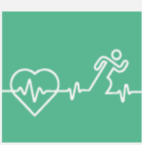

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AUTONOMOUS MEDICATION MANAGEMENT GROUP AS A HEALTH PROMOTION STRATEGY IN A PSYCHOSOCIAL CARE CENTER III

GRUPO DE GESTÃO AUTÔNOMA DA MEDICAÇÃO COMO ESTRATÉGIA DE PROMOÇÃO DA SAÚDE EM UM CENTRO DE ATENÇÃO PSICOSSOCIAL III

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ABSTRACT: The objective of this study was to report the experience of applying the Medication Self-Management Guide with patients at a Psychosocial Care Center III, aiming to assess its feasibility within the local sociocultural context. A qualitative, exploratory, and descriptive intervention-type study was conducted, using focus groups and presented as an experience report on the application of the Guide. The group consisted of 10 women with mental disorders, who were users of the service and had been taking psychotropic medications for over a year. The patients' socioeconomic conditions required the facilitators to adapt the Guide in order to ensure a better understanding of the objectives of the meetings. The participants showed difficulties in understanding concepts such as autonomy, medication, and patient rights. The stigma associated with people with mental disorders, which often results in imposed guardianship, represents the main barrier to the pursuit of autonomy. The Medication Self-Management Guide proved to be an effective tool for encouraging patients to reflect on their health conditions and treatments.
KEYWORDS: Mental health; health education; pharmaceutical care; autonomy; medication management.

RESUMO: O objetivo deste trabalho foi relatar a experiência da aplicação do Guia de Gestão Autônoma da Medicação em pacientes de um Centro de Atenção Psicossocial III, a fim de avaliar sua viabilidade na realidade sociocultural local. Foi realizado um estudo qualitativo, exploratório, descritivo, do tipo pesquisa-intervenção, com recurso a grupos focais, apresentado por meio de relato de experiência sobre a aplicação do Guia. O grupo foi composto por 10 mulheres com transtornos mentais, usuárias do serviço e em uso de psicotrópicos há mais de um ano. A realidade socioeconômica das pacientes exigiu dos moderadores adaptações no Guia para garantir melhor entendimento dos objetivos dos encontros. As participantes apresentaram dificuldades em compreender conceitos como autonomia, medicamentos e direitos dos pacientes. O estigma atribuído às pessoas com transtornos mentais, que frequentemente resulta na imposição de tutelas, representa o maior obstáculo à busca pela autonomia. O Guia de Gestão Autônoma da Medicação se mostrou como ferramenta eficaz para promover a reflexão dos pacientes sobre suas condições de saúde e tratamentos.
PALAVRAS-CHAVE: Saúde mental; educação em saúde; cuidado farmacêutico; autonomia; gestão da medicação.

INTRODUCTION

Autonomy is a polysemic term that, in mental health, reflects the individual's ability to establish norms for their life based on their ability to expand their social relationships.[1] The autonomy of people with mental disorders is not always respected[2], and Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS), which are mental health units that offer services to people with severe mental suffering, play a fundamental role in the development of this autonomy, with care in freedom.[3]

The beginning of psychiatric reform occurred with the emergence of psychotropic medications in the 1950s, and, since then, pharmacotherapy has become the main approach in mental health care.[4] Medications made it possible to replace psychiatric hospitals with outpatient care, allowing individuals with mental disorders to be reintegrated into society.[5] Furthermore, knowledge about new disorders, the increase in diagnoses, and the synthesis of new pharmaceuticals have increased the consumption of psychotropics in the world, with Brazil currently being one of the largest consumers of these medications.[6]

Communication between physician and patient can be impaired by several factors, such as lack of clarity in transmitting information, insufficient listening, cultural and linguistic barriers, lack of empathy and humanization, and inadequate use of technology. It is observed that problems arise due to difficulty in understanding during the appointment.[7] Patients often have difficulty communicating to their physician what they are feeling, and, in addition, physicians have a certain degree of difficulty in reaching a diagnostic hypothesis based on the patient's report.[8]

Within the strategies developed to promote the autonomy of people with mental disorders in making decisions about their medication treatment, the Guide to Autonomous Medication Management (*Gestão Autônoma da Medicação*, GAM) was created. Conceived by people with mental disorders and developed in partnership with health professionals and researchers from Quebec in 2001,[9] the Guide was adapted to the Brazilian reality in a multicenter study led by Onocko Campos et al., in 2012.[10] The Canadian Guide is divided into two parts: the first invites people with mental disorders to reflect on their health condition and consider possible improvements in search of a better quality of life; the second presents the method for progressively reducing or withdrawing medication, if desired by the patient. In addition, the Guide encourages the search for information and access to support networks.[9]

The Brazilian version (GAM-BR)[10] modified the entire second part of the original Guide because, according to the authors, the reduction or withdrawal of medications was not a demand of people with mental disorders in Brazil, but rather greater access to these medications. The GAM-BR does not exclude the possibility of withdrawing or reducing the use of medications, as well as increasing the dose or changing medications, but this must be assessed on a case-by-case basis.[10]

The implementation of GAM has shown significant growth in several Latin American countries, such as Brazil, Mexico, Argentina, Chile, and Colombia.[11] In Brazil, the use of GAM is spreading and becoming a practice in many CAPS in all regions of the country.[12-14] In Canada, since its implementation, GAM has been a reality in the Quebec health system,[15] and is referenced by the Association of Care Groups in Defense of Mental Health Rights (AGIDD-SMQ), the Schizophrenia Society (*Sociedade de Esquizofrenia*, SEQ) and the Quebec Alternative Mental Health Services Grouping (RRASMQ).[16-18] Another country that has used the Guide is Spain, where numerous initiatives have gained strength, mainly in the region of Catalonia.[19-22] While in Brazil the application of the Guide occurs in public services, such as Psychosocial Care Centers (CAPS), public health policy, in other countries, such as Colombia, Spain and even Canada, this occurs more through associations and other social movements, which brings certain peculiarities to the contextualization of autonomy, where the involvement of family members, caregivers and society as a whole is more prominent.[11]"

GAM is considered a health promotion tool, as it aims to enable patients to manage their treatment more effectively and safely, especially regarding the use of medications, guiding patients on how to correctly take prescribed medications, how to identify possible adverse effects, and drug interactions. Furthermore, it promotes health education, encouraging the patient to take an active role in their treatment process, which can improve medication adherence, reduce medication errors, and, consequently, improve the effectiveness of treatment and the patient's quality of life.[23,24]

Understanding that encouraging greater autonomy for people with mental disorders is one of the pillars of psychiatric reform and that the use of psychotropics has become the main form of therapy, it is extremely important to adopt strategies, such as GAM-BR, so that patients have greater participation and autonomy in decisions about their treatments. Thus, the objective of this study was to report the experience of applying GAM-BR to patients with mental disorders, users of CAPS III, aiming to observe its viability in the local sociocultural reality of those involved.

METHODS

This is a qualitative, exploratory, and descriptive study of the intervention research type, using focus groups. The focus of the study is on the participants' experiences and their relationships with the health team, family members, and the community. The results are presented through an experience report on the application of the GAM-BR,[10,25] with a narrative representation of the data obtained. The participants' speeches were collected through recordings, which were later transcribed and analyzed, with some selected to illustrate the group's discussions.

The CAPS included in this research serves people with mental disorders from the age of 18 and has a multidisciplinary team composed of a social worker, nurse, pharmacist, workshop facilitator, physical education professional, psychologist, psychiatrist, occupational therapist, nursing technician, in addition to the administrative and general services team. The service is also a setting for Medical Residency, Multiprofessional, and internships for several undergraduate courses.

CAPS users were invited at random on the first day of the workshop. Those who agreed to take part in the research by signing the informed consent form, who had been taking psychotropic medication for more than a year, and who could understand the proposed activities were included. Seven meetings were held weekly during the second half of 2023, following the themes and guidelines provided by GAM-BR,[10,25] the steps of which are summarized below. The meetings were facilitated with the participation of residents, undergraduates, and service professionals.

The GAM tool is composed of texts, figures, tables, and questions to help people reflect on their experiences in using medicines and promoting patient health, and improve their quality of life. Its two fundamental principles are the right to information and the right to accept or refuse treatment. The active participation of patients in decisions about their treatment is a central element. The Guide is structured in six steps, as detailed in the Support Guide for Moderators.[25] The first step consists of inviting patients to join the GAM, with the support of the service team and, whenever possible, the inclusion of family members or caregivers. The first meeting is dedicated to presenting the GAM, addressing its origin, the strategy adopted, and the purpose of working with the Guide. During this moment, the concerns and interests of the participants are also heard. After this introduction, the process develops in the following six steps.

In Step 1, the participants introduce themselves and share information about their lives, tastes, preferences, and activities, creating an environment for getting to know each other. This is also a time to

create "rules" for the smooth running of the group. In step 2, each participant discusses their day-to-day life, their preferences, and personal relationships, as well as analyzing the impact of medications on their routine and well-being. In Step 3, the group explores each participant's support networks and addresses patients' rights, encouraging reflection on access and the importance of these rights in the care process. In Step 4, participants discuss the medications they use, discussing their therapeutic effects, possible adverse effects, and the relevance of the medication in the context of their lives. Step 5 is intended to review the points discussed so far, summarizing the main ideas and themes addressed in the previous steps, promoting deeper reflection. Finally, in Step 6, participants identify the problems faced and define action strategies to overcome them, exploring therapeutic and complementary alternatives to medication treatment.[25]

The study was approved by the Ethics and Research Committee of the University Hospital of the Federal University of Sergipe, under CAAE number: 92400618.4.0000.5546. The research follows all the ethical requirements established by Resolution 466/2012 of the National Health Council (NHC), committing to maximize the benefits, minimize the harms, and guarantee justice and equity in the consideration of the interests involved, ensuring the rights and duties of the participants.

RESULTS AND DISCUSSION

Ten women with mental health problems participated in the study, all black, with low levels of education (incomplete elementary school) and in a situation of economic vulnerability (income less than US$ 8 per day). The clinical diagnoses were as follows: schizophrenia (n=2), bipolar disorder (n=2), and borderline personality disorder (n=6). All of them lived in the northern part of the city, had been attending the service for more than a year, and were using psychotropic medications.

(1) EXPERIENCE REPORT ON THE SEVEN MEETINGS PLANNED BY THE GAM GUIDE

1st Meeting: Presentation of the Guide, invitation, and creation of rules

In line with the GAM-BR version for moderators,[25] the first meeting was aimed at presenting the material and inviting people to take part in the study. Initially, the concepts and history of the Guide were explained, followed by an approach to central themes such as autonomy, co-management, co-responsibility, and protagonism. To ensure that these terms were properly understood by the participants, the facilitators used synonyms, practical examples, and comparisons, facilitating the assimilation of the concepts, which are essential to the Guide itself. The strategy of keeping the original terms was aimed at solidifying and homogenizing these concepts among the participants, so that they would become an integral part of the discussions in subsequent meetings.

Furthermore, the concepts and proposal of GAM were contextualized within the history of psychiatric reform and the anti-asylum struggle in Brazil. The participants initially demonstrated little knowledge of the subject, but as the discussion progressed, the concepts began to make sense within the context. According to Onocko Campos et al.,[10,25,26] psychiatric reform has neglected fundamental principles such as the autonomy and protagonism of people with mental disorders.

After clarifying the concepts and awakening the participants' interest in the GAM Guide, the times and duration of the meetings were defined. However, the participants showed some difficulty in expressing their opinions on the rules, which led the moderators to centralize some discussions. Finally,

the meeting was assessed by the group through the question "What did you think of today's group?", and the feedback was largely positive, with comments such as: "*I've never taken any decisions in my life*" and "*how good it is to work in groups*".

2ND MEETING: STIGMA OF BEING "CRAZY"

The previous meeting was reviewed to establish continuity, addressing again issues such as psychiatric reform, CAPS, autonomy, and co-management. Phrases such as: "*In asylums, there are cells, bars, you're locked up; here in the CAPS, it's open, you have people to talk to*" were frequently repeated by the participants. Some members of the group shared their experiences with hospitalizations in psychiatric clinics, bringing to light their personal experiences. When asked if they had more autonomy in the CAPS, the answer was unanimous: "*yes*".

In the second moment, the phrase "I am a person, not a disease" was read, present in the first step of the Guide, which directs the discussion about the stigma of being "*crazy*". When asked about how they understood and felt about this phrase, the participants stated that "*they are people like anyone else*" and that "*everyone has a disease*". Dealing with the weight of the stigma of "craziness" is extremely difficult for those facing mental problems. As discussed earlier, these individuals are often placed in a position of incapacity, with their subjectivity undervalued.[27,28] The surprise when raising this discussion was that the participants shared their own experiences, including family and social difficulties, and the stigma they face. The study by Paranhos et al. (2023) confirms this reality of stigma and prejudice within the family environment, which limits the support network necessary for the greater exercise of autonomy.[29]

After the discussion, each participant was asked to write a brief presentation about themselves on paper. Then, each person was asked to introduce the person next to them, reading what had been written and assessing whether the information was similar. This dynamic, inspired by the GAM-BR questions in the topic "Getting to know a little about yourself", was designed to explore how people with mental health problems are often labeled by others, often based on their illness, and how, in many cases, the patient himself also internalizes this label.

During the presentations, all participants mentioned the disorder or CAPS at some point. However, in the presentations of their colleagues, the fact that the person "*is also going through difficult times*" and that "*they met at CAPS*" was highlighted, which brought to light a strong sense of community. Furthermore, the dynamic aimed to bring the group members closer together, facilitating greater knowledge among them. The GAM process contributes to people's self-knowledge, helping them to name their emotions, identify the consequences of their lifestyle, and reflect on their relationships with others. This allows participants to find new forms of support and strategies, expanding their ability to act in situations of suffering and crisis.[30]

3RD MEETING: ROUTINE

The second step of the "Observing Yourself" Guide was applied, which addresses the patients' daily activities. To make the process more dynamic, a table was created in which the participants recorded the time and the corresponding activity they performed throughout the day. After constructing this table with the help of the moderators – as many of them have difficulties with reading and writing – the discussion moved on, where each participant had the opportunity to share their daily routine. Following the questions from the second step, about "what they like about their routine", CAPS emerged as a common point among all of them. They reported how "*the day they go to CAPS is important*", how

these activities make them "*feel happy*" and how the service "*welcomes*" them, highlighting that this relationship, in contrast, "*is difficult at home*". At this point, the importance of good welcoming in health services was discussed, emphasizing that relationships with family, friends, and other services in the health and social care network are also fundamental and deserve to be valued. Similar results were observed in the study by Veloso et al. (2023), which found that the majority of participants in the GAM Group, held at CAPS II in Montes Claros, MG, preferred to be at CAPS rather than at home.[31]

Continuing with the Guide, when asked about "what they would change in their routine", reports emerged about the anguish related to the daily use of multiple medications. Although many mentioned that "*without them it is more difficult*", others highlighted that "*with faith in God, we will get through this*". Polypharmacy – the simultaneous use of several medications – is a recurring problem, mainly due to the risks of drug interactions, adverse events, and toxicity,[32] which increase as the number of medications prescribed rises, in addition to reducing treatment adherence.[33] In psychiatry, the variety of prescriptions is wide and depends on the physician's experience,[34] and many medications are used off-label. In addition, many patients who use psychiatric medications also use other medications to treat comorbidities, which further increases the risks of drug interactions and adverse effects.

A relevant topic that came up during the discussion was the overload of "household chores", a topic initiated by the participants themselves, most of whom were mothers and housewives. They shared the pressure of having to perform all the household chores on their own daily, without receiving recognition for it. The role of women in society was discussed, along with the valorization of domestic work and co-responsibility for raising children with the children's partners and/or fathers. Many expressed opinions, such as "*I was raised that way*" or "*these are women's obligations*", reflecting the structural sexism present in society. The debate on the role of women was challenging, mainly due to the peculiarities of this group, where female empowerment is deeply related to social and racial issues, highlighting the need to advance these discussions.[35]

Despite social barriers, the strength of the women in the group in being able to speak openly about these topics and share experiences with other women in similar situations was very enriching. Throughout the meetings, it was possible to observe that both the speeches and the critical view on the topics discussed were strengthened as mutual trust between the participants and the service professionals intensified. The presence of two psychologists as moderators was essential for the conversation's dynamics, and all group members, including the men present, had the opportunity to contribute. The participation of men also proved to be important, as their presence helped to broaden the discussion.

4th Meeting: Support network

For the 4th meeting the focus was on interpersonal relationships, starting with the "ball of yarn" dynamic, where the participant had a roll of string in her hands and had to say her quality, hold the end of the string and then choose another participant, say what this person represents in her life and throw the roll, and so on, until everyone was holding the string. The idea is that, in the end, they could visualize the network, seeing themselves as part of it, and the more people who built this network, the stronger it would be. Discussions were held on what a support network is and how important it is for mental health. At the end, everyone had to fill in information about their support network.

Social relationships are extremely important for people suffering from mental illness. In the Finnish experience of open dialogue, for example, this appears as a point to be worked on in crisis prevention.[36]

Social relationships are one of the main resources that the subject has in terms of the support received, with an association between healthy human development and the quality of social relationships.[37]

In the second dynamic, on cardboard, a diagram of the Minimum Map of Relationships (Figure 1) was made,[38] in which the participants were asked who or what they would put closest to them, and who they would put furthest away. Initially, they put family members, some closer and others further away, then they included neighbors and friends.

Finally, when asked about the CAPS, church, Basic Health Unit (BHU), and other services, the participants included these services in their answers. For all of them, the CAPS was always located nearby, while the BHU was far away. This difference was used to discuss with them the importance of accessing other spaces and health services, since, in most cases, care was concentrated only in the CAPS.[40] The relevance of community entities, assistance services, associations, and churches was also addressed, which function as spaces for the exchange of experiences, encouragement of personal change, and formation of bonds between people.[26]

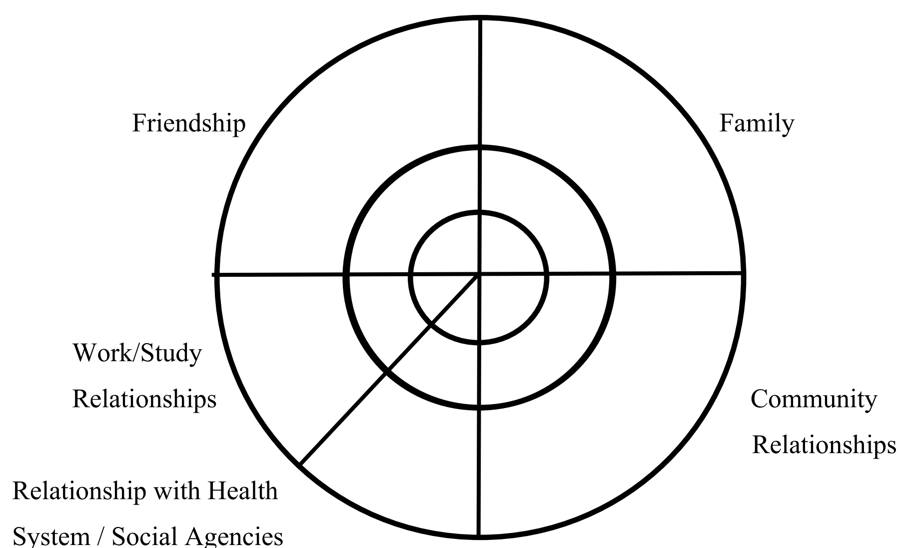

Figure 1. Minimum Map of Social Relationships. Source: Adapted from SLUZKI, 1997.[39]

In the last activity, the support network chart was used (Figure 2: Support Network),[10] in which the participants had to record the name, relationship, telephone number, and contact availability of the people in their network. With this activity, they were able to realize that they were not alone and that they could count on the support of other people besides the CAPS professionals. However, it was challenging to deal with certain cases, as some participants had significant difficulties in building their support network, something that was worked on with the support of the multidisciplinary team. Similar difficulties in building the support network were reported in other GAM groups with mental health users.[29,31,41]

This situation was handled effectively, providing participants with the support they needed to find these allies and reinforcing the importance of building bonds and having supportive people around them.[37] Family and social relationships tend to be strengthened with treatment, promoting greater balance in interactions between the user and those around them. This is because the patient's emotional and mental instability often negatively impacts their social bonds.[26]

SUPPORT NETWORK			
Name	Telephone	Where he/she is	Available timetables

Figure 2. Support Network. Source: GAM-BR Guide.[10]

5TH MEETING: USERS' CHARTER OF RIGHTS

In the second part of step three of the GAM Guide, the Users' Charter of Rights was worked on. On cardboard, some rights were written down, some were true, and others were false. Then, the papers were folded and placed in the basket so that each participant could take the paper, read it aloud, and, finally, say whether the right was true or false. This dynamic made it easier for the patients to understand, considering that long texts can be tiring and difficult to assimilate.[10]

Discussing health rights is essential, because with adequate knowledge, it is possible to demand better services and exercise more autonomy in decisions about proposed treatments.[26,27] People with mental health problems are often not seen as capable of understanding and demanding their rights. The right to decide whether or not to accept prescribed treatment, which is the fourth principle of the Users' Charter,[42] was the most debated point, as many participants were unaware of this right and were generally afraid of being punished if they refused to take prescribed medication. Often, they continued with treatment even when experiencing drug-related problems (DRPs), which are events related to errors in medication use, which can lead to complications and undesirable outcomes for the patient.[42]

From this discussion, it became clear that it is common for mental health professionals to blame and punish patients who refuse to take their medications. Some professionals require adherence to medication treatment as a condition for the patient to continue being monitored at the CAPS or to have access to night care, for example. However, patients have the right to choose other forms of treatment in addition to medication, such as therapeutic workshops, psychological care, physical activities, and integrative practices, such as the use of herbal medicines, auricular acupuncture, cupping, Reiki, among others.

The patient also has the right to refuse hospital admission, which will only be considered after all alternative approaches have been exhausted. In the case of compulsory mental health admission, it must be assessed by a physician, and the Public Prosecutor's Office must be notified within 72 hours[42]. This information was quite new to the participants, some of whom had already been hospitalized without all these procedures being followed.

As well as rights, the duties were also discussed, the main one being co-responsibility for treatment. As mentioned, it is impossible to talk about autonomy without considering responsibility. Having the right to decide also implies assuming the consequences of that decision. However, this must be seen as part of the process of building autonomy, in which the individual acquires the power to decide about his/her life, removing this responsibility from other people, especially when many patients with severe mental disorders are under the care of family members or guardians. There was also a discussion on the right to medical reports and certificates, a topic of great interest to the participants, as many of them need these documents to apply for social benefits.

It is important to emphasize that understanding the shared responsibility between users and mental health professionals is essential for the full exercise of patients' rights. Developing skills so that patients can participate more actively in their treatment necessarily involves reflecting on their health rights.[41]

6TH MEETING: MEDICATIONS

The group was asked about the participants' relationship with the use of medications throughout their lives. Most of the participants had been using psychotropics for a long time, as reported by the patient who began treatment "*since she was a child*" and has already undergone several changes of medication, stating that "*she has taken everything, and some were better than others*". Both chronic use and frequent changes in drug prescriptions are realities present in current psychiatry, frequently questioned by several authors.[4,43] Similar reports were found among participants in the GAM Group held at CAPS II in Montes Claros, MG.[29]

When asked about the effectiveness of the treatment, all participants reported feeling better. However, some expressed dissatisfaction with the constant changes in medication, demonstrating a certain preference, especially for anxiolytics. This preference is corroborated by the literature, which indicates greater rejection of antipsychotics, mainly due to their side effects. In the study by Paranhos et al. (2023), the participants in the GAM Group emphasized the importance of knowledge and access to information about treatment, as ways of promoting greater patient adherence and autonomy in the co-management of their treatment.[29] By providing clear and practical information on the use of medications, the Guide helps to empower patients, facilitating the management of their health condition autonomously, but always within the context of appropriate professional monitoring. This process can contribute to greater confidence in one's health and ability to make informed decisions, improving patients' quality of life.[43]

Polypharmacy is a common practice in the prescriptions of the participants in this study. This phenomenon is not exclusive to psychiatry, but is present in various areas of medicine.[33,34] A more open relationship between the professional and the patient favors the individualization of treatment, contributing to the reduction of side effects. However, this model of mental care often faces challenges due to the discontinuity in professional relationships, resulting from the high turnover of psychiatrists in CAPS.[26]

Most participants did not have direct access to their medications, and many did not have a thorough understanding of their pharmacotherapy, with those responsible for storing and administering the medications mostly being family members or caregivers. GAM advocates that users have the right to information and the ability to adapt their treatment to their needs.[27] The GAM process is not limited to providing technical information about medicines; it should be approached more comprehensively, considering how people interpret their experiences of suffering and the use of medicines. The aim is to facilitate dialogue and cooperation with health professionals, mental health professionals, friends, and family, in a joint search for the best ways to deal with problems and symptoms.[30]

A basic explanation was given about the main classes of psychotropics and their most common medications. The group demonstrated difficulties in understanding due to the complexity of the subject. In psychiatry, the same medication can be used for different clinical conditions, reacting differently in each patient, which generated many doubts about indications and adverse effects.[4,33] The importance of following the correct administration of medications on an ongoing basis was also highlighted to ensure the effectiveness of the treatment. Medications promote mental stability, but constant monitoring for drug interactions and excessive use is essential. Therefore, both the physician and the multidisciplinary mental health team must clarify any doubts about the therapy, providing greater autonomy to the patient concerning their therapeutic plan.[26]

The main objective of this meeting was to guide participants on how to obtain information about their medications and treatments, given the complexity of the topic. To this end, different leaflets were distributed to each participant, and together the information contained in them was identified. The

difficulty in reading and understanding the leaflets was expected, and the importance of consulting a health professional, such as a pharmacist, for additional clarification was highlighted. In addition, the most common types of prescriptions dispensed at CAPS were discussed, by Ordinance 344 and its regulations.[44] This clarification was very helpful, as many participants did not understand why medications were so controlled. According to del Barrio et al. (2013), physicians and other mental health professionals should be encouraged by the GAM approach, as it assumes that the patient is taking an active role in their care.[30] However, studies point to the dissatisfaction of CAPS professionals with psychiatrists due to the difficulty in communication and superficiality in care, which is often brief and not very in-depth.[45] This reinforces the need to use tools such as GAM, so that communication and the quality of this consultation improve.

7TH MEETING: OTHER THERAPEUTIC APPROACHES

At the last meeting, the last part of GAM-BR, which deals with other therapeutic approaches, was discussed. For this moment, the “Corridor of Sensations” dynamic was prepared, where each user entered blindfolded, one at a time, guided by the facilitator. The first stage was a corridor made up of crepe paper blinds and dry leaves scattered on the floor. The user was then led to a chair, where her feet were immersed in a basin of marbles. After some time, she was led to the table, where she was encouraged to handle the gelatinous mass (Amoeba®). Finally, she sat in another chair, where her feet were bathed. After this sequence, the participants opened their eyes, shared their experiences, and discussed their perceptions.

The most common feedback from users was that they all felt very cared for and valued, something they had never experienced before. Many reported that they were able to relax and trust, which was essential to the success of the activity. This feeling of trust was particularly important because the activity required trust in the facilitator so that the patient could relax and enjoy the experience. This result is a positive reflection of the work carried out by the Group, as trust is built over time, especially through the relationship established during meetings. It is a fundamental instrument in mental health care, being the essential link for the therapeutic process.[12]

During the meeting, participants were also asked whether they could identify other forms of care at CAPS. Although they encountered some difficulty, with the support of the facilitators, they began to talk about groups and workshops, in addition to individual care. From this, a presentation was made on the importance of therapeutic approaches beyond medication. CAPS has a multidisciplinary team that offers several therapeutic alternatives, and these practices must be recognized and valued by service users.

The topic of integrative and complementary therapies, in addition to traditional and community therapies, was also discussed. Some of these practices emerged in the users' statements, such as the use of medicinal plants (through teas and baths), music, interpersonal relationships, physical activity, and participation in churches or community groups. These practices play an important role, as they encourage patient autonomy, decentralizing the relationship with health professionals and the CAPS. In this context, users can redefine the role of medication in their treatments. Although medication plays an important role in controlling symptoms, it is essential to recognize the coexistence of other therapeutic approaches in this process.[26]

At the end of the last meeting, a joint assessment of the GAM Group and the entire process was carried out. For the participants, the bonds created were the most striking aspect. Many said: "*I made friends in the GAM group*", or "*we became a family*." Furthermore, discussing such close social issues as race, gender, and society was essential for self-knowledge and the development of greater autonomy.

Phrases such as "*now I know I can talk to the* physician", "*during the consultation, I will talk more about how I feel*", and "*I want to change my medication at the next consultation*" demonstrated the results achieved with the application of the Guide.

Finally, the GAM group proved to be transformative for the participants, as the medication became just another element in their lives. Although it is important, the medication cannot be the limiting factor. The users also highlighted the need to speak out more to their physicians about the problems they face with the use of prescribed medications and to participate more actively in choosing their treatments.

(2) DIFFICULTIES IN WORKING ON PATIENT AUTONOMY IN MENTAL HEALTH

Since it is a tool that is still little used in Brazil, the proposal to apply GAM-BR with users of this CAPS III was innovative, especially when relating to patient autonomy and co-management of medication treatment. At CAPS, as in other health services, treatment is usually centered on the use of medications, with the decision to prescribe being the responsibility of the psychiatrist. The clinician rarely shares responsibility for therapeutic decisions with other members of the health team.[46,47] Furthermore, as evidenced in the reports collected and in other studies, family members themselves often distrust the narratives of patients with mental disorders, due to characteristics specific to the disease, which hinders the development of autonomy.[26]

This lack of trust in the narratives of CAPS users compromises the integration between patient, physician, and multidisciplinary team, harming the comprehensiveness of treatment.[48] According to Peralta et al., for the pharmaceutical industry to expand its business, the emergence of new patients is essential, and the physician plays a key role in this. According to the authors, medical prescriptions give professionals greater control over patients.[4]

The CAPS Pharmacy Service is responsible for the dispensing and logistics of medications, a high-demand task that limits the in-depth clinical work of this professional with patients and prescribers, although this does happen in some situations. However, the pharmacy service is unable to provide comprehensive individualized pharmaceutical monitoring due to the shortage of professionals in the area, both in the CAPS studied and in other services of the city's Psychosocial Network. In many cases, there is not even a pharmacy or pharmacist integrated into the multidisciplinary team. The nursing team, in turn, is responsible for administering and monitoring the use of medications by patients, but has limited interaction with problems related to medication treatment. The space for multidisciplinary discussions about medication treatment is limited, especially because prescribers rarely participate in these discussions. Thus, the introduction of GAM-BR, which proposes sharing therapeutic decisions between the prescriber, the multidisciplinary team, the patient, and their support network, contrasts with the current reality found in treatment practices.

(3) WORKING WITH THE GAM GUIDE: ADAPTING THE GUIDE TO THE GROUP'S REALITY

The application of the GAM-BR methodology faced several difficulties, especially due to the social and cultural differences between the original context, in Canada, and the adaptation for Brazil.[9,10] However, as GAM-BR itself highlights, the guide is a proposal that must be adapted to the reality and profile of each group.[26,30,49] This innovative approach was well received by users of the service, promoting creative use that respects local sociocultural characteristics, while maintaining the fundamental principles of the methodology.[50]

To ensure the most effective application of the Guide, it was necessary to consider the social reality of the place where the CAPS is located. Aracaju, one of the Brazilian capitals with the greatest social inequality, is no different from the reality of many other cities in the country.[51] The North Zone, where the CAPS is located, has an average *per capita* income of around R$500.00,[52] with the population facing high levels of economic vulnerability.

Furthermore, Brazil's educational profile is markedly different from that of Quebec. According to the Programme for International Student Assessment,52 Canada is among the ten best countries in the world in terms of education, while Brazil occupies one of the last positions among the countries participating in the Organization for Economic Co-operation and Development (OECD). At the national level, the educational disparity between the southern and southeastern regions and the northern and northeastern regions of Brazil is evident. According to data from the National Household Sample Survey (*Pesquisa Nacional por Amostra de Domicílio*, PNAD), released by the IBGE in 2022,[51] approximately 38.7% of the northeastern population over the age of 14 did not complete elementary school. In the municipal context, neighborhoods in the northern zone, such as Porto Dantas, Japãozinho, Palestina, among others, are points with high social vulnerability, with families living in precarious conditions, marked by high rates of illiteracy and low education, reflecting the significant social inequality in the city.[53]

(4) PRACTICAL IMPLICATIONS: CORRESPONSIBILITY IN TREATMENT

The changes observed in the behavior of patients participating in the Guide were evident throughout the weeks of the workshops and continued to manifest themselves after the end of the study. Patients began to demonstrate greater responsibility in monitoring their health conditions, questioning more frequently about medication treatments, asking about which medications they were taking and their purposes, for example. Many participants began to request a review of their Individualized Treatment Plan (ITPs), to adapt them to their preferences and routines. This movement required greater availability and attention from the service team, ensuring more rigorous monitoring and assessment of the effectiveness and safety of the implemented changes. Furthermore, greater socialization was observed among group members, as well as greater interaction with other service users, in addition to more intense engagement in workshops and other activities carried out at CAPS.

Patients must be properly instructed to understand the importance of adherence to treatment, the correct time to take medication, the recommended dosages, as well as adverse effects and possible drug interactions. Educational programs are essential for patients to learn how to read and interpret medication leaflets, understand interactions between them, and recognize signs of adverse effects.[54] The application of the GAM Guide may require the use of supporting technologies, such as health monitoring applications, home measurement devices, and communication platforms between patients and healthcare professionals.

Autonomous medication management transforms the dynamic between patient and health professional, moving from a paternalistic approach to a more collaborative and co-responsible one. This model of health promotion can improve patients' quality of life, as they have more control over their treatment.[55] The implementation of the Autonomous Medication Management Guide has brought significant implications for both patients and healthcare professionals. While it offers benefits such as patient empowerment and reducing the burden on the healthcare system, it also requires considerable commitment to education, ongoing monitoring, and the efficient use of technology to ensure the safety and efficacy of treatment.

CONCLUSION

The GAM is an effective and viable strategy to be implemented in a variety of contexts and health services, proving to be a valuable tool for encouraging patients to reflect on their health conditions and treatments. Despite having been developed and adapted in a different context, the GAM incorporates terms and methodologies that can be replicated in other realities. The innovative content of the Guide should be integrated into mental health services as a tool to boost psychiatric reform.

The difficulties observed in the group studied, such as understanding the rights and duties of SUS users, the need for greater participation in decision-making about the prescribed treatment, the handing over of guardianship without the development of autonomy, stigma, and fragile social relationships, can be generalized to the majority of CAPS users. The active participation of patients and their families and/or caregivers in the treatment process should be an ongoing practice in mental health services, pursued by prescribers and multi-professional teams, so that users develop autonomy and become co-directors of their treatment.

Health promotion is a concept that goes beyond the treatment of diseases and is fundamental to improving quality of life and preventing adverse health conditions. By stimulating patients' autonomy and encouraging their active participation in the care process, as seen in the GAM strategies, a comprehensive and continuous approach to mental health is promoted. In this sense, health promotion involves not only health education, but also the creation of environments that favor self-care, the strengthening of support networks, and the reduction of the social determinants of health. In contexts such as CAPS, health promotion is essential for patients to feel empowered and able to make informed decisions about their treatment and well-being, contributing to building a healthier society.

The main difficulty encountered by the group of women in this study was their low level of schooling, which results in reduced health literacy. These difficulties are perceived differently between users of CAPS AD and those of other CAPS, as shown by various published studies. Patients with mental disorders, due to the characteristics of their illnesses, are often under-stimulated and over-tutored, which makes it difficult for them to seek health information and other needs.

Despite the challenges presented by the participants in the GAM group, there was a noticeable increase in awareness of their rights as service users, an understanding of the importance of talking to the psychiatrist about the effects of medication to minimize adverse effects, and greater participation in workshops and other forms of therapy offered at the CAPS at the end of the group's activities. Greater integration among prescribers, teams, and users is essential, so that the treatment is understood and followed by the patient, which can increase adherence and the effectiveness of medication treatment. In addition, it is important to ensure more personalized care, according to the specific needs of each patient concerning their treatment. Qualified listening and individualized follow-up contribute to improving patients' clinical conditions, facilitating a better quality of life, and promoting healthier habits.

As future prospects, the continued implementation of strategies such as GAM in mental health services could increase patient autonomy and strengthen psychiatric reform, providing more humanized and efficient treatment. Limitations include the small sample size and the possibility of bias due to the lack of control of external variables, such as the participants' level of education, which can affect their understanding of the content covered. In addition, the generalization of the results to other realities needs to be done with caution.

REFERENCES

1. Silva GAD, Cardoso AJC, Bessoni E, Peixoto AC, Rudá C, Silva DV, et. al. Deinstitutionalization and autonomy: outcomes from a Brazilian mental health policy. Ciência e Saúde Coletiva. 2022;27(1):101-110. https://doi.org/10.1590/1413-81232022271.19872021
2. Mendonça SM. Dignity and autonomy of patients with mental disorders. Revista Bioética. 2019;27(1):46-52. https://doi.org/10.1590/1983-80422019271285
3. Almeida IS, Campos GWS. Analysis of the implementation of a Mental Health network in a major city. Ciência e Saúde Coletiva. 2019;24(7):2715-2727. https://doi.org/ 10.1590/1413-81232018247.20122017
4. Peralta PEC, Nascimento AKC, Santiago E. Medicalization, mental health and biopower: an integrative review. Saúde e Pesquisa. 2023;16(2):1-19. https://doi.org/10.17765/2176-9206.2023v16n2.e11360
5. Brasil. Agencia Senado. Após 20 anos, reforma psiquiátrica ainda divide opiniões. Senado Notícias, 2021a. https://www12.senado.leg.br/noticias/materias/2021/04/06/apos-20-anos-reforma-psiquiatrica-ainda-divide-opinioes
6. Oliveira JRF, Varallo FR, Jirón M, Ferreira IML, Siani-Morello MR, Lopes VD, et. al. Consumption of psychotropic medications in primary healthcare in Ribeirão Preto, São Paulo State, Brazil. Caderno de Saúde Pública, 2021;37(1):e00060520. https://doi.org/10.1590/0102-311X00060520
7. Campos CFC, Fígaro R. The medical-patient relationship under the light of communication and work. Revista Brasileira de Medicina da Família e Comunidade. 2021;16(43):2352. https://doi.org/10.5712/rbmfc16(43)2352
8. Defante MLR, Monteiro SON, Silva CO, Santos LR, Leonardo RS. The impacts of inadequate communication on the physician-patient relation. Revista Brasileira de Educação Medica. 2024;48(1):e007. https://doi.org/10.1590/1981-5271v48.1-2023-0146
9. del Barrio LR, Corin E, Poirel ML. Le point de vue des utilisateurs sur l'emploi de la médication en psychiatrie: une voix ignorée. Revue Québécoise de Psychologie. 2001;22(2):1-23, 2001. https://www.rrasmq.com/publications/RevueQPsy_2001_voix_ ignoree .pdf
10. Campos RTO, Palombini AL, Silva AE, Passos E, Leal EM, Serpa ODJ, et. al. Multicenter adaptation of the guide Autonomous Management of Medication. Interface Comunicação Saúde e Educação. 2012; 16(43):967-80. https://doi.org/10.1590/S1414-32832012005000040
11. Hernández-Holguín DM, López BEA, Martínez-Hernáez A. Collective mental health: a review of the concept in the academic literature of Brazil, Colombia and Spain. Saúde e Sociedade. 2023;32(3):e210693. https://doi.org/10.1590/S0104-12902023210693es
12. Medeiros WS, Londero MFP, Amorim AKMA. Northeastern Nomad Care Trails Between GAM and Harm Reduction. Revista Polis e Psique. 2023;13(2):97-116. https://doi.org/ 10.22456/2238-152X.126902
13. Renault L, Passos E. Do isolamento à cogestão: a Gestão Autônoma da Medicação (GAM) com Familiares. Psicologia: Ciência e Profissão. 2022;42, e235329. https://doi.org/ 10.1590/1982-3703003235329
14. Gonçalves LG, Caliman LV, César JM. Participação Infantil no Cuidado em Saúde Mental: Um Grupo GAM no CAPSi Psicologia: Ciência e Profissão. 2021;41:e223921. https://doi.org/10.1590/1982-3703003223921
15. Jetté C, Bergeron-Gaudin JV. Innovation sociale et travail institutionnel : le rôle des organismes communautaires dans l'évolution des politiques sociales au Québec Canadian Journal of Nonprofit and Social Economy Research. 2020;11(1):43-61. https://doi:10.29173/cjnser.2020v11n1a329
16. Association des Groupes D'intervention en Défense des Droits en Santé Mentale du Québec (AGIDD-SMQ) Mon guide personnel gestion autonome de la médication em santé mentale. 2025 https://www.agidd.org/publications/mon-guide-personnel-gestion-autonome-de-la-medication-en-sante-mentale/

17. Société Québécoise de Schizophréni. Conférence Virtuelle SQS - La Gestion Autonome de la Médication en Santé Mentale. 2025. https://www.schizophrenie.qc.ca/fr/evenements/detail/ grand-public-conference-virtuelle-sqs-la-gestion-autonome-de-la-medication-en-sante-mentale/66228
18. Regroupement des Ressources Alternatives em Santé Mentale du Québec. La Gestion autonome de la médication. 2025. https://www.rrasmq.com/gam/
19. Serrano-Miguel M, Silveira M, Palombini AL. The Guide for Autonomous Management of Medication: a Brazilian experience of social participation in mental health. Revista de la Asociación Española de Neuropsiquiatría. 2016;36(129):157-170. https://doi.org/ 10.4321/S0211-57352016000100010.
20. Avarca CAC, Serrano-Miguel M, Vicentin MCG, Martínez-Hernáez A. The autonomous medication management (AMM) model as a generator of autonomy in mental health care. Interface Comunicação, Saúde, Educação. 2022;26:e210506. https://doi.org/ 10.1590/interface.210506
21. Alegre-Agís, E., García-Santesmases, A., Pié-Balaguer, A. Martínez-Hernáez A, Bekele D, Morales-Sáez N, et al.. Unraveling Reactionary Care: The Experience of Mother-Caregivers of Adults with Severe Mental Disorders in Catalonia. Cult Med Psychiatry 47, 790–813 (2023). https://doi.org/10.1007/s11013-022-09788-z
22. Martínez-Granados F, Briones-Vozmediano E, Ronda E. Living with psychotropic drugs: A community photovoice study in people with high treatment adherence in Southeastern Spain. Salud Colectiva. 2024;20:e5090. https://doi.org/10.18294/sc.2024.5090
23. Wu T, Xiao X, Yan S, Fang Y, Wang M, Zu F, et al. Digital health interventions to improve adherence to oral antipsychotics among patients with schizophrenia: a scoping review. BMJ Open. 2023;13:e071984. http://orcid.org/0000-0001-6798-41101
24. Loots E, Goossens E, Vanwesemael T, Morrens M, Rompaey B, Dilles T. Interventions to Improve Medication Adherence in Patients with Schizophrenia or Bipolar Disorders: A Systematic Review and Meta-Analysis. International Journal of Environmental Research and Public Health. 2021;18(19):10213. https://doi.org/10.3390/ ijerph181910213
25. Campos RTO, Palombini AL, Passos E, Gonçalves LLM, Santos DVD, Melo SSJ, et. al. Gestão Autônoma da Medicação: Guia de Apoio a Moderadores. DSC/FCM/UNICAMP; AFLORE; DP/UFF; DPP/UFRGS, 2014, 44p. http://www.fcm.unicamp.br/fcm/laboratorio-saude-coletiva-e-saudemental-interfaces
26. Jorge MSB, Campos RTO, Pinto AGA, Vasconcelos MGF. Experiments with autonomous management of medication: narrative of mental health users in focus group meeting in psychosocial care centers. Physis Revista de Saúde Coletiva. 2012;22(4):1543-1561. https://doi.org/ 10.1590/S0103-73312012000400015
27. Palombini A. Pasini V, Zanchet L, Bongiovanni J, Zambillo M, Guerra SZ, et. al. Autonomy and Rights Exercise in Autonomous Management of Medication Experience. Psicologia Ciência e Profissão. 2020;40(e190411):1-13. https://doi.org/10.1590/1982-3703003190411
28. Favero CP, Rodrigues J, Silva IP, Santos DVD, Barroso TMMDA, Barbosa SS, et al. Autonomous medication management group in a psychosocial care center: participants' experience. Referência Revista de Enfermagem. 2019;4(21):91-100. https://doi.org/ 10.12707/RIV19002
29. Paranhos ICM, Pires RCJ, Sampaio TLA, Barbosa LC, Rocha LA, Souza IF, et. al. Autonomy in relation to psychopharmacological treatment: perceptions of users of a Psychosocial Care Center. Peer Review. 2023;5(18):1541-1389. https://doi.org/ 10.53660/929.prw2523
30. del Barrio LR, Cyr C, Benisty l, Richard P. Gaining Autonomy & Medication Management (GAM): new perspectives on well-being, quality of life and psychiatric medication. Ciência & Saúde Coletiva. 2013:18(10):2879-2887. https://scielosp.org/ article/csc/2013.v18n10/2879-2887/

31. Veloso LM, Noronha EM, Barbosa LR, Sampaio TLA, Pires RCJ, Rocha LA, et. al. Autonomy and care in mental suffering: ananalysis of the insertion of the GAM strategy in a CAPS in the North of Minas Gerais. Peer Review. 2023;5(21):1541-1389. https://doi.org/ 10.53660/1075.prw2629
32. Sun L, Mi K, Hou Y, Hui T, Zhang L, Tao Y, et al. Pharmacokinetic and pharmacodynamic drug-drug interactions: research methods and applications. Metabolites. 2023;13(8):897(1-17). https://doi.org/10.3390/metabo13080897
33. Caldas ALL, Sá SPC, Oliveira VDCF. Perceptions of pharmaceutical services among elderly people on polymedication. Revista Brasileira de Enfermagem. 2020;73(5):e20190305. https://doi.org/10.1590/0034-7167-2019-0305
34. Rolim CHS, Carneiro RG, Araújo FJ. Analysis of the consumption of psychotropic drugs in Basic Health Units. Revista Contexto & Saúde. 2023;23(47):e13272. https://doi.org/ 10.21527/2176-7114.2023.47.13272
35. Oliveira-Macedo S, Almeida HB. Salve Quebradas! Raça, Educação e Articulações Feministas na Periferia de São Paulo. Dissertação (Mestrado). Biblioteca Digital USP. 2021, 186p. https://doi.org/10.11606/D.8.2021.tde-12112021-134026
36. Kantorski LP, Cardano M. Open Dialogue: the finnish experience and its contributions. Saúde & Debate. 2017;41(112):23-32. https://doi.org/10.1590/0103-1104201711203
37. Borges CD, Faria GJ. Social networks and mental health care: a literature review. Revista de Psicologia da IMED. 2017;9(1):159-174. https://doi.org/10.18256/2175-5027.2017.v9i1.1798.
38. Domingues MARC. Mapa Mínimo de Relações: adaptação de um instrumento gráfico para configuração da rede de suporte social do idoso. 2000. Dissertação (Mestrado) – Universidade de São Paulo, São Paulo, 2000. https://repositorio.usp.br/item/001098121
39. Sluzki CE. La red social: frontera de la practica sistêmica. 1º ed. Casa do Psicólogo. São Paulo, 1997, 145p. ISBN:9788585141776
40. Boska GA, Oliveira MAF, Seabra P. Integrated embracement in Psychosocial Care Centers for Alcohol and Drugs in the perspective of the protection of human rights. Ciência & Saúde Coletiva. 2022;27(6):2417-2426. https://doi.org/10.1590/1413-81232022276.17692021
41. Santos DGPML, Silva FP, Guedes TG, Ventura CAA, Silva RA, Frazão IS. Guide to the autonomous medication management as an educational tool for nurses in psychosocial care. Enfermagem em Foco. 2023;14:e-202371. https://doi.org/10.21675/2357-707X.2023.v14.e-202371
42. Brasil. Ministério da Saúde. Os direitos e deveres dos usuários da saúde. Portaria nº 1.820, de 13 de agosto de 2009. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2009/ prt1820_13_08_2009.html
43. Shamsuddin SMS, Ahmad N, Sutan R, Ibrahim R. The role of self-efficacy towards health-promoting lifestyle among patients with non-communicable disease: a systematic literature review. BMJ Yale. 2025;6:1-19. https://doi.org/10.1101/2025.01.05.25320027
44. Brasil, Ministério da Saúde. Regulamento Técnico sobre substâncias e medicamentos sujeitos a controle especial. Portaria nº 344 de maio de 1998. https://bvsms.saude.gov.br/bvs/saudelegis/svs/1998/prt0344_12_05_1998_rep.html
45. Medeiros WS, Londero MFP, Amorim AKMA. Northeastern Nomad Care Trails Between GAM and Harm Reduction. Revista Polis e Psique. 2023;13(2):97-116. https://doi.org/10.22456/2238-152X.126902
46. Rocha DAS, Batista DCA. The deprescription process of benzodiazepines with emphasis in its use and dependence. Revista Multidisciplinar do Sertão. 2023;S2(1):S108-S116. file:///C:/Users/User/Downloads/510-Texto%20do%20artigo-955-1-1020230106 %20(2).pdf
47. Megiani IN, Peruche PRCM, Silva BNR, Trento SDSF, Trento RDSF, Fernandes JMDS. Equipes multidisciplinares: trabalho profilático na assistência médica e psicossocial. Revista Corpus Hippocraticum. 2023; 1(1):1-11. file:///C:/Users/User/Downloads/

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48. Melo APS, Bonadiman CSC, Andrade FM, Pinheiro PC, Malta DC. Depression Screening in a population-based study: Brazilian National Health Survey 2019. Ciência & Saúde Coletiva. 2023;28(4):1163-1174. https://doi.org/10.1590/1413-81232023284.14912022
49. Palombini A, del Barrio LR. Gaining Autonomy & Medication Management, from Quebec to Brazil: a participatory commitment. Saúde em Debate. 2021;45(128):203-15. https://doi.org/10.1590/0103-1104202112816
50. Ferrer AL, Palombini A, Azambuja M. Autonomous Medication Management: a look over ten years of participative mental health production from Brazil. Revista Polis e Psique. 2020; 10(2):1-8. https://seer.ufrgs.br/index.php/PolisePsique/article/view/ 105275/57653
51. Brasil. Instituto Nacional de Estudos e Pesquisas Educacionais Anísio Teixeira-Inep. Programa Internacional de Avaliação de Estudantes (Pisa), 2021. https://www.gov.br/inep/pt-br/areas-de-atuacao/avaliacao-e-exames-educacionais/pisa
52. Brasil. IBGE: Instituto Brasileiro de Geografia e Estatística. Pesquisa Nacional por Amostra de Domicílios Contínua: Educação, 2023, 16p. https://biblioteca.ibge.gov.br/ index.php/biblioteca-catalogo?view=detalhes&id=2102068
53. Brasil, Prefeitura Municipal de Aracaju, Secretaria Municipal da Família e da Assistência Social. Mapografia Social do Município de Aracaju, 2019, 51p. https://www.aracaju.se.gov.br/userfiles/observatorio/arquivos/OSERVATORIO-Mapografia-Social-de-Aracaju-para-o-Observatorio-Social-final.pdf
54. Waqas A, Correia JC, Ahmad M, Akhtar TN, Meraj H, Angelakis I, et al. Therapeutic patient education for severe mental disorders: A systematic review. Global Mental Health. 2024;11:e78. https://doi.org/10.1017/gmh.2024.68
55. Kim SK, Park SY, Hwang HR, Moon SH, Park JW. Effectiveness of Mobile Health Intervention in Medication Adherence: a Systematic Review and Meta-Analysis. Journal of Medical Systems. 2025;49(1):13. https://doi.org/10.1007/s10916-024-02135-2