as the other community, work, support and neighbourhood networks. Considered

a strategic element in the new scenario of mental health because it enables the inclusion and citizenship of people with mental distress, this territory also comprises a set of social forces that can be triggered or reformulated⁽⁶⁾. Therefore, it is in the midst of this new configuration that the mental health services should act and guide their actions toward drug users.

From this perspective, we highlight the importance of Psychosocial Care Centres ("CAPS") as strategic services in the reform process. They are responsible for establishing the necessary links between the service and the territory, understanding the social problems, coordinating other services and people, and intervening according to their healthcare needs. The CAPS must, in accordance with the precepts, approach the territory as if it were the stage of the movement of life. Some studies⁽⁷⁻⁸⁾ have sought to demonstrate the importance of this relationship, but they also state that when the CAPS is having difficulties moving inside the territory, it runs the risk of becoming encapsulated⁽⁹⁾, disjointed from the network.

Thought on the work in the territory and incorporating it as a location rich in life stories and existences can bring many benefits to the relationship between professionals and users. We must also seek the autonomy of users in the care and perception process of drugs beyond the disease and in all its complexity according to the life context of the subjects.

Accordingly, the guiding question of this research proposal is "What are the care strategies for crack users that the CAPS employ for/in the territory?" The aim of this study was to know the care strategies for crack users in the territory from the perspective of the Psychosocial Care Centres for alcohol and other drugs ("CAPS").

■ METHOD

This is a qualitative and descriptive study that is part of a dissertation entitled, "*O cuidado ao usuário de crack: análise da concepção de território de trabalhadores de um CAPS AD*"⁽¹⁰⁾.

The field of study was the CAPS AD of a city in the metropolitan region of Porto Alegre/RS, Brazil that assists around 200 users with an open-door policy, in which all users and their families are welcomed and oriented according to the premises of the Psychiatric Reform and National Mental Health Policy. The research participants were eight professionals. The inclusion criterion for the study was professionals working for least six months in the CAPS AD, and the exclusion criterion was professionals on medical leave and/or on holidays.

The participating team consisted of two psychologists, a psychiatrist, an occupational therapist, a workshop instructor, a nurse, a nursing technician, and an administrative assistant. One professional was excluded because he was on leave, and another was excluded because he was on holidays at the time of data collection.

Data were collected by means of an open-ended interview with the following guiding question: "Tell me what you understand by territory in care for crack users". The interviews lasting from 20 to 30 minutes. The data collection period was between February and March 2013.

The data were subjected to content analysis, thematic mode, that consists of finding the nuclei of meaning that make up a communication when the presence or frequency mean something to the analytic object that is being studied⁽¹¹⁾. The three thematic content analysis stages are pre-analysis, material exploration, and processing of empirical data.

In the first stage, we created the body or *corpus* from the transcriptions of the interviews. The material was skim read to identify aspects that could answer the research objectives.

The second stage, exploration of the material, consists of data encoding from that which is considered the "creation of nuclei for the comprehension of the text". This way, we developed the "information units" that contain specific information and ideas detected in each interview. The theoretical framework was created with the "information units" that, once grouped, formed "units of meaning" that finally generated two categories of analysis.

The third and final stage consisted of processing and interpreting the results. The raw data were analysed and discussed in light of literature on the subject. In this article, we discuss aspects of the second category of analysis that includes care strategies for crack users in the territory, from the reality of a psychosocial care centre for alcohol and drugs.

The project was submitted for evaluation to the research ethics committee (CEP) at the Universidade Federal do Rio Grande do Sul (UFRGS), and received a favourable opinion (protocol 20157/2011). At the request of the CEP/UFRGS, it was evaluated by the CONEP/MS, receiving a favourable opinion (337/2012) as a sub-project of the study "Avaliação qualitativa da rede de serviços em saúde mental para usuários de crack".

Research observed the ethical requirements of Resolution 466/2012 of the National Health Council⁽¹²⁾ regarding the informed consent statement. To protect their anonymity, we identified the team members with the initial "E" followed by the order in which they attended the interview. Example: E6, E3.

■ RESULTS AND DISCUSSION

In the category "Care strategies in the territory", four of the eight professionals talk about their practical reflections to approach the concept of territory, beyond the physical, and including the ways of life of the population.

Care strategies in the territory - *practical reflections to approach the concept of territory that includes the ways of life of the population.*

Care in the territory proposes a new way to do clinical work, different from the traditional clinic work (based on control and supervision). This new clinic considers the user as an active participant in the care process, and incorporates their life experience and residence in the formation of new mental health actions. The mental health team had some considerations regarding this topic:

So, the idea of forming an itinerant team is based on that, that is those users who do not come to the CAPS, that do not have the CAPS as support, sometimes they do [...] Anyway, they came here once and never came back, didn't believe the CAPS could be a service that helps, that there is no subjective organisation because CAPS is occupied territory, and that's what got us thinking: no, but we have to reach out to these people, we have to go out onto the streets... So then, well, we thought more structurally and appointed it like this, tried to appoint a itinerant team, and the plan is that we have a team, that is not the whole CAPS team, because we need to have people in here too, but a part of the team to go mark that presence in the territory and the territory can be the home, the streets, it can be the subject alone, it can be a group, it can be a vulnerable area [...] (E7).

We have many escape vectors in the geographical territory, going after the users, making a HV. To the extent that we have a family inside a house in a neighbourhood, it modifies something in these relationships with the user, with the territory [...] (E1).

The workers of the CAPS AD mention two care strategies that strengthen the social space as the location of the service they provide. One of the professionals proposed the creation of itinerant teams as a possibility for care in the territory. This strategy is suitable for users who do not recognise the CAPS as a care device, who have fragile ties with the service, and have difficulties accessing the service. The professional team stressed the importance of being where the people are, on the street, in the city, in the home, and proposed new projects of life for the population and professionals in this reality.

The term “itineration” refers to the use of care technologies that help professionals travel to the users’ territory. Itineration provides greater care coverage for population groups with the most difficulty accessing services and creating bonds, such as the homeless, indigenous people, nomads, and drug users, who do not fit into the traditional model of treatment at these services⁽¹³⁾.

The itinerant team can still be considered a political movement that acts in contact with the elements of the territory, somehow affecting it and being affected by it. Itineration can comprise three elements: movement toward the users of the territory, movement enabled by monitoring the workers with the users (confirming their place in the territory) and, finally, the invention of new ways of thought and in the real social setting⁽¹³⁾.

According to the testimony of E7, the CAPS is an inside service that must have a team that works “inside” their space. However, the construction of itinerant teams allows professionals to enter the territory and know its routine, which creates new alternatives of care and enables the accessibility of users who do not see the CAPS as a place of care.

Contrarily, E1 stated that home visits are an important strategy for the territory. He reported that the fact that the service is in a space, a neighbourhood, a city, with families and populations, supports the need to create ties between the team and the territory, and home visits are a valid care strategy in this sense.

Home visits are a powerful care instrument in the territory since it is through these visits that professionals can enter the family context and provide care to all the members involved, while not merely considering the users, but the social factors as well, and build a moment to establish links and relationships through qualified listening⁽¹⁴⁾.

Moreover, home visits are a punctual activity in the work process; workers go to the user’s home and return to the healthcare service with knowledge of the family environment without becoming too involved in that context. The construction of itinerant teams, however, proposes a shift in the care model; the professional works in the territory and promotes meetings among users and workers by inserting himself or herself in the living environment of these users.

Therefore, itineration shows that occupying the territory of these subjects is a powerful strategy in the care of crack users. It causes a shift in the view of the workers toward the population. The care strategy in the territory mentioned by E7 supports this type of process, which does not connect with the internal context of the health service, but rather to the social spaces of the community – the neigh-

bourhood, the city, the territory - and incorporates them as care sites.

The CAPS AD professionals state important and necessary changes in their work process, and recognise a clinic that still focuses on the inside of the service, with punctual actions in the territory, such as home visits. However, these actions do not yet encompass the complexities of life of the population, and these spaces of drug use and existence refer to the relationship of user with drugs, with their social networks and desire for care. The research revealed the need for changes in mental health practices that must include this territory of life and existence as a place of care.

Thoughts about the territory as a place of care, as a powerful space to practice psychosocial care, are stated below:

[...] talking a little about drug dependency, in crack users, we can't not think about life projects, the power of life, of exploring these issues in the territory of that subject. And I think that, in the health service, we, here in the CAPS AD, we are concerned with seeing that individual beyond the disease. Thinking at the level of crack users in the territory, we have to think about that subject's family, the friends, in what that person does during the day, what he does at nights, and what he does other than work, what he does besides the CAPS [...] And I think, the more possibilities that territory has to offer, the more that subject will be investing in other possibilities of life, beyond that use of chemical substance (E2).

The workers are concerned with the construction of a clinic for the subject that functions beyond the disease and creates life projects from contact with the user’s reality, the relationship with their families, their daily lives, and their likes and dislikes. The statement shows that the professionals need to discover the subjects, their territory, and their relations since this would allow the construction of a powerful and creative care. Investing in opportunities for care in the territory is to invest in life and build a new relationship of the users with the chemical substance.

Thinking about care in the territory of mental health unmask a new way of organising work processes and producing care actions. The aim is to work in an interdisciplinary team according to the individual needs of users, which include various biological, cultural, socioeconomic, political, existential, and religious dimensions. In order to consider the users as the starting point in their territory and the complexity of forming therapeutic projects that recognise the breadth of issues involving the subject, the team needs to work together and break the fragmentation of knowledge and hierarchical relations⁽¹⁵⁾.

The Extended and Shared Clinic refers to the expansion of healthcare for everyone, while fully valuing human beings and respecting their individuality. Understanding the extended clinic involves more than care guided by techniques and protocols; it refers to a shared and interdisciplinary care. In addition, health practices in this context provide creativity, natural care, listening, and sharing of knowledge to this setting⁽¹⁶⁾.

Consequently, care in the territory is linked to the ways of providing clinical care, and require a shift in the care model that incorporates the clinic of the subject into the context of substitute services.

With the formation and reformulation of the clinic, we have the construction of life projects that see the subjects and their social space in their entirety, bringing the use of crack as part of the existence of the individual, and not as the focus of care. The possibility of a new user relationship with the substance can be possible with the creation of new care spaces in the territory, and with the perception of the real needs of the subjects and work on quality of life and the user beyond crack.

Working with the subjects involved in their social processes as opposed to the drug dependency is to think about care strategies in the territory. The change would include their experiences, their life stories, their social relations, and their contexts as the guidelines of this care, thus creating spaces to open the network for the community, living territories, used territories.

These territories in healthcare include the physical characteristics of a given area and the man-made marks, the social relations, and how the subjects organise and move within the territory. There is a structural, functional and procedural inseparability between society and the geographical space. It is a used territory since it is a part or fraction of the space qualified by the subject, a space lived by man⁽¹⁷⁾.

Another statement addressed care strategies in the territory as an area of care and as the professional's place of residence:

[...] there are multiple ways to view the territory, my territory with users not only the service where I work; it is also the place where I live. What I find important is, it does not happen in all the health services, but I think it would be important, relevant, to live in the territory you work in, then you have a better perception [...]. I believe this: when you live in your place of work, I think you have a larger vision of the territory [...]. For me it is easier to have my daily life in my work, and it becomes an extension of the service. An example that I have is that several users live in the place where I live, I've been on the bus with him, I greet them, they come

here, I also greet them, so there is a continuation of my work territory that is also my residence, and this creates a very interesting link, really nice, for the user's treatment or my territory belonging to him [...]. (E6).

The participant highlighted the importance of living in the same territory as the users since it helps the workers understand the context of the users and facilitates their work in the territory. This idea is used in the primary care of the SUS, in the family health strategies, where the community agents must live in the same locations where they work to increase their bonds with users and better promote health in the territory.

By thinking of care in the territory as a complex web formed by several services, professionals, users, and care devices, we see that the professionals do not necessarily need to live in the user's territory insofar as they are "occupied" with building care proposals to better coordinate the network and the different territories.

In this context, primary care can be an important ally for the care of crack users because it is inserted in the territory and understands the way of life of these people, thus allowing more effective actions to meet their healthcare needs⁽¹⁸⁾.

An inherent feature of mental healthcare is the development of singular practices that are based on ties with the families, the users, and their communities to create strategies in the territory⁽¹⁹⁾. Since primary care is a service that occurs in the territory, it might be closer to strategies that recognise the ways of life of people and include them in the therapeutic care projects.

Therefore, it is understandable that the fact that CAPS workers live in the territory of the users can reinforce the idea that the CAPS is the "centre" of the mental health network, the only reference for care. However, the CAPS should be a service geared toward the territory that seeks to communicate with other devices⁽²⁰⁾.

In practice, the challenge continues to be the composition of a mobile, flexible, and problem-solving network that facilitates the transit of users and embraces their different demands. From the management perspective, alternatives are needed for the demands of care and reference systems, and counter references are required to consolidate the challenge of building networks. There seem to be more isolated services that are closed inside their routines than articulated networks that meet the demand of users. The composition of a flexible, mobile, problem-solving network requires communication and a good relationship between network devices^(15, 20).

Thus, care in the territory needs to recognise the multiplicity of its dimension and the incorporation of strate-

gies, both in the field of macropolitics and micropolitics of the service. Carefully arranged networks should also be constructed to broaden relations between the workers and users, and improve access and the communication of services with reality. The professionals, the users, and their families are actors of this process of building care in the territory, and the challenge is the consolidation of a clinic of the subject that does not only focus on the disease, but also the chemical dependency for the creation of care plans.

We need strategies that incorporate the social space as a place to learn and practice, thus changing the paradigms of care, because this is the only way to consolidate the reform proposal with regard to citizenship, social rehabilitation, and the reception and the inclusion of users in the living space.

■ FINAL CONSIDERATIONS

Care in the territory is considered an innovation in the field of mental health since it enables a healthcare that focuses on the social, cultural, and historical context of the users. Therefore, social reintegration and the search for new ideas for treatment are not limited to the strategies used inside the services.

Itinerant teams take care to the places where people are, which allows them to know the community spaces and the true reality of crack users, and enables a healthcare that includes the desires, the experiences, and the social spaces where the users live. This strategy is essential to users who do not recognise the CAPS as a care device, who have fragile ties with the service, and who have difficulty accessing the service.

The forms of “doing clinical work” can create a new relationship of the individual with the drug. A clinic that views the subjects and their existence in their social space removes the focus from drug use and seeks to rescue their life stories. Thus, the perception of the real needs of users and interest in knowing users and contextualising drugs reveals a clinic extended to the subject that can create opportunities for new care spaces that recognise the territory.

The care strategy in the territory was based on the fact that the territory of residence of the CAPS AD professionals was also the territory of the users. It should be noted that this idea is produced in primary care, where the community agents must reside in the same location as the users in order to strengthen ties and broaden their point of view regarding that specific social context. The territory, from the perspective of a complex web of relationships that articulates and complements and contradicts itself, reveals

that the CAPS must communicate with other network devices, such as primary care. Therefore, this care strategy in the territory can strengthen the idea that the CAPS AD is the “centre” of this network and, often, the only reference to mental healthcare.

The findings also show that home visits are a powerful instrument of care in the territory, and that, through this instrument, the professionals can get to know the family environment and the social context in which the users and their relatives are inserted, and therefore provide care to all the people involved. However, these actions can be punctual, meaning that the proposal of itinerant teams offers a model of care that extends the workspace beyond the residence of users, while occupying their lived territory.

When the territory is incorporated as an area of care, it can trigger transformations in mental health practices when observed beyond the physical space, with the cultures, stories, and affections, that is, a social site that allows the construction of new perspectives regarding healthcare and drug use. Thus, the focus is the subjects and their relationship with drugs and society, and not only their physical and chemical dependency that generate a “disease”. These transformations include team-building practices in the territories, the coordination of different devices, and different ways to provide clinical services: the clinic of the subjects.

The limitation of this study was the use of one mental health service, the CAPS AD, which prevents the generalisation of these results regarding other services. Therefore, we suggest further studies to address this perspective, and new research and practices that include the perception of users on the care territory, their understanding of the subject, and their experiences and expectations of a treatment that includes other spaces in addition to the health services.

■ REFERENCES

1. Vogel NW, Slob EMGB. Crack: o que se sabe e o que deve-se saber sobre essa droga tão poderosa. *Rev Saúde Desenvolvim.* 2014;6(3):167-84.
2. Medeiros KT, Maciel SC, Sousa PF, Tenório-Souza FM, Dias CCV. Representações sociais do uso e abuso de drogas entre familiares de usuários. *Psicol Estudo.* 2013;18(2):269-79.
3. Magalhães DEF, Silva MRS. Cuidados requeridos por usuários de crack internados em uma instituição hospitalar. *REME Rev Min Enferm.* 2010;14(3):408-15.
4. Alves VS. Modelos de atenção à saúde de usuários de álcool e outras drogas: discursos políticos, saberes e práticas. *Cad Saúde Pública.* 2009;25(11):2309-19
5. Souza ML. O território: sobre espaço e poder: autonomia e desenvolvimento. In: Castro IE, Gomes PCC, Corrêa RL, organizadores. *Geografia: conceitos e temas.* Rio de Janeiro: Bertrand Brasil; 2001. p. 77-116.
6. Dutra VFD, Oliveira RMP. Revisión integradora: las prácticas territoriales de cuidado en salud mental. *Aquichan.* 2015;15(4):529-40.

7. Pinho LB, Hernandez AMB, Kantorski LP. Serviços substitutivos de saúde mental e inclusão no território: contribuições e potencialidades. *Cienc Cuid Saude*. 2010;9(1):28-35.
8. Santos MRP, Nunes MO. Território e saúde mental: um estudo sobre a experiência de usuários de um Centro de Atenção Psicossocial, Salvador, Bahia, Brasil. *Interface - Comunic Saude Educ*. 2011;15(38):715-26.
9. Leão A, Barros S. Território e serviço comunitário de saúde mental: as concepções presentes nos discursos dos atores do processo da reforma psiquiátrica brasileira. *Saúde Soc*. 2012;21(3):572-86.
10. Silva AB. O cuidado ao usuário de crack: análise da concepção de território de trabalhadores de um CAPS AD [dissertação]. Porto Alegre (RS): Escola de Enfermagem, Universidade Federal do Rio Grande do Sul; 2014.
11. Minayo MCS. O desafio do conhecimento. 12ª ed. São Paulo: Hucitec; 2013.
12. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. *Diário Oficial da União [da] República Federativa do Brasil*. 2013 jun 13;150(112 Seção 1):59-62.
13. Lemke RA, Silva RAN. Um estudo sobre a itinerância como estratégia de cuidado no contexto das políticas públicas de saúde no Brasil. *Physis*. 2011;(3):979-1004.
14. Antunes B, Coimbra VCC, Souza SA, Argiles CTL, Santos EO, Nadal MC. Visita domiciliar no cuidado a usuários em um centro de atenção psicossocial: relato de experiência. *Cienc Cuid Saude*. 2012 jul/set;11(3):600-4.
15. Sampaio JJC. O trabalho em serviços de saúde mental no contexto da reforma psiquiátrica: um desafio técnico, político e ético. *Cienc Saúde Coletiva*. 2011;16(12):4685-94.
16. Sousa YG, Medeiros SM, Enders BC, Chaves AEP, Araújo MS. Multidisciplinary working process of the psychosocial care centers in the extended clinic context. *Int Arch Med*. 2016 jun;9(98).
17. Santos M. O Brasil: território e sociedade no início do século XXI. 9. ed. São Paulo: Cortez; 2006.
18. Schneider JF, Roos CM, Olschowsky A, Pinho LB, Camatta MW, Wetzel C. Atendimento a usuários de drogas na perspectiva dos profissionais da estratégia saúde da família. *Texto Contexto Enferm*. 2013 jul/set;22(3):654-61.
19. Andrade AB, Bosi MLM. Qualidade do cuidado em dois centros de atenção psicossocial sob o olhar de usuários. *Saúde Soc*. 2015;24(3):887-900.
20. Liberato MDM. Desinstitucionalizar é ultrapassar fronteiras sanitárias: o desafio da intersectorialidade e do trabalho em rede. *Cad Bras Saúde Mental*. 2009 jan/abr;1(1):1-10.

■ **Corresponding author:**

Aline Basso da Silva

E-mail: aline_basso@hotmail.com.br

Received: 09.30.2016

Approved: 02.01.2017