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Original Article

Mental health professional perception of the *embracement* towards psychoactive substance user in CAPSad[1]

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Abstract: Introduction: Adherence to chemical dependency treatment is still a great challenge for both, users and health care professionals. Currently, public healthcare policy is a tool to assist in the development of a humanized care model, which advocates for the practice of user inclusion. Objective: Investigate the perception of professionals who work in the mental health field, to understand the inclusion offered to users of psychoactive substances in Psychosocial Care Centers for alcohol and drug users (CAPSad). Method: A descriptive and exploratory study conducted at the CAPSad in São Paulo. Active professionals in the mental health field working at the CAPSad participated in the present study. For data collection a semi-structured questionnaire was used with 27 self-report questions, 15 closed questions, analyzed through statistics and 12 open questions, with speech analysis. Results: The questionnaires of six professionals with a mean of 14.3 years working at the CAPSad, revealed that they had no prior training about inclusion. Five participants responded that they carried out inclusion in the presence of the family, four responded without the presence of family and just one responded according to user choice (each participant could choose more than one option). The results show ambiguity regarding the concept of user inclusion, as all reported that inclusion hampers user reception, qualified listening, guidance and making necessary referrals. Conclusion: The need to create formal spaces for knowledge exchange, case discussion, and encourage professional training, promoting the identity of the service and improving user adherence to treatment was highlighted.

Keywords: *Substance-Related Disorders, User Inclusion, Mental Health Service.*

Percepção de profissionais da área de saúde mental sobre o acolhimento ao usuário de substância psicoativa em CAPSad

Resumo: Introdução: A adesão ao tratamento da dependência química ainda consiste em um grande desafio não só aos usuários, mas também aos profissionais da saúde. Atualmente, as políticas públicas apontam, como ferramenta auxiliar, o desenvolvimento de um modelo de tratamento humanizado, que preconiza a prática do acolhimento. Objetivo: Investigar a percepção dos profissionais de saúde mental sobre o acolhimento oferecido ao usuário de álcool e outras drogas em Centro de Atenção Psicossocial para usuários de álcool e outras drogas (CAPSad). Método: Trata-se de um estudo do tipo exploratório descritivo e qualitativo, realizado em CAPSad do interior paulista. Participaram do estudo, seis profissionais. Para coleta de dados, foi utilizado questionário semiestruturado com 27 perguntas de autopreenchimento, sendo 15 perguntas fechadas, analisadas através de estatística descritiva, e 12 abertas, analisadas pelo método de análise de conteúdo. Resultados: Participaram do estudo, seis profissionais com tempo médio de atuação de 14,3 anos e, destes, nenhum possui capacitação em relação à prática do acolhimento. Neste estudo, cinco responderam realizar acolhimento com presença de familiar, quatro sem a presença de familiar e

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um prefere deixar a critério do usuário (o mesmo participante poderia assinalar mais de uma resposta). Os resultados demonstram ambiguidade da concepção de acolhimento, já que todos relataram que acolher restringe a recepção do usuário, a escuta qualificada, a orientação e a realização de encaminhamentos necessários. Conclusão: Evidenciou-se necessidade de criação de espaços formais para troca de saberes, discussão e encaminhamentos dos casos, bem como necessidade de incentivo à capacitação profissional, promovendo a identidade do acolhimento no serviço e favorecendo a adesão do usuário ao tratamento.

Palavras-chave: *Transtornos Relacionados ao Uso de Substâncias, Acolhimento, Serviços de Saúde Mental.*

1 Introduction

Currently, chemical dependency and abuse of psychoactive substances are an important public health, social and justice problem.

To the World Health Organization (ORGANIZAÇÃO..., 2008), chemical dependency is a set of physiological, behavioral and cognitive phenomena that may develop after repeated use of psychoactive substances. Recent research of Carvalho et al. (2011) and Silva, Guimarães and Salles (2014) show that the main reasons that lead to the use of psychoactive substance are: pleasure, anxiety, social inclusion, tension and avoiding the displeasure of the abstinence symptoms.

The psychiatric reform, law No. 10,216 of April 6th, 2001 (BRASIL, 2001) assured users of mental health services, including those who suffer from disorders arising from the consumption of alcohol and other drugs, the universality of access and the right to health care, as well as their integrity, valuing the decentralization of the healthcare model. This law determines that the services are guided by the social conviviality of users, paying attention to the existing inequalities, and that they must meet the needs of each population.

According to the Ministry of Health (BRASIL, 2003) in its integral care to users of alcohol and other drugs policy, medical assistance to these users must cover three levels of care, having as a priority the out-of-hospital care; in this case, in the Center of Psychosocial Care for Alcohol and Drugs (CAPSad). For the Ministry of Health, the goals of a CAPSad are: i) offer assistance to population, respecting a defined area, offering therapeutic and preventive activities to the community, seeking to provide daily attendance to the users of the services, within the logic of harm reduction; ii) manage the cases, offering personalized care; iii) offer intensive, semi-intensive and non-intensive assistance, ensuring that users of alcohol and other drugs receive healthcare and reception; iv) offer conditions for home and ambulatory detoxification for users who require such care; v) offer care for relatives of services users; vi) promote, through various actions (involving work, culture, leisure, enlightenment and education of the population), social reintegration of users by intersectoral resources, i.e. from different sectors, such as education, sports, culture and leisure, developing combined strategies to face the problems; vii) work together with users and their families the protective factors for the use and dependence on psychoactive substances in order to minimize the influence of risk factors for such consumption; viii) work to decrease stigma and prejudice regarding the use of psychoactive substances through preventive/educational activities.

The Ministry of Health proposes the service humanization as guiding axis of healthcare through the program *Humaniza SUS* so, in this perspective, the inclusion becomes important and crucial point of discussion for the development of humanized assistance. Carvalho et al. (2008) relate that inclusion means the humanization of healthcare, involving the work processes, which contribute to the relationship between health services and health workers with its users. The inclusion enables and encourages user's access, listening to their health needs in a qualified way, allowing the team the possibility of sharing the responsibility with the user in their treatment. This form of care provides a new "gateway", which should welcome the user with quality, offering and resolving the demands inherent in each sector, leading to other services, when necessary, thus ensuring the flow of service to the user.

According to Miller and Rollnick (2001), users of psychoactive substances are marked by ambivalent feelings when they get help; Thus, they become more sensitive to how they are received into the service. From this assumption, it is believed that mental health professional comprehension on the understanding of the importance of the alcohol and other drugs user inclusion can contribute to the organization of the service, the strengthening of the care network and for permanent education of these professionals, providing thus specific and individual care, and promoting the increase of their binding and adherence to the service and treatment.

As a way of identifying training and development needs of health professionals, and fortifying qualification strategies and management in health care, the Ministry of Health established the National Policy of Permanent Education in Health (EPS), from the Ordinance No. 198, February 2004 (BRASIL, 2004). Thus, as mentioned by Carotta, Kawamura and Salazar (2009), discussions based on reception and humanization become an integral part of management in health, as a priority goal of the *Sistema Único de Saúde* (SUS).

The objective of this study was to investigate, from the perception of mental health professionals, the understanding on the inclusion offered to the alcohol and other psychoactive substances users in CAPSad.

2 Method

This is an exploratory descriptive and qualitative study, held in a CAPSad of a city in the State of São Paulo. According to information from the Ministry of Health in the year 2012 (BRASIL, 2012), there were 69 CAPSad in the State of São Paulo, but Silva et al. (2015) assure that, in 2015, the year in which this research was developed, there were only 65 CAPSad in operation throughout the State. Yet, according to these authors, the quantitative composition of the technical team of the São Paulo State CAPSad varied quantitatively, being five professionals the smaller technical staff and 23 professionals the largest.

It should be noted that the service studied is unique in the treatment of chemical dependency in the region, and is linked to a medical school. Nevertheless, it is composed of a short technical team. Six professionals that perform the reception and inclusion in the unit participated in the research, including: a psychologist, two nursing assistants, a nurse, a social worker and a doctor. One of the criteria for exclusion are not working on reception and inclusion or non-acceptance to participate in the study.

The entry in this service happens through spontaneous demand or via Basic Health Units, Family Health Units or Hospitals referrals, and even by court order.

The research was supported by the Research Ethics Committee of the Medical School of Marília, under 916,902 Protocol. Participants received all the information and guidance about their participation in the research and signed an informed consent.

For data collection, the research team elaborated and applied a questionnaire with 27 auto fill questions, being 15 questions closed and 12 open-ended questions, allowing the professional to specify their perception about the reception and inclusion to the user of the alcohol and drugs service. The content of the questions was about the professional's choice in relation to the service area, to reception and inclusion understanding, to the possibility of developing discussions about the topic and a self-evaluation on their performance and professional reality.

The instrument was answered on an individual basis, as the researcher oriented. The information on the project were given so as not to influence the participant's answers. Data collection was carried out between December, 2014 and January, 2015.

The results of the closed questions were analyzed through simple descriptive statistic, for better data exposure. The analysis of the results of the open-ended questions was held as proposed by Bardin (1977), through the analysis of thematic content. The themes were selected by the researcher for better data exposure, as the objective proposed by the research.

3 Results

Currently, work in the CAPSad searched nine health professionals, among them: three psychiatric physicians, a social worker, a psychologist, two nurses and two nursing assistants, and, of those, six professionals have agreed to participate in the research. Those who agreed were: a doctor, a psychologist, a social worker, a nurse and two nursing assistants. The average age of the participants was 45.8 years old with a standard deviation of ± 7 years, with an average of graduation time of 18.3 ± 8.5 years, being 50% (3) female and 50% (3) male.

Participants showed an average length time of professional experience of 14.3 ± 6.7 years. When asked whether working with chemical dependency was their professional choice, 33% (2) had affirmative answer and 67% (4) reported not being their first choice. In relation to the first contact with users who abuse of psychoactive substances, 50% (3) reported it happened in the family environment, while 33% (2) responded they had the first contact in the professional environment and 17% (1) with friends. As for having specializations in mental health, 50% (3) responded affirmatively, being referred to: a training course, two specializations and a master's degree. In relation to training courses only two professionals (33%) reported having some type

of training course in the area, one of them being also a specialist. Among the specific trainings on the subject reception and inclusion, 100% (6) said they never had.

With respect to source of resources that support the specializations and training courses, 50% (2) reported having performed with own resources, 25% (1) with institutional resource and 50% (2) attended free courses. It is important to note that, in this item online training courses were referred to, 50% (2) out of four professionals who have some sort of expertise or training course answered they attended the courses after entering the service and 50% (2) attended before and after entering the service.

Among the participants, 33% (2) are on charge of 25 users each, 17% (1) with Higher Level Education is on charge of 15 users; the remaining 50% (3) are reference technicians with no users on charge.

In relation to the theme "understanding on reception and inclusion", all participants reported that they understand by receive and include, receiving the service user, listening to their demands in a qualified way, guiding and making the necessary referrals, as highlighted by the line:

> *Reception and inclusion is listening in a qualified way individual complaints to identify the users' requirements and respond to complaints and needs, involving them in the treatment* (P1).

It was pointed out that reception and inclusion is the beginning of the patients' treatment monitoring, which is well evidenced in this speech:

> *Reception and inclusion is the beginning of follow-up* (P6).

As for the type of reception and inclusion performed, 100% (6) of participants reported making individual reception to the user and, among these participants, 67% (4) said they also perform reception in groups. In another item, asked whether they carry out the reception accompanied or not, 83% (5) do it with the presence of a family member, 67% (4) without the presence of a family member and 17% (1) leave the choice at the user's discretion.

The professionals responded that they do not establish an amount of reception moments to each user, being this number flexible according to their needs.

> *It depends on the needs of each person* (P3).

When asked about the way they perform the service, 100% (6) responded it is via spontaneous demand and 17% (1) via previous schedule.

In the item "reception systematization", only 17% (1) reported using some kind of protocol, being such a document drawn up by other members of the service and which encompasses aspects such as type of substance consumed, abstinence period, previous treatments, among others.

In relation to team discussions about the reception and inclusion held, 83% (5) responded that they always have discussions and 17% (1) responded that the discussion is not always held. As the professionals with whom they discuss, 100% (6) reported discussing with a multidisciplinary team, and in some cases exclusively with the medical team.

The subjects raised in the discussions about the reception, according to participants, are mainly related to data collection performed during the reception, in order to enable referring and/or treatment modality offered to the user, as evidenced in:

> *Motivation, abstinence length time, data collection, therapeutic proposal and/or conduct* (P4).

When asked whether there are periods and/or formal meetings for the reception discussions, 83% (5) responded negatively and 17% (1) positively, being referenced the weekly team meeting as the time for such discussions.

In referring to the "user's reception function", all participants assured the reception is a form of guidance during treatment. Among these, only 33% (2) related the reception is a way to encourage adherence to treatment, since it is the beginning of the service /user bond, explained as:

> *Listen to the user, guide on the treatment, stimulate adherence* (P2).

> *Receive the individual, have an expanded listening on their difficulties, create a bond and offer therapeutic proposal* (P4).

In the category related to possible changes in their reception, 67% (4) replied affirmatively, evidenced in the speech:

> *It is always possible to improve* (P5).

The last selected theme relates to the "understanding on ideal reception", in which responses' analysis all participants pointed to the concern of an agile and immediate care, prioritizing qualified listening, the realization of necessary guidelines and possible referrals. They also highlighted the need for a well-structured support network, explained in:

> *The ideal reception and inclusion should have multidisciplinary team designated to receive, listen to people that need the service, have more*

> *professionals on the team, have a welcoming work not only with a treatment vision, but also to orientate* (P3).
>
> *If there were structured support network health policies* (P4).
>
> *Time is short in front of the demand, structure conditions as well as team performance…* (P6).

4 Discussion

The results showed that the choice to work with mental health is often associated with a job offer and not necessarily it is the first choice of the worker. This can result in services composed of a professional team that is not often identify with the environment, with the type of service provided and the user attended to. In this study, participants reported that working with chemical dependency was not a professional and personal choice, which is corroborated by Tavares (2006), in research conducted with professionals in mental health services where the job offer not always allows to choose the desired area.

It is known that the drug use has intensified and compounded each year together with the increase production and concomitant development of new substances (UNITED…, 2013), being the contact with a psychoactive substance user more and more common and frequent. When asked about the first contact with psychoactive substances users, part of the participants answered that the first contact took place in the family environment; on the other hand, Lopes et al. (2009) indicate that the first contact, when surveyed nursing students, was in the professional environment, which can be related with little understanding about substance abuse in society in general.

Specializations and training courses are ways to present the professional to new techniques and knowledge of their professional practice, which facilitates, provides support and gives greater autonomy when dealing with unknown situations. To Silva et al. (2007), courses and trainings can be disjointed with the real needs of the worker and the user of the service so it is important the development of approaches to behold the institutional context, articulating dialogue and the establishment of relationships between the actors of the treatment (professionals/users).

In this research, half of the participants have some specialization, special courses for Higher Education professionals in the area of chemical dependency or mental health. Such fact contributes favorably to a best service planning since among the higher education professional participants, only one reported not having any specialization course.

About "training courses", some of the participants responded having attended some, and one of them also held a specialization course; they mentioned that they paid these courses with their own resources. A factor that can also collaborate to the difficulty in carrying out training and specializations courses may be related to the lack of encouragement from the institution itself, which often does not give a license for courses, issue also pointed by Vargas and Duarte (2001).

The need for professional specialization and training courses in mental health have always been considered and reaffirmed in the documents of the Ministry of Health, including new techniques and training of these professionals in order to cope with the new paradigm of health as assured by Silva, Oliveira and Postigo (2014). In addition to the need already cited, Gallassi and Santos (2013) bring the difficulties encountered when approached the subject of chemical dependency, confirming that the courses are rare and often distant from the professional needs, a short academic training course on the subject and the issue still very rooted in a moral concept, historically.

Mângia et al. (2006) relate that the technical reference promotes a process in working in which a professional is designated to take over the negotiations in a qualified way with the user about their treatment needs. The technician, most of the times, is the professional with a strongest bond with the user, enabling the division of tasks between the professionals of the team. In this study, the professionals refer to be technicians, being one of them the doctor assigned to the case. In this sense, there is a concern with the professional/user bond that may not be as close, since not all staff are available for this task what can cause an overload to the performers of this function.

According to the Ministry of Health (BRASIL, 2006), the reception and inclusion, far beyond its semantic meaning, is a way to operate the work processes in health care area in order to provide care to all those who need a qualified service. The reception is, then, the front door of the service and its qualification can be directly related to the user's adhesion to the treatment, since it influences the flow of users who remain willingly in that service, favoring a main role in their own treatment.

For Oliveira et al. (2011), the reception and inclusion means the qualified listening to the demands of every user who comes to any health service, and the professional is expected to show resolution to user's complaints while demonstrates the need for the co responsibility in their treatment, taking into account all their socio-historical and family background. According to Andrade, Sousa and Quinderé (2013), the reception must be judgment free, respecting the user's needs, desires and differences, what is appointed also by Alves and Oliveira (2010), which define the qualified listening must be without judgment, as to the content or even the nexus at this time because the simple sharing of suffering motivates them to seek for treatment in a health service. It is necessary to pay attention to the user's background, their history, long before any possible intervention structure.

The results pointed to the sensitivity of the participant professionals about the reception and inclusion and their importance as the crucial moment in the formation of user/service bond. On the other hand, they showed a huge concern to collect data and provide a rapid response to user's needs and the development of a therapeutic project or possible referrals, being the reception, sometimes, similar to triage itself, as also noted by Andrade, Sousa and Quinderé (2013).

It is believed that the similarity, present in some moments, between reception and triage should call the attention of the team, whereas this patient can be in a moment of previous contemplation for treatment and their motivation may be floating. The reception was also considered to be of great value to the completion of the user/service binding and adherence to the treatment.

As for the types of reception, they are consistent with the guidelines of SUS regarding the reception function, although the speech related to the reception in group differs from the proposed. According to Azambuja et al. (2007), the reception in group must work as a group in a waiting room, in which users can share ways of thinking in health, not excluding the individual care service.

It is known that the chemical dependency directly affects the family context. Thus, it is extremely important the participation of the family throughout the treatment process. The participation of the family in the role of treatment supportive, during the reception and inclusion, can generate greater confidence in the patient on the exposure of their problems and contribute to better contextualization of the situation. Seadi and Oliveira (2009), in research conducted, found greater patient compliance to treatment when relatives also participate or collaborate directly in this process, corroborating with the found of this search regarding the presence of the family during reception and inclusion.

As the reception is a form of qualified listening, that must attend every user who arrives at the service, setting a determined amount of receptions per user will impact against the proposed individual treatment. In this study, the participants demonstrated good understanding on the need to accommodate the demand brought by each individual. When it comes to floating motivation of psychoactive drugs user related to the treatment, the immediate reception enables a better treatment adherence (CASTRO; PASSOS, 2005), corroborating with this research finding.

Adopting a reception protocol can be a way to simplify the listening and approachment to triage. This fact can be connected, often, to the lack of availability of enough professionals for a suitable reception, which is corroborated by Oliveira et al. (2010), who discuss the reduced number of specialized professionals or insufficient resources to maintain a multidisciplinary team available to only reception.

Vargas and Duarte (2001) highlight the importance of the information exchange between the service workers as a source of knowledge, since the expertise and training are not very widespread in these environments. Discussions, when not held in formal spaces, as found in this research, do not favor the strengthening of knowledge exchanges and experience of the team, since only a few professionals are part of this moment. This dispersed mode together with the lack of specific training on reception may cause a difficulty in creating a bond with this user, who will have to adapt themselves to the individual ways of each professional to deal with reception which deprives a service identity.

In relation to the matters dealt with in the discussions about reception the data collection performed during the reception served as an auxiliary and even main way of routing the user to the offered treatment modality. We must take care not to confuse reception with the simple data collection, leaving aside the uniqueness of each individual. To Rêgo (2009), the reception must provide a situational diagnosis of each user in order to immediately elaborate the therapeutic plan. Maybe, in this first moment, it is difficult to trace the treatment modality in which the individual fits, leaving no space for the uniqueness and background brought by each user who comes to the service.

The reception is then a great ally to treatment adherence, as referenced by Andrade, Sousa and Quinderé (2013), Solla (2005) and Schmidt and Figueiredo (2009). With the number of participants reporting the reception as a way to aherence, it is demonstratds a weakness in understanding the reception function, according to the guidelines of the SUS and is evident the guidance as the main function of the reception to the participants.

It was also evident the participant's critics for possible improvements in the reception. When asked about the "ideal reception", participants named the need for a multidisciplinary team dedicated exclusively to reception, to favor the listening at the moment in which the user looks for the service, as well as better structure conditions. The reduced number of staff and the inadequacy of the environment have been items highlighted by Oliveira et al. (2010), that refer the vulnerability of these items makes the proposal to rethink the work processes weak, dealing with the frustration of the professionals when acting between the expectation and the reality of their job, even limiting the time available for each function.

5 Conclusion

The study made it possible to highlight the perception of mental health professionals about the reception to the user of psychoactive substances in a CAPSad.

Through the questionnaire used, it was possible to identify a concern to provide a reception to every user who seeks the service, but also pointed out the difficulty in keeping the guidelines of SUS, what can be perceived because of the short number of courses held and little incentive for such. It was evident that the reception conception it is still linked to the need for data collection.

A way to deal with the limited number of courses would be the implementation of formal spaces of team discussion, encouraging the exchange of knowledge and facilitating the creation of identity to the service reception, in addition to the implementation of permanent education to working professionals.

The overload of work sometimes caused by the lack of staff is a subject to be discussed in all the health services network, which today works with the minimum required staff. Thus, performing all the functions in a qualified form can bring enormous overload and stress to the professional, who, besides having to deal with their own frustrations, should always be available to the use since poor reception may difficult the user's adherence to the treatment.

Through the items and deployed discussed above we must take care to avoid substitute services become simple drug shelters care. To this end, investment in knowledge and subsidies for professional is extremely important.

Rethinking the issue by structuring the service and contemplate trading and training spaces is to provide a quality service to the user and also provide professional welfare maintenance in order to give them autonomy and management to deal with the situations experienced in the everyday life of the treatment of chemical dependency.

With this study, we hope to contribute to reorganize the work processes, fostering knowledge exchange spaces, strengthening reception as a form of care based on qualified listening, prioritizing each individual uniqueness, without pre-established concepts, and favoring thus greater user adherence to treatment and, consequently, less evasion.

New research may contribute for further reflections on the professional look of this area, allowing more and more discussions that contribute to the qualification and strengthening of the psychoactive substances user attendance network in the service provided.

References

ALVES, M.; OLIVEIRA, R. M. P. Enfermagem psiquiátrica: discursando o ideal e praticando o real. *Escola Anna Nery Revista de Enfermagem*, Rio de Janeiro, v. 14, n. 1, p. 64-70, 2010.

ANDRADE, A. T.; SOUSA, M. L. T.; QUINDERÉ, P. H. D. Acolhimento no Centro de Atenção Psicossocial para álcool e outras drogas: concepções dos trabalhadores de saúde. *Pesquisas e Práticas Psicossociais*, São João del-Rei, v. 8, n. 2, p. 166-175, 2013.

AZAMBUJA, M. P. R. et al. Relato de experiência: o acolhimento em grupo como uma estratégia para a integralidade. *Psico-USF*, Itatiba, v. 12, n. 1, p. 121-124, 2007.

BARDIN, L. *Análise de conteúdo*. Lisboa: Portugal: Edições 70, 1977.

BRASIL. Lei nº 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. *Diário Oficial [da] República Federativa do Brasil*, Poder Executivo, Brasília, DF, 9 abr. 2001.

BRASIL. Ministério da Saúde. Secretaria Executiva. Coordenação Nacional de DST/Aids. *A política do Ministério da Saúde para atenção integral a usuários de álcool e outras drogas*. Brasília, 2003.

BRASIL. Ministério da Saúde. Portaria nº 198 GM, de 13 de fevereiro de 2004. Institui a Política Nacional

de Educação Permanente em Saúde como estratégia do Sistema Único de Saúde para a formação e o desenvolvimento de trabalhadores para o setor e dá outras providências. *Diário Oficial [da] República Federativa do Brasil*, Poder Executivo, Brasília, DF, 13 fev. 2004.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. *Acolhimento nas práticas de produção de saúde.* Brasília, 2006.

BRASIL. Ministério da Saúde. *Saúde Mental em Dados - 10*. Brasília, 2012. Informativo eletrônico de dados sobre a Política Nacional de Saúde Mental, ano VII, n. 10.

CAROTTA, F.; KAWAMURA, D.; SALAZAR, J. Educação Permanente em Saúde: uma estratégia de gestão para pensar, refletir e construir práticas educativas e processos de trabalhos. *Saúde e Sociedade*, São Paulo, v. 18, p. 48-51, 2009. Suplemento 1.

CARVALHO, C. A. P. et al. Acolhimento aos usuários: uma revisão sistemática do atendimento no Sistema Único de Saúde. *Arquivos de Ciências da Saúde*, São José do Rio Preto, v. 15, n. 2, p. 93-95, 2008.

CARVALHO, R. M. C. et al. Causas de recaída e de busca por tratamento referidas por dependentes químicos em uma unidade de reabilitação. *Columbia Médica*, Colombia, v. 42, n. 2, p. 57-62, 2011.

CASTRO, M. M. L. D.; PASSOS, S. R. L. Entrevista motivacional e escalas de motivação para tratamento de dependência de drogas. *Archives of Clinical Psychiatry*, São Paulo, v. 32, n. 6, p. 330-335, 2005.

GALLASSI, A.; SANTOS, V. O abuso de drogas: desafios e opções para a prática do profissional de saúde no Brasil. *Brasília Médica*, Brasília, v. 50, n. 1, p. 51-57, 2013.

LOPES, G. T. et al. Nursing students' conceptions about the user of drugs. *Revista Brasileira de Enfermagem*, Brasília, v. 62, n. 4, p. 518-523, 2009.

MÂNGIA, E. F. et al. A construção de projetos terapêuticos. *Revista de Terapia Ocupacional da Universidade de São Paulo*, São Paulo, v. 7, n. 2, p. 87-98, 2006.

MILLER, W. R.; ROLLNICK, S. *Entrevista motivacional*: preparando as pessoas para a mudança de comportamentos adictivos. Porto Alegre: Artes Médicas, 2001.

OLIVEIRA, E. et al. Práticas Assistenciais no Centro de Atenção Psicossocial de Álcool, Tabaco, e outras Drogas. *Revista de Terapia Ocupacional da Universidade de São Paulo*, São Paulo, v. 21, n. 3, p. 247-254, 2010.

OLIVEIRA, L. S. A. et al. Percepções de monitores do pet-saúde mental sobre o acolhimento aos indivíduos atendidos no CAPS-AD do Distrito Glória/ Cruzeiro/ Cristal. In: SALÃO DE ENSINO, 7., 2011, Porto Alegre. *Anais...* Porto Alegre, 2011.

ORGANIZAÇÃO MUNDIAL DE SAÚDE – OMS. *Classificação estatística internacional de doenças e problemas relacionados à saúde - CID-10.* São Paulo: EDUSP, 2008.

RÊGO, M. Toxicomania: movimento de uma clínica. In: NERY FILHO, A. (Ed.). *Toxicomanias*: incidências clínicas e sociantropológicas. Salvador: EDUFBA CETAD, 2009. p. 207-220.

SCHMIDT, M. B.; FIGUEIREDO, A. C. Acesso, acolhimento e acompanhamento: três desafios para o cotidiano da clínica em saúde mental. *Revista Latinoamericana de Psicopatologia Fundamental*, São Paulo, v. 12, n. 1, p. 130-140, 2009.

SEADI, S. M. S.; OLIVEIRA, M. S. A terapia multifamiliar no tratamento da dependência química: um estudo retrospectivo de seis anos. *Psicologia Clínica*, Rio de Janeiro, v. 21, n. 2, p. 363-378, 2009.

SILVA, C. R. et al. Mapeamento da atuação do terapeuta ocupacional nos Centros de Atenção Psicossocial Álcool e Drogas (CAPS ad) do interior do estado de São Paulo. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 23, n. 2, p.321-334, 2015.

SILVA, J. A. M. et al. Capacitação dos trabalhadores de saúde na atenção básica: impactos e perspectivas. *Revista Eletrônica de Enfermagem*, Goiânia, v. 9, n. 2, p. 389-401, 2007.

SILVA, M. L.; GUIMARÃES, C. F.; SALLES, D. B. Risk and protective factors to prevent relapses of psychoactive substances users. *Revista RENE*, Ceará, v. 15, n. 6, p. 1007-1015, 2014.

SILVA, S. P.; OLIVEIRA, A. L.; POSTIGO, Q. Capacitação em saúde mental: entre a realidade e as ofertas do ministério da saúde. *Sistema & Gestão*, Rio de Janeiro, v. 9, n. 3, p. 406-416, 2014.

SOLLA, J. J. S. P. Acolhimento no sistema municipal de saúde. *Revista Brasileira de Saúde Materno Infantil*, Recife, v. 5, n. 4, p. 493-503, 2005.

TAVARES, C. M. M. A educação permanente da equipe de enfermagem para o cuidado nos serviços de saúde mental. *Texto & Contexto - Enfermagem*, Florianópolis, v. 15, n. 2, p. 287-295, 2006.

UNITED NATIONS OFFICE ON DRUGS AND CRIME – UNODC. *World Drug Report*. Austria, 2013.

VARGAS, D.; DUARTE, F. A. B. Enfermeiros dos Centros de Atenção Psicossocial em Álcool e drogas (CAPSAD): a formação e a busca pelo conhecimento específico da área. *Texto & Contexto - Enfermagem*, Florianópolis, v. 20, n. 1, p. 119-126, 2001.

Author's Contributions

Daiane Bernardoni Salles and Meire Luci da Silva participated fully and equally in all stages of the elaboration and writing of the article. All authors approved the final version of the text.

Notes

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