

## Health care for adolescents who are susceptible to drug use

### *Cuidado em saúde ao adolescente em vulnerabilidade ao uso de drogas*

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**ABSTRACT** This article deals with adolescences, in the plural, as a socio-historical construction of a dynamic process and with the experience of adolescents with their lifestyle and self-expression in a unique socio-historical context. It assumes that purely prescriptive measures are insufficient to address the complexity of mental illness processes in contemporary society. This study aims to understand the context of health care practices for vulnerable youth, particularly those involved in substance use, through the lens of tensions in health practice domains. This is an exploratory, descriptive study using a qualitative approach, with interviews conducted with health professionals (in Basic Health Unit and Psychosocial Care Center for Children and Adolescents). The study highlights the tensions within health practice between the biomedical model and the war on drugs and a community-based psychosocial approach; it underlines the need for reducing stigmatization, improving access, harm reduction, and individualized care. It also emphasizes the importance of considering and promoting a shift in mentality towards mental illness in order to develop care strategies. This process was carried out in line with the principles of the Brazilian Mental Health Reform, with advances and setbacks that affect the updating of health practices, which are more oriented towards proposals for psychosocial and vulnerability-reducing actions.

**KEYWORDS** Adolescents. Recreational drug use. Health vulnerability. Mental health.

**RESUMO** *Este artigo trata das adolescências, no plural, como construção histórico-social de um processo dinâmico, e do adolescente perante seus modos de vida e expressão em um contexto histórico-social e singular. Entende-se aqui que ações meramente prescritivas são insuficientes para responder às complexidades dos processos de adoecimento mental na sociedade contemporânea. Objetivou-se compreender o contexto das práticas de cuidado em saúde ao adolescente em vulnerabilidade, diante do uso de drogas, na dimensão das tensões dos campos de práticas do cuidado em saúde. Estudo descritivo exploratório de abordagem qualitativa, que realizou entrevistas com profissionais da área da saúde (Unidade Básica de Saúde e Centro de Atenção Psicossocial Infantojuvenil). Destacam-se as tensões no campo de práticas entre o modelo assistencial biomédico e de guerra às drogas versus o psicossocial/comunitário; redução de estigma; acesso; redução de danos e nos atendimentos individuais, bem como a importância de refletir e fomentar o processo de mudança da mentalidade diante do adoecimento mental, visando atualizar as formas de cuidar. Esse processo tem sido realizado conforme os princípios da Reforma Psiquiátrica Brasileira, com avanços e retrocessos que repercutem na atualização das práticas de cuidado em saúde mais alinhadas às propostas de ações psicossociais e redutoras de vulnerabilidade.*

**PALAVRAS-CHAVE** Adolescentes. Uso recreativo de drogas. Vulnerabilidade em saúde. Saúde mental.

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## Introduction

We start by assuming that there are adolescences, in the plural, because the concept is constructed as a contemporary and complex socio-cultural phenomenon, distinct from the purely biological, age-related, normalizing and homogenizing aspects that surround adolescence, thus contributing to a unique understanding of the subject of adolescence<sup>1-5</sup>.

During adolescence, several situations are experienced for the first time with great curiosity, intensity, and creativity. These new and different experiences are made possible by their social and cultural environment, which gives the way of life and lifestyle unique characteristics<sup>6-8</sup>.

The way healthcare is organized for this population is currently being restructured and some efforts have been made to support these practices, such as the adolescent and youth care line in the Unified Health System (SUS) in the state of São Paulo<sup>9</sup>. This new approach assumes that the care process considers the subject in its entirety, in a biopsychosocial way, permeated by the ways of living and working, i.e. influenced by the economic, cultural, and social conditions. Health practices are always plural and contribute to a continuous and dynamic understanding of this complexity and integrity of the singular and collective subject<sup>10</sup>.

To develop a care plan for young people in vulnerable situations – in line with the SUS (especially with regard to comprehensiveness) with the Psychosocial Care Network (Raps) and with Harm Reduction (HR) strategies – the Singular Therapeutic Projects (PTS) in accordance with the theory of vulnerability in healthcare have far-reaching and potentially more effective measures, as they understand the disease process in a complex and interconnected way through the situations experienced by adolescents, emphasizing here the complexity related to the use or vulnerability to the use of alcohol and other drugs.

Vulnerability is understood in terms of three dimensions or components: individual, social, and programmatic, which are interconnected and interdependent. Vulnerability theory in public health provides tools to analyze the complex and diverse realities experienced by subjects that make up population health and disease processes<sup>11-13</sup>.

The concept of vulnerability in health has expanded in the face of the crisis process of biomedical care practice. Purely prescriptive measures are not sufficient to respond to the complexity of the mental illness processes of the population in today's society. The subject in need of health care is seen as an actor in their own lives who must go beyond their 'willpower' to grasp the information about what they 'should' or 'can' do in terms of vulnerability-reducing behaviors<sup>11-13</sup>. Thus, the aim of this study was to understand the context of health care practices for young people vulnerable to drug use, in the dimension of tensions in health care practices and individual care.

## Material and methods

This is an exploratory, descriptive study with a qualitative approach using discourse content analysis<sup>14</sup>, the product of a PhD thesis. The three areas with the highest youth vulnerability index in the eastern zone of the capital of São Paulo were selected – a Center for Psychosocial Care of Children and Adolescents (Caps IJ) and a Basic Health Unit (UBS) in each of the areas. Semi-structured online and individual interviews were conducted, lasting an average of 40 minutes, recorded and transcribed.

The following people participated in the study: nine professionals, all female and between 35 and 47 years old, six of whom work in Caps IJ and three in UBS. Regarding the educational background of the participants, there were four social workers, one occupational therapist, one nurse, two psychologists,

and one pedagogue who works as a journalist. The analysis of the data obtained was carried out in three phases: preliminary analysis, exploration of the material, and processing of the results: inferences and interpretation. We tried to understand the meaning of the communication and above all looked for secondary meaning or message that could be seen through or alongside the first one.

The preliminary analysis included the first contact with the material, its organization and operational definitions, and the systematization of ideas, developing an analysis plan. The material was organized, analyzed, and once in possession of the content, the following operational sequence was carried out: float reading; selection of documents; formulation of hypotheses and objectives, referencing of indexes; and preparation of the material to be analyzed<sup>14</sup>. The data presented in this article refer to the axis of analysis related to adolescent health care practices within the field of health care practices. The category presented refers to the practices in the care relationship with adolescents with vulnerability to drug use. The subcategories were: the scenario of practices based on the biomedical and asylum model versus psychosocial and community practices; war on drugs versus harm reduction; stigma; access; individual care; and understanding different patterns of use and motivations for use. The research was approved with the CAAE 30166520.4.0000.5505 and opinion 4.072.119.

## Results and discussion

Since the health reform, the health care model in Brazil has been subject to tensions that question biomedical practices. Because they are often costly and not very solution-oriented, they focus on the ailments themselves and intervene in the effect, not the cause<sup>15</sup>.

In Brazil, there is a historically evolved, hospital-centric model of care for the mentally ill that has led to enormous

marginalization and stigmatization of these people. These practices are shaped by notions of the medical-moral model, which has consolidated psychiatric treatment with an emphasis on medication and discipline, implying mistreatment, coercion, and neglect, depriving those affected of their autonomy. The concept of mental illness, which has its roots in this model of care, focuses on the illness, the medicine, the hospitalization, the doctor, and the obedience<sup>16</sup>.

Psychosocial practices conceptualize mental illness as a biopsychosocial phenomenon that aims to understand the person who becomes ill as unique and influenced by their environment and relationships. The care practices to be developed therefore take into account the completeness and uniqueness of the person and integrate into this understanding the different dimensions of their life, such as the family, social, community, economic and cultural context<sup>11</sup>.

Professionals report that they find themselves in a crisis related to health care practices characterized by a striking duality that puts tension between the models of biomedical care and psychosocial care, with a demand (social and family) in which the logic of hospitalization prevails.

*E2: The challenge has to do above all with the request for hospitalization. This culture comes from the fact that the teenager or child has to be placed in a group and you are only in a hospital environment with other people providing care without giving the person any autonomy. When we talk about Caps' proposal for support, we are opposing this idealization of hospitalization and being free. So it's a very unequal fight, and then we say to the family: 'Let's get to work', and the family says: 'I'm very tired, I'd rather he was somewhere else'.*

This 'somewhere else' is a place of internment, closed and 'far' from the social reality of the teenager's lifestyle. The hospital

context or a closed institution is an ‘artificial’ place, as it does not represent the real challenges that this adolescent faces in his community and that characterize the geographical and existential conditions. This allows us to affirm that a departure from this reality, i.e. from situations that make one vulnerable, is not sufficiently taken into account or dealt with during hospitalization and that, once discharged, the teen returns to his environment with all the situations that make him vulnerable. Thus, he becomes disconnected from care practices that are more effective in developing healthier behaviors and attitudes. It is important to emphasize that in the care and monitoring of young people, it is crucial to know how they use drugs or even the ‘what for?’, ‘why?’, ‘how?’ dimensions in their lives in order to develop ways of tailoring care to their needs and what makes sense to them, through participatory health education strategies with an emancipatory intent<sup>17,18</sup>.

It is therefore necessary to observe, develop, and prepare projects through practical measures that concretely change living conditions through psychosocial interventions that are tailored to the needs of adolescents and enrich them personally and socially<sup>19</sup>.

The area of health practices for adolescents operates within this field of tension. In the following subcategories, analyses are presented to enable health professionals to carry out care and monitoring processes for adolescents in order to build interventions and a caring relationship that are more aligned with the biopsychosocial model.

Anti-asylum resistance and activism become particularly important. In the face of several situations that are seen as an attack on the already consolidated achievements of national mental health policies and the resulting setbacks in health practices that hinder the progress of the psychosocial model, it is particularly important to resist and advocate for the person, protect their rights, and offer health practices that are aligned with the psychosocial model.

## War on Drugs versus Harm Reduction

Given the contextualization of the scenario of practices in the care of drug users, one of the challenges lies in the practices anchored in the understanding of the war on drugs model that results from a set of moralistic and prohibitionist conceptions of drug use that blame the subject and assign to him/her exclusively the decision to stop using drugs, that is, the ‘success’ of the treatment is understood when (and only when) abstinence from the use of the psychoactive substance is achieved. The moral bias towards ‘drug users’ reduces them and thus limits the perception of what and how this person can be cared for. It assumes that abstinence from drugs is the only therapeutic horizon, and strategies such as hospitalization are valued to the detriment of other care options<sup>20</sup>.

HR seeks to understand the dynamics of the drug use at that point in life of the person and consequently broaden the possibilities of care, beyond the dichotomy of drug use or non-use, as the focus is not on the drug but on the person/young person. Thus, successful care is expanded beyond the abstinence from drugs<sup>13</sup>.

HR aims to carry out a process of care and practices aimed at generating moments of reflection on the drug user’s choices and how he or she does or does not take the lead in these choices, or even whether he or she has opportunities to make these ‘choices’ differently<sup>11,21-23</sup>.

Professionals notice and question the contradictions between prohibitionist and harm-reductionist practices. The following perception reflects what this inconsistency can look like in everyday life.

E9: [...] *There’s a sign like this, ‘No Smoking’ right there and then the teenager, how am I supposed to hold a teenager here and tell him we’re thinking about him and he’s not using marijuana. He’s not using crack, but he’s asking to smoke a [nicotine] cigarette and I’m saying no, how am I supposed to*

*handle that? That we get out of this box that's so closed. It's not a box where we can open the sides, leave it and come back, no, it's a very closed box and it's always very unique, right??*

The above perception triggers an important reflection on the coherence of health practices based on harm-reducing actions that expand the possibilities of understanding and even discussing these perceived limitations with the adolescent to also invite him/her to contribute to the construction of care practices that propose to reformulate strategies that are always plural and often limited to the 'closed box'.

Setting expectations about what is successful and what is not in the adolescent care process is fundamental to the management and implementation of care practices in the team.

When professionals and teams perceive a barrier to accessing health services, they reinforce active seeking strategies and change work processes that are confined to the health unit space to take place in the community on an ongoing basis, building longitudinal care projects and in partnership with other services and community leaders<sup>9</sup>.

## Stigma

The construction of the asylum care model and the war on drugs have worked together to reinforce the social construction of a system of beliefs about the person who uses drugs as a 'paranoid', 'slut', who has 'character deviation', who is not 'strong', who is not willing enough to stop using drugs, or even 'unable' to change their behavior<sup>24</sup>.

The stigmatization of people who use drugs can be as disabling as the disease process, i.e. the more stigmatizing the environment in which the person lives, the greater the difficulties and barriers to treatment, as social stigma makes work impossible, prevents autonomy, and has a negative impact on the person's treatment and quality of life<sup>24</sup>.

*E5: There is still this stigma surrounding mental health because it has to be seen by a mental health professional, but I use it recreationally, it does not interfere with my life at all, I go to school and move around the neighborhood. So I see that we really have this difficulty in raising awareness, you know, so that families understand that drug use is very naturalized in some moments. When there is harm, it's because of violence, illness, etc.*

One of the measures to reduce social stigma is to talk about it. First, however, health workers themselves need to engage in self-reflection and team meetings on this topic. This can be done, for example, by asking the question: "*How do I see the [adolescent] who uses drugs?*". These opportunities offer staff the chance to question and reflect on their own views on this issue.

Other actions in the community include: approaches such as protesting derogatory language and images published by the media in relation to drug users, creating links between different people in the community to encourage the sharing of experiences, and providing the opportunity to destigmatize the issue by having the chance to recognize that misconceptions exist<sup>24</sup>.

## Access

Guaranteeing access to the health system is one of the rights of the population that integrates and discusses the fundamental principles of the SUS, which are interdependent and interrelated. For example, it is the principle of universality that drives the construction of access for all<sup>11</sup>. With this in mind, what are some of the challenges for adolescents accessing health services that serve them (or for which there are guidelines for them to receive care)?

As one of the elements of the health care system, access is one of the ways to develop the quality of health care. By understanding the barriers that populations face in accessing services, strategies can be developed to

facilitate access to services and thus improve continuity of care.

The characteristics that hinder access to health services are considered in two main dimensions: organizational and geographical<sup>25</sup>. These include: the location of the health unit, not knowing where to seek medical care outside of emergency situations, and the difficulty of reaching the health service due to factors such as insecurity and lack of transportation. Barriers such as confidentiality, lack of knowledge about what services are available, and unwillingness to talk to professionals about their health problems are the factors that keep adolescents away from these services<sup>25</sup>.

According to the Adolescent and Young People's Care Line (LCA&J)<sup>9</sup>, confidentiality and secrecy must be ensured and explicitly communicated to young people throughout the service to guarantee their rights<sup>26</sup> and help them feel safe and open to report their complaints.

There is a huge gap between what adolescents need and the way health team staff have worked to date<sup>9</sup>. How can we build bridges to ensure and increase access to this population?

*E9: One of the challenges that bothers me a lot is how they arrive; they do not arrive. We have very few teenagers who are registered here, who have a medical record and who use it. We have very few... And even with those that can be reached in the department, it's a challenge to engage them in therapeutic care. Yes, that's a challenge that really worries me and makes me take a lot of measures, not just for harm reduction but also for prevention, you know?*

Professionals detect that there is a demand for care for adolescents, especially in the UBS, but that they do not in fact have access to this service. They wonder what the reasons are for teenagers having so many barriers or not accessing health services, even when it comes to the prevention of health problems.

The 'non-place' of these teenagers in these spaces are forms and movements of a logic of

functioning of services and work processes. These spaces are often not attractive to teenagers for several reasons: due to a lack of knowledge about the responsibilities of services; because they believe that they should only seek treatment for problems or complaints (pain or injury) or in certain situations, such as immunizations and requirements related to sexuality (condoms, pregnancy test, morning-after pill, HIV test), or even due to the demands of puberty, such as menarche<sup>9</sup>.

'Non-places' are intertwined with anthropological places, the dichotomy of built spaces and lived spaces. Anthropological places are charged with social meaning. The school, the street, the house, or the health service are the places where every movement is interpreted. Suddenly and quickly, places are replaced by non-places, turning the city more and more into a space of anonymity and solitude – where (individual) freedom wins out over (social) meaning<sup>27</sup>.

In today's society, where there is great and rapid change, where the pace of change exceeds the pace of life, nothing waits, everything is constantly changing. According to Sá<sup>27</sup>, non-places enable a great circulation of people, images, and symbols who are only spectators of a spectacle in which no one really participates. From this it can be concluded that these are processes that directly influence the construction of identity and belonging among young people.

Knowledge of youth cultures, in the sense of trying to understand (in part) what they want or even what they do not want, expands the possibilities and the development of care strategies that can help them find their place in the world, understanding that the denial of the current culture, constantly imposed on the teenager by the previous generation, is part of the process of identity formation and the construction of new places in the world. Not just because of what they are becoming, but because of what they are in the present<sup>9</sup>. Knowing the situations in which these adolescents seek health services helps to

understand part of the dynamic, which is that they only seek health services when a behavior is perceived as dysfunctional, problematic, and unpleasant.

In order to contribute to a functional logic of the health system that is more consistent with psychosocial guidelines, early detection, and active search, and prioritizing prevention measures, services that have Community Health Agents (ACS) are more effective in talking to adolescents and their families in their community setting. Active seeking is a guiding principle in the work of family health teams and is also a recommendation found in LCA&J for work with adolescents and young people<sup>9</sup>.

An important point to understand other barriers that prevent extremely vulnerable adolescents from accessing health services is the impact of prejudice, discrimination, and violence they experience when accessing these services. They report that they experience discriminatory situations while waiting for treatment, and even when they are treated, they feel humiliated and often react violently to these situations (they feel judged and attacked when they are ‘interrogated’)<sup>28</sup>.

They repeatedly feel discriminated against because of the way they dress, the way they walk, and the use of slang, and often respond with violence<sup>28</sup>.

One of the ways to engage with adolescents is through intersectoral coordination between health and education. This is a care strategy in which professionals move through the areas they serve, building proximity and bonds and demonstrating that health care is offered on a wider scale and that it is not necessary to have a complaint or problem to access health services<sup>9</sup>.

This change of attitude requires a change of mentality regarding the concept of health both in the population and in the functional logic of health services, which still function according to the biomedical logic and measure their productivity by the number of services that operate in contradiction with already

consolidated and weakened public policies, a situation that is exacerbated by the pandemic context. The challenges therefore lie both in the characteristics of the young population and in the way services are organized.

## Individualized services

What are the main guidelines for individualized care for adolescents? Some characteristics of this population make it necessary for professionals to reflect on the approach and delivery of care.

*E6: Our difficulties in relation to teenagers are precisely this issue of criticism, you know? You work with them on the issue of harm reduction, on the issue of loss, that they can consume this substance, but can also take up spaces in the community.*

It is important to listen in order to understand how adolescents live and perceive their reality, accepting that these experiences and perceptions are very different. The clinician is the one who develops their interpersonal skills, such as an empathetic attitude and skilled listening, and realizes the importance of controlling their tendency to want to ‘fix’ things and having to ‘convince’ the teen that what they are evaluating is the best or right thing to do<sup>29</sup>.

The prepared and confident healthcare professional not only tries to speak the teen’s language, but also believes that there is great diversity even among teens. It is therefore important to be open to the young person’s perspective, to offer them a space in which they can express themselves and feel recognized, not judged, and accepted for who they are. Recognition, legitimacy, and non-judgement of the adolescent’s statements therefore show acceptance and help to build bonds and trust, which significantly improves the quality of individual care<sup>30</sup>.

*E9: But I’m happy that when the kid understands that this space is a space of care for him, then there*

*is such satisfaction in reaching that level of understanding, 'hey, not everyone wants to see me as bad, huh'.*

Here, the importance of recognizing the potential of adolescents, such as creativity and commitment, to create individual and collective spaces where they can collaborate is emphasized, so that they have more opportunities to build their identity and be the protagonists of this construction. In this way, it becomes possible to find spaces for their expression and ways to make good use of this energy to make healthy choices for their growth and development. In this way, their well-being and quality of life should be enhanced by creating spaces that promote mental health and provide safe spaces for living together among peers and in the community<sup>9,31</sup>.

### **Understanding different motivations and usage patterns**

There are different motivations for drug use and part of the care process is to understand 'what', 'when' and 'in search of what' (pleasure, escape...) the teenager reports starting to use drugs, and even understand the reasons why he continues to use drugs, i.e. what is the current pattern of drug use. It is important to examine the drug(s) chosen, route of administration, amount used, frequency, duration, and locations of use – on the street, at a party, at home and whether they use it alone or with friends.

The different use patterns described in the literature are: recreational, heavy episodic drinking – related to the consumption of alcohol (described as binge drinking), abusive or harmful, and addictive. These have diagnostic criteria with which the clinical examination is carried out, how the person uses drugs, whether there are withdrawal symptoms, tolerance and craving, and what behavioral changes result from this, such as possible losses in school and in interpersonal relationships – family and friendships. The point is to understand whether there is a narrowing of the repertoire, that is, whether the adolescent spends most of his time acquiring, using, and recovering from drugs<sup>18</sup>.

*E4: We try to understand, right? For the most part, it is the use of marijuana itself. We understand that when it is a recreational use, when he already has an idea of the harm it causes him, when it already affects not only family relationships but for example, school, learning, socialization and his health.*

Drug use has been found to be part of a disease process that ranges from seeking relief from symptoms of mental and emotional distress, such as sadness, to self-mutilating behaviors, and may also be associated with suicidal thoughts and behaviors.

*E3: Yes, this teenager had great difficulty maintaining the desire, I don't know if that's a correct term, maintaining the desire to stop using drugs. Because in addition to the problem of consumption, she had great psychological suffering, sadness, so she was hurting herself.*

*E4: We already had a case of a teenager with very abusive alcohol consumption, at the age of 16 she even attempted suicide.*

These reports make it clear that drug use is often accompanied by other mental suffering. The COVID-19 pandemic has also impacted on aspects related to the increase in the psychological suffering of adolescents in general, including drug use.

*E6: So we have these difficulties, right? Of power and adherence itself is... the frequency of teenagers, right? Generally, teens are more likely to come during a crisis, but there are some that create bonds, right? They start to come to groups... Now with the pandemic, we realize that this teen problem with drug use, right? Because of isolation, you know? These cold and distant relationships like the ones from the internet, you know?*

The crisis in health practices, mainly due to the COVID-19 pandemic, requires a different way of thinking and acting in relation to practices that affect adolescents:

E1: *I think the approach needs to be rethought. Maybe I have this view because I work in mental health and I think differently, and I understand that my colleagues are there [UBS], they are in a very serious moment, a health crisis and so on. But I think we need to look at it a bit more broadly. Because the family is giving up, the network is giving up, and I can't tell you if it's more of an individual thing or a collective thing, but again, at different times the question is: What do I still have to offer? What will my colleagues still have to offer?*

Knowing the specific reasons and motivations of each adolescent regarding drug use allows professionals to deconstruct stigmatizing views and bring them closer to the adolescent. In this way, he can express that he is interested in knowing the life story of these young people, with the aim of jointly developing care strategies in the elaboration of their life project, even rescuing desires and dreams, cultivating a space of hope and the capacity for transformation, through resilience and the strengthening of a support network.

The increasingly urgent work of intensifying collective educational actions and mobilizing the construction of spaces for creation and discussion aims to identify and reflect on the nature of health (re) production, with the aim of reflecting and promoting a change of mentality in the management of mental illness and, consequently, updating the nature of care. It is noteworthy that this work has historically been carried out since the beginnings of the Brazilian Psychiatric Reform, but there is still a strong push for the return of asylum spaces and setbacks in achievements<sup>9,18,28</sup>.

Practices oriented to the holism of needs, goals, articulations and interactions are an important guide for adolescent health care. In this sense, they include dimensions that incorporate the user into the health service and the perspective of health vulnerability in its individual, social, and programmatic dimensions, allowing health teams to reflect and position themselves in a more qualified way in the face of the complex situations

that adolescents and their families experience in this context in which they are vulnerable.

## Final considerations

One of the main contributions of the dimension discussed here is that the themes presented were important in highlighting, reflecting, and promoting the idea that there is a fruitful process of demystification in relation to mental illness that actualizes the way care is provided. It is worth noting that this transition is historical, as it has been taking place since the beginnings of the Brazilian Psychiatric Reform, but there are still important movements that need to be consolidated, as we are still living with intense pressure for the return of asylum spaces and setbacks in achievements, given the government's current efforts to dismantle Raps and 'frozen' investments for services such as Caps, Therapeutic Residential Services, and Community and Cultural Centers. As more professionals broaden and change their view of young people and adolescents, their ways of being in the world, the family as a system and the social, economic, and political scenarios in which they live, influence and are influenced, they are updating the ways in which care is provided.

It is important to emphasize that a limitation of the present study is that it represents only one facet of a problem of great magnitude and does not capture the complexity of this contemporary phenomenon, which is permeated by many other social, economic, and political aspects, which leads us to reflect on the continuity of studies on this topic.

## Collaborators

Mancilha GB (0000-0002-2698-7347)\* and Covic AN (0000-0001-9700-7169)\* contributed to the conception, data collection, analysis and preparation of the text. ■

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