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REVISÃO
REVIEW

A literature review on strategies for building autonomy in Brazilian healthcare services for drug users

Uma revisão bibliográfica sobre as estratégias de construção da autonomia nos serviços públicos brasileiros de atenção em saúde a usuários de drogas

Una revisión bibliográfica sobre las estrategias de construcción de la autonomía en los servicios públicos brasileños de atención en salud a consumidores de drogas

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Abstract

The theoretical and practical frameworks that comprise the psychosocial paradigm in the field of drugs, featuring harm reduction and health promotion, focused attention on the suffering individual in relation to the social reality. Such frameworks value the uniqueness of users and healthcare workers for understanding the health-disease process and building effective health policies. The concept that underlies and unites these characteristics is autonomy. However, there are diverse definitions and practices pertaining to autonomy, with intrinsic plurality in the development of mental health and drug policy in Brazil. The article aims to describe the strategies for building autonomy for persons with abusive drug use. The method was an integrative review, searching the PsycInfo, PubMed, Virtual Health Library (VHL), and Web of Science databases for studies that analyzed the process of care for drug users. The review systematized actions that build autonomy and the barriers to care. Twenty-two studies were selected, of which 18 were studies in CAPS AD (Centers for Psychosocial Care for Alcohol and Drug Abuse) and 4 in primary care services. The review highlighted actions aimed at reclaiming individual social value, unique individual treatment plans, and harm reduction workshops. Barriers include the requirement of abstinence, lack of inter-sector collaboration, lack of social rehabilitation through work, and lack of participation in community and political spaces. The evidence points to a set of contradictory and diffuse practices, with some that build autonomy and others that impose control over users. Even so, the actions by CAPS AD and primary care are essential for reclaiming autonomy in the face of stigmatization and marginalization.

Personal Autonomy; Mental Health Services; Drug Abuse

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Introduction

Healthcare services and actions for persons with abusive drug use have been consolidated at the national level in Brazil since the early 2000s, based on the Policy of Comprehensive Care for Users of Alcohol and Other Drugs (PAIUAD 2003) [1]. Previous government drug policies had been limited historically to the narrow and violent spaces of law enforcement, prisons, and/or mental hospitals. The approach to users, when it existed, was done from the logic of control and punishment [2,3,4].

The very distinction between drug use and drug dealing was only consolidated in the 21st century, approximately 15 years ago, with *Resolution n. 3/2005* by what was then the Brazilian National Anti-Drugs Council (CONAD), allowing a specific approach to abusive use without strictly legal contradictions. Drug abuse is characterized by producing physical, psychosocial, and/or social harms, including a range of health harms, aggravating users' vulnerability and social conflicts [5].

The inclusion of a new paradigm on drugs is based at the national level on the above-mentioned PAIUAD [1]. The policy launched a set of theoretical frameworks and respective practices of care that had been developed in various places, including psychosocial care and harm reduction, aligned with the public system under the field of collective health. This came to be understood as the psychosocial or collective health paradigm in the field of drugs [6,7]. However, the policy did not prevent the dispute for spaces with notions of control and punishment based on a moralistic and biomedical approach [8,9].

These frameworks that comprise the psychosocial paradigm share an important pillar, namely the counterpoint to the biomedical-psychiatric and moral model (which joins liberal economic policies to constitute the "War on Drugs") [10,11]. The biomedical model and its conception of health was heavily criticized in the late 20th century for failing to explain the population's health-illness process, health systems planning, and the effectiveness of measures of care [12,13].

Thus, the new orientation based on empirical processes and the expanded concept of health developed new definitions in the collective terrain of care. This concept of health reveals the conditions of production and reproduction of life for populations, the bonds established under these conditions, and the uniqueness of individual subjects [14]. The process launched a valuing of the subjective dimension and the potentialities of users and healthcare workers, fostering new perspectives for reflection and action [15,16]. The understanding was that not only institutional actions impact the health of subjects and groups, but that actions by these subjects can also impact health and the development of practices of care. The concept that unifies the importance of subjectivity and subjects' protagonist role is building autonomy [17,18].

According to Kinoshita [17], building autonomy contends that subjects should be acknowledged as bearers of social value, that they are no less responsible due to their suffering and diagnosis, and that it is necessary to respect their wishes in practices of care, besides seeking to allow participation in building a new social place for individuals excluded by stigmatization. Amarante [19] emphasizes that the principal way of assessing services resulting from the psychiatric reform (e.g., current services in the field of drugs) should be the degree of autonomy established between users, healthcare workers, and society, and that there should always be a critical assessment of actions and places of care, to prevent the transformation of the logic of care from merely becoming a kind of technocratic and institutional reorganization.

Therefore, the construction (by care) of autonomous subjects is the objective of therapeutic processes in healthcare services for persons with abusive drug use. Furthermore, the frameworks that comprise this new healthcare policy led to numerous actions and conceptions that develop the notion of building autonomy [20,21].

However, as far as we known there is no study that addresses these various practical actions in different realities. Furthermore, the clash with the "War on Drugs" policy has been intense, potentially leading to the loss of the development of the foundations for building autonomy (which was achieved during the years in which the psychosocial paradigm was consolidated). An example of this clash in Brazil is the undermining of harm reduction in the national drug policy by *Executive Order n. 9,761/2019*, which proclaims total abstinence, in addition to major public investments in therapeutic communities that exceed the funding for the entire Network of Psychosocial Care (RAPS) [22]. Changes to the legislation on primary healthcare have also led to budget cuts, a possible decrease in the number

of community health agents, and reversal of prioritization for the territorial base of Expanded Center for Family Health (NASF) teams [23,24].

The current study thus aims to describe the strategies for building autonomy identified in healthcare services, producing an overview of the RAPS and verifying whether the actions are consistent with the objectives and guidelines of Brazil's mental health and drug policy. Given this policy's dismantlement, the study also aims to identify the necessary transformations, including as the basis for assessment of the changes under way.

The current article thus aims to describe the strategies for building autonomy identified in Brazilian public healthcare services for persons with abusive use of crack cocaine, alcohol, and other drugs, based on an integrative review.

Method

This study is a qualitative literature review that followed the methodological stages for the development of integrative literature reviews [25].

Integrative review is a method that allows adding knowledge from different studies on the same theme, including studies from different disciplines and with distinct methods [26,27]. Integrative review thus allows the synthesis of results, so long as the data are organized and analyzed rigorously, explaining their basis and methodology [27]. Integrative review allows approaching different objectives such as the definition of the studies' concepts and review of theories or methodological analysis [25,26].

Importantly, integrative review fosters an understanding of healthcare, which is characterized as complex work requiring collaboration and integration of different areas of knowledge. Healthcare thus features not only the development of the basis for policies and procedures, but also the critical thinking required for such care [28]. According to Ercole et al. [25], the variety in the sample's composition and the multiplicity of purposes result in a situation *"of complex concepts, theories, or problems pertaining to healthcare"* [25] (p. 9).

Selection and organization

From August to September 2019, searches were conducted in the databases PsycInfo, PubMed, VHL (Virtual Health Library), and Web of Science.

The searches were performed according to an appropriate protocol for each database, especially with the descriptors or keywords found in their thesaurus, but also dictionaries. Each database was thus accessed with the following descriptors and combinations, with terms in both the singular and plural.

Terms in the search protocol in Portuguese: *(serviço de saúde mental, serviço de higiene mental, centro de atenção psicossocial, centro de tratamento de abuso de substâncias, centro de tratamento de dependentes de drogas ilícitas, centro de tratamento de toxicômanos, centro de tratamento de abusos de drogas, centro de reabilitação de drogados, CAPS, CAPS-AD, consultório na rua, unidade básica de saúde, atenção primária, saúde da família), AND (usuário de drogas, dependente químico, drogadito, farmacodependente, viciado em drogas, drogas ilícitas, drogas de abuso, drogas recreativas, drogas, crack, cocaína, álcool), AND (autonomia, autonomia pessoal, empoderamento, cidadania, direitos do paciente, direitos civis)*.

Terms in the search protocol in English: *(mental health services, mental hygiene services, substance abuse treatment centers, drug rehabilitation centers, drug abuse treatment centers, drug treatment centers, psychosocial care centers, CAPS, CAPS-AD, primary health care, family health, street clinic, street office, street outreach office) AND (drug user, drug abuser, addict, drug-dependent, doper, druggie, stoner, junkie, drugs, crack, cocaine, alcohol, street drugs, drug abuse) AND (personal autonomy, free will, self-determination, empowerment, freedom of choice, civil rights, client rights, interpersonal control, autonomy, patient's rights)*.

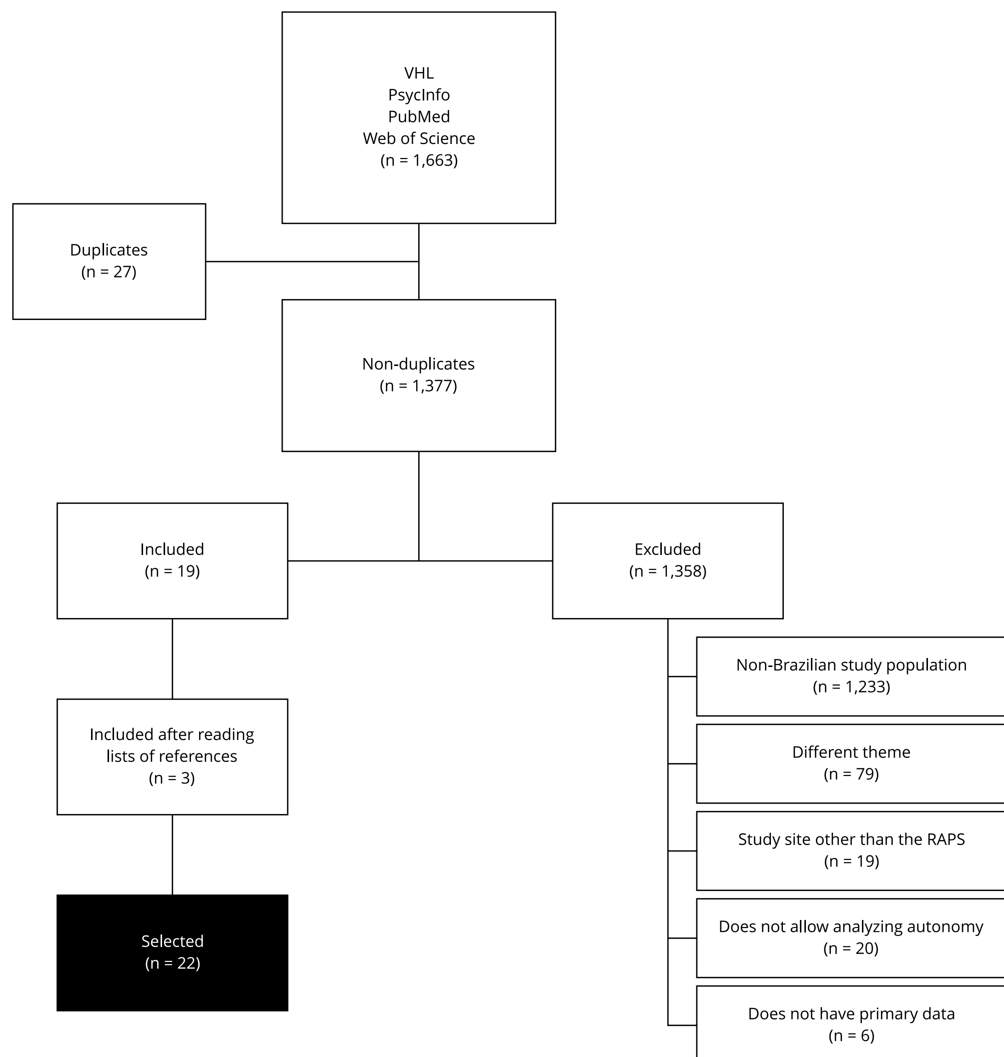
After searching the databases with the search protocols and the exclusion of duplicate studies in the End-Note Web program (https://endnote.com/), the exclusion and inclusion criteria were applied according to the review's objective. The exclusion criteria were: (1) studies in which the population or object was not Brazilians; (2) the study's theme was different from care for persons with abusive drug use; (3) the study site did not correspond to public services or the data on the site or service were

insufficient; (4) the studies addressed aspects that did not allow the analysis of building autonomy; (5) the study's data were not primary. Studies were selected if they: (1) addressed the concept of autonomy and (2) used primary data. After verification of these criteria, 19 articles were left. After reading the articles, three more were added based on the list of references. Figure 1 summarizes the selection and exclusion flow.

The results presented here were produced according to the steps for analysis of qualitative data developed by Minayo [29], which include ordering of the data, classification, and final analysis. The ordering stage corresponds to mapping the respective data. The classification stage includes a survey of the relevant information concerning the data's content, based on questions grounded in the theoretical references, where it is possible to elaborate synthesis-categories. The final analysis stage aims to form linkages between the data and the theoretical references, which should be directed to the study's objectives.

Figure 1

Stages in study selection.



RAPS: Network of Psychosocial Care; VHL: Virtual Health Library.

Analytical path

The following stages were performed to systematize and describe the actions and barriers in the strategy for building autonomy by the services discussed in the selected studies.

The first stage was the development of an instrument for systematization, referring to Box 1, which presents a set of 16 actions pertaining to the process of building autonomy and five principal difficulties.

These 16 actions and five difficulties were selected and organized according to three references: the RAPS guidelines [30]; the orientation in the technical material by the Brazilian National Secretariat for Drug Policy (SENAD) [4]; and the principles of psychosocial care as state in Yasui [31], resulting in Box 1.

The actions described in Box 1 were divided into three dimensions, corresponding to the first three columns in the chart. The latter come from the conceptual synthesis on building autonomy, based mainly on Kinoshita [17], Merhy [18], and Onocko-Campos & Campos [32], namely: (1) uniqueness, reclaiming autonomy in the therapeutic process, (2) bonds, in shared construction of autonomy, and (3) the social and political dimension, building autonomy with a collective scope.

The second stage involves the verification of which actions in Box 1 are developed in the selected services and which barriers in the strategy for building autonomy were found in the selected studies. This verification was based on an exhaustive reading of the 22 studies.

Results and discussion

We begin with the data on identification and publication of the 22 selected studies in Box 2. These include the first author's undergraduate training, year of publication, journal in which the study was published, title, categorization/location of the health service, and study's objective.

These 22 studies addressed primary healthcare services (health units and street clinics) and specialized care (Centers for Psychosocial Care for Alcohol and Drug Abuse – CAPS AD). Box 3 presents the actions developed in each site.

Box 1

Actions and initiatives in dimensions of autonomy for Brazilian drug users.

DIMENSION OF UNIQUENESS: RECLAIMING AUTONOMY IN THE THERAPEUTIC PROCESS	DIMENSION OF BONDS: SHARED RESPONSIBILITY IN BUILDING AUTONOMY	SOCIAL AND POLITICAL DIMENSION: BUILDING AUTONOMY IN THE COLLECTIVE SCOPE	DIFFICULTIES FOR BUILDING AUTONOMY
(1) Deinstitutionalized care (in liberty); **(2)** Sheltering, and reference care provider; **(3)** Development of UTP; **(4)** Territory-based service; **(5)** No requirement of abstinence; **(6)** Groups and workshops.	**(7)** Shared responsibility for the UTP; **(8)** Territory-based activities (social centers, city squares, theaters, etc.); **(9)** Care in network format (PHC/CAPS, CRAS, School...), ARCTs, SRTs; **(10)** Family's participation in the services; **(11)** Harm reduction strategies/workshops.	**(12)** Collective organization/administration of service/assemblies; **(13)** Initiatives in generation of employment and income; **(14)** Participation in the local health council and conference; **(15)** theater group, radio program, band, choir in the service; **(16)** Development of association of users, families, caregivers, and former users.	**(A)** Requirement of abstinence; **(B)** Stigmatization/Drug use treated as pathological by healthcare staff; **(C)** Difficulties in relationship with services in the inter-sector network or lack of a network; **(D)** Lack of healthcare staff or lack of professional training; **(E)** Lack of infrastructure.

ARCT: temporary residential care; CAPS: Center for Psychosocial Care; CRAS: Reference Center for Social Assistance; PHC: primary healthcare; SRT: residential treatment service; UTP: unique treatment plan.

Box 2

Characteristics of selected studies.

STUDY	1st AUTOR (TRAINING)	YEAR	JOURNAL (DATABASE)	TITLE	SITE	OBJECTIVE
1 [63]	Ribeiro JP (Nursing)	2019	*Investigación y Educación em Enfermería* (VHL)	*Strategies of Care for Adolescent Users of Crack Undergoing Treatment*	CAPS AD and CAPSi (Rio Grande do Sul State)	Analyze strategies of care of adolescent users of crack cocaine in treatment
2 [64]	Lago RR (Nursing)	2018	*International Journal of Mental Health & Addiction* (PsycInfo)	*An Exploration of the Relational Autonomy of People with Substance Use Disorders: Constraints and Limitations*	CAPS AD (North of Brazil)	Analyze how persons with abusive drug use exercise their autonomy in mental health services
3 [65]	Vasconcelos MP (Psychology)	2018	*Gerais* (VHL)	*O Cuidado aos Usuários de Drogas: Entre Normatização e Negação da Autonomia*	CAPS AD and Therapeutic Community (Minas Gerais State)	Understand the perceptions of health professionals that work in the RAPS concerning care for persons with problems due to drug use
4 [47]	Peiter P (Architecture/ Geography)	2018	*Social Science and Medicine* (PsycInfo)	*Homeless Crack Cocaine Users: Territories and Territorialities in the Constitution of Social Support Networks For Health*	Street clinic (Rio de Janeiro City)	Analyze how crack users in Rio de Janeiro relate to the territory and build support networks in the face of daily challenges and health needs
5 [66]	Subrinho Queiroz L (Nursing)	2018	*Saúde e Sociedade* (VHL)	*Cuidado ao Consumidor de Drogas: Percepção de Enfermeiros da Estratégia de Saúde da Família*	PHC (Vitória/Espírito Santo State)	Understand how nurses in the FHS perceive care for drug users in health units
6 [67]	Galhardi C (Occupational Therapy)	2018	*Cadernos de Saúde Pública* (VHL)	*O Cotidiano de Adolescentes em um Centro de Atenção Psicossocial de Álcool e Outras Drogas: Realidades e Desafios*	CAPS AD (municipality in São Paulo State)	Understand the daily routine of adolescents in relation to drugs in the CAPS AD and other contexts they attend, from their own perspective
7 [68]	Santos JM (Occupational Therapy)	2018	*Revista Gaúcha de Enfermagem* (VHL)	*Responsabilização e Participação: Como Superar o Caráter Tutelar no Centro de Atenção Psicossocial Álcool Drogas?*	CAPS AD (Ouro Preto/Minas Gerais State)	Analyze the degree of responsibility and participation of users in treatment in CAPS AD from the perspective of harm reduction policy
8 [59]	Lacerda CB (Social Service)	2017	*Interface – Comunicação, Saúde, Educação* (Web of Science)	*Significados e Sentidos Atribuídos ao Centro de Atenção Psicossocial Álcool e Outras Drogas (CAPS AD) por seus Usuários: Um Estudo de Caso*	CAPS AD II (Campinas/São Paulo State)	Present meanings and senses assigned by users of a CAPS AD
9 [69]	Paula ML (Psychology)	2017	*Ciência & Saúde Coletiva* (PubMed)	*Experiências de Adolescentes em Uso de Crack e seus Familiares com a Atenção Psicossocial e Institucionalização*	CAPS AD II, CAPSi II, and reference shelter (Fortaleza/ Ceará State)	Understand the implications of psychosocial care and institutionalization in care for needs of adolescents that use crack, and their families

(continues)

Box 2 (continued)

STUDY	1st AUTOR (TRAINING)	YEAR	JOURNAL (DATABASE)	TITLE	SITE	OBJECTIVE
10 [70]	Silveira M (Nursing)	2017	*Ciência, Cuidado e Saúde* (VHL)	*Autonomia e Reinserção Social: Percepção de Familiares e Profissionais que Trabalham com Redução de Danos*	2 CAPS AD (Southern Brazil)	Identify the perceptions of family members of users of alcohol and other drugs and health professionals concerning the concepts of autonomy and social rehabilitation underlying the harm reduction approach
11 [71]	Lago RR (Nursing)	2017	*Substance Abuse Treatment, Prevention, and Policy* (PubMed)	*Harm Reduction and Tensions in Trust and Distrust in a Mental Health Service: A Qualitative Approach*	CAPS AD (North of Brazil)	Explore the relations between users, health professionals, family members, and society according to harm reduction approach and actions
12 [72]	Nasi C (Nursing)	2015	*Revista de Pesquisa, Cuidado é Fundamental Online* (Web of Science)	*O Trabalho da Equipe Orientado pelas Motivações dos Usuários no Capsad: Estudo Fenomenológico*	CAPS AD III (Porto Alegre/Rio Grande do Sul State)	Understand the work by the CAPS AD team, oriented by users' motivations
13 [58]	Wandekoken K (Nursing)	2015	*Revista Subjetividades* (VHL)	*Biopolítica na Assistência aos Usuários de Álcool e Outras Drogas*	CAPS AD	Analyze biopolitical strategies in care for users of alcohol and other drugs
14 [49]	Cardoso MP (Nursing)	2014	*Aletheia* (VHL)	*A Percepção dos Usuários sobre a Abordagem de Álcool e Outras Drogas na Atenção Primária à Saúde*	PHC (Caxias do Sul/ Rio Grande do Sul State)	Investigate the perceptions of users on actions developed by healthcare workers in PHC, aimed at identifying relevant actions in the approach to drug abuse
15 [45]	Vasconcelos SC (Nursing)	2013	*Revista Enfermagem UERJ* (VHL)	*Demandas de Autocuidado em Grupo Terapêutico: Educação em Saúde com Usuários de Substâncias Psicoativas*	CAPS AD (Recife/ Pernambuco State)	Identify treatment demands in self-care among users of psychoactive substances through a health education group
16 [73]	Zanatta AB (Nursing)	2012	*Revista Baiana de Saúde Pública*	*O Centro de Atenção Psicossocial Álcool e Drogas sob a Percepção do Usuário*	CAPS AD (Western of Santa Catarina State)	Study the experiences of users in a CAPS AD and evaluate the service's importance for their recovery
17 [74]	Moura FG (Occupational Therapy)	2011	*SMAD, Revista Eletrônica Saúde Mental Álcool e Drogas* (VHL)	*O Cuidado aos Usuários de um Centro de Atenção Psicossocial Álcool e Drogas: Uma Visão do Sujeito Coletivo*	CAPS AD (Salvador/ Bahia State)	Analyze users' perception of the care provided by the CAPS AD
18 [75]	Giffoni FA (Medicine)	2011	*Revista Latino-Americana de Enfermagem* (VHL)	*Terapia Comunitária como Recurso de Abordagem do Problema do Abuso do Álcool, na Atenção Primária*	4 PHC courts (Fortaleza/Ceará State)	Identify the potential of therapeutic communities as a resource for approaching alcohol abuse by PHC, from a user's perspective
19 [76]	Oliveira E (Nursing)	2010	*Revista de Terapia Ocupacional da Universidade de São Paulo*	*Práticas Assistenciais no Centro de Atenção Psicossocial de Álcool, Tabaco e Outras Drogas*	CAPS AD (São Paulo City)	Identify and analyze health professionals' representations of CAPS AD concerning practices of care

(continues)

Box 2 (continued)

STUDY	1st AUTOR (TRAINING)	YEAR	JOURNAL (DATABASE)	TITLE	SITE	OBJECTIVE
20 [77]	Pinho PH (Psychology)	2009	*Revista da Escola de Enfermagem da USP*	*Reabilitação Psicossocial dos Usuários de Álcool e Outras Drogas: A Concepção de Profissionais de Saúde*	CAPS AD (São Paulo State)	Identify the concepts of health professionals in a center for treatment of problems related to alcohol and other drugs concerning psychosocial rehabilitation
21 [78]	Moraes M (Psychology)	2008	*Ciência & Saúde Coletiva* (VHL)	*Modelo de Atenção Integral à Saúde para Tratamento de Problemas Decorrentes do Uso de Álcool e Outras Drogas: Percepções de Usuários, Acompanhantes e Profissionais*	2 CAPS AD (Recife/ Pernambuco State)	Investigate the perceptions of users, accompanying persons, and health professionals concerning the model of healthcare for drug users
22 [79]	Souza J (Nursing)	2006	*SMAD, Revista Eletrônica Saúde Mental Álcool e Drogas* (VHL)	*Vínculos e Redes Sociais de Indivíduos Dependentes de Substâncias Psicoativas sob Tratamento em CAPS AD*	CAPS AD (South of Brazil)	Identify the social networks and bonds established by persons with dependence on psychoactive substances in treatment at a CAPS AD

CAPS AD: Centers for Psychosocial Care for Alcohol and Drug Abuses; CAPSi: Centers for Psychosocial Care for Children and Adolescents; FHS: Family Health Strategy; PHC: primary healthcare; RAPS: Network of Psychosocial Care; VHL: Virtual Health Library.
Source: elaborated by the authors.

The first column in Box 3 lists the study number. The second to fourth columns list the actions developed, organized in the three dimensions presented in Box 1. The fifth column describes the limitations encountered in each service. In the last column, the service was categorized according to the predominant dimension of building autonomy.

We used the results of the review to describe the set of actions in building autonomy that have occurred in the respective services, as well as their limitations, which was the proposed objective. This allows highlighting characteristics of the RAPS that have produced progress or setbacks in this process.

The key activities include those related to the first dimension, or uniqueness, reclaiming autonomy in the therapeutic process. These actions, namely receiving deinstitutionalized care (i.e., with the user in liberty), with solidarity and a reference healthcare provider, development of a unique treatment plan (UTP), care in a territory-based facility, and the organization of groups and workshops were found in most of the services. No requirement of abstinence was most infrequently cited action (11 studies). Many services also report actions in the second dimension, such as the promotion of shared responsibility in the therapeutic process (13 studies), collaborative care with other facilities in the network (9 studies), and harm reduction strategies/workshops (8 studies).

In the social and political dimension of building autonomy, almost no actions were reported, only five in different services (initiatives in work/income generation and participation in users' associations, three and two times, respectively). However, all the services showed difficulties or limits for building autonomy, especially difficulties in "relations with facilities in the inter-sector network or lack of network" and "lack of healthcare professionals or professional training", cited in 18 and 12 studies, respectively.

The studies thus show that there are important consolidated services in Brazil with various actions in care for drug users, aimed at building their autonomy through healthcare. There is a cohesive set of practices in keeping with the theoretical foundations of the psychosocial paradigm. How-

Box 3

Set of actions developed by the studies.

STUDY	RETRIEVAL OF AUTONOMY	SHARED BUILDING OF AUTONOMY	SOCIAL AND POLITICAL DIMENSION	DIFFICULTIES FOR AUTONOMY	MAIN DIMENSION
1	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Shared responsibility in UTP; territory-based activities; care in network format; family participation	Employment generation	Establishment of network; lack of healthcare staff; lack of infrastructure	Shared building of autonomy
2	Deinstitutionalized care; sheltering and reference caregiver; territory-based service; groups and workshops	-	-	Abstinence; establishment of network; stigmatization by staff; lack of healthcare staff	Retrieval of autonomy
3	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service;	Harm reduction strategies	-	Stigmatization by staff; lack of healthcare staff	Retrieval of autonomy
4	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence	Shared responsibility in UTP; care in network format; harm reduction strategies	-	Lack of infrastructure	Shared building of autonomy
5	Deinstitutionalized care; sheltering and reference caregiver; territory-based service; no requirement of abstinence; groups and workshops	Care in network format	-	Stigmatization by staff; establishment of network; lack of healthcare staff	Retrieval of autonomy
6	Deinstitutionalized care; sheltering and reference caregiver; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP	-	Establishment of network; lack of healthcare staff; lack of infrastructure	Retrieval of autonomy
7	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Territory-based activities; care in network format	Participation in users' association	Abstinence	Retrieval of autonomy
8	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Shared responsibility in UTP; care in network format	-	Establishment of network; lack of infrastructure	Retrieval of autonomy
9	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	-	-	Establishment of network	Retrieval of autonomy

(continues)

Box 3 (continued)

STUDY	RETRIEVAL OF AUTONOMY	SHARED BUILDING OF AUTONOMY	SOCIAL AND POLITICAL DIMENSION	DIFFICULTIES FOR AUTONOMY	MAIN DIMENSION
10	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; family participation; harm reduction strategies	Employment generation	Establishment of network; lack of healthcare staff; lack of infrastructure	Retrieval of autonomy
11	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Shared responsibility in UTP; family participation; harm reduction strategies	-	Abstinence; establishment of network; lack of healthcare staff	Retrieval of autonomy
12	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; Groups and workshops	Shared responsibility in UTP; family participation	-	Establishment of network	Retrieval of autonomy
13	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	-	-	Abstinence; establishment of network; stigmatization by staff; lack of healthcare staff; lack of infrastructure	Retrieval of autonomy
14	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; territory-based activities; care in network format	-	Establishment of network	Shared building of autonomy
15	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; harm reduction strategies	-	Lack of healthcare staff	Shared building of autonomy
16	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; harm reduction strategies	Participation in users' association	Abstinence; establishment of network	Retrieval of autonomy
17	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; care in network format; harm reduction strategies	-	Establishment of network	Shared building of autonomy

(continues)

Box 3 (continued)

STUDY	RETRIEVAL OF AUTONOMY	SHARED BUILDING OF AUTONOMY	SOCIAL AND POLITICAL DIMENSION	DIFFICULTIES FOR AUTONOMY	MAIN DIMENSION
18	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Care in network format	-	Establishment of network	Retrieval of autonomy
19	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; no requirement of abstinence; groups and workshops	Shared responsibility in UTP; harm reduction strategies	-	Establishment of network; lack of healthcare staff; lack of infrastructure	Shared building of autonomy
20	Deinstitutionalized care; sheltering and reference caregiver; UTP; territory-based service; groups and workshops	Shared responsibility in UTP; territory-based activities	Employment generation	Establishment of network	Retrieval of autonomy
21	Deinstitutionalized care; sheltering and reference caregiver; territory-based service; groups and workshops	Care in network format; family participation	-	Abstinence; stigmatization by staff; establishment of network; lack of healthcare staff; lack of infrastructure	Retrieval of autonomy
22	Deinstitutionalized care; sheltering and reference caregiver; territory-based service; groups and workshops	-	-	Establishment of network; lack of healthcare staff; lack of infrastructure	Retrieval of autonomy

UTP: unique treatment plan.
Source: elaborated by the authors.

ever, many of these services still emphasize abstinence, and the healthcare providers display a limited understanding of these theoretical foundations. These actions are constituted by the territory-based facilities, functioning with open doors and promoting deinstitutionalized care (in liberty) through interdisciplinary teams.

Within the specificities of each service (CAPS AD and primary care), most of the services analyzed here develop such actions, which prove to be essential for users to view them as places of care in which they can place their trust, addressing their immediate health needs and with continuous follow-up.

However, according to the psychosocial paradigm, the strategy of building autonomy should not apply only inside the facilities' walls. The services are immersed geographically in their territory precisely to articulate it, to discover and explore the established bonds, as well as to create new possibilities for support networks, to create facilities to guarantee rights, leisure, art, and culture [31,33]. They should also link actions to generate employment and income to the facilities in the RAPS and integrate the users' families with the institutions involved in the therapeutic process. This allows users, who often need to deal with stigmatization, to be part of the social milieu, to develop the autonomy provided by reclaiming value and self-care within the services [21].

Thus, viewing the systematization of actions and considering the previous reflections, we find that actions in relational autonomy fall short of actions in the dimension of valuing uniqueness. The strategy of building autonomy in the social and political dimension, namely the development of citizenship within society, is practically nonexistent.

Thus, the actions by services that users say develop their autonomy, such as sheltering, the unique treatment plan, and nonmandatory groups, stand out as a huge stride in comparison to approaches based on reclusion and objectification. This is consistent with other authors who report that users feel welcomed and in a process of territory-based care with adequate treatment plans [34,35]. The notion of respect for choices and the characteristics of the second dimension of autonomy, i.e., network-based care, allow shared responsibility for treatment, as recommended in the literature [17,18].

Non-obligation is also an important factor for the therapeutic process to develop, since it allows the continuity of bonds, which happens frequently in the care for users by street clinics [36,37]. Furthermore, the notion of conquering their space and bonds, even in conditions that entail vulnerabilities, show that users fear returning to a life that also included many difficulties, such as violent family relations, unhealthy work relations, poverty, etc. [36,38].

Thus, when the approach to users builds bonds of trust, they acknowledge the service's importance, since in these studies healthcare providers and users report that the stigmatization towards abusive drug use is real and brings real losses, such as loss of employment, family ties, and material goods, beyond the health difficulties, so that users want to adhere to the therapeutic process. That is, respect and shared responsibility are essential principles, as affirmed by Onocko-Campos & Campos [32].

Another important action related to valuing users and shared responsibility is the service's collective organization [20,39,40]. Examples include discussions in assemblies, joint development of workshops, in which users themselves can reclaim and share their values and knowledge (on music, poetry, and other arts, computer work, carpentry, photography, etc.), organization of events such as seminars (on health and drugs, the city and the territory, etc.), and commemorative events (Deinstitutionalization Day, June Festivals, Carnival, etc.). However, these actions are infrequent in practice, as evidenced in the chart on systematization, corroborating other studies [41,42,43].

The groups approaching harm reduction are also important, with collective education on drugs and the relationship to healthcare and reduction of social risks, including sharing the users' own knowledge. Users share not only their experiences with drug use, but also difficulties in the territory, violence, and access to healthcare [44]. Groups are especially important in the health units, where follow-up daily or several times a week would be difficult. Groups thus allow overcoming certain health iniquities while also increasing self-esteem and autonomy in daily life processes [45].

The notion of relational autonomy is also highlighted in the studies through users' immersion in an external support network, among other reasons because even while attending the services they do not fail to have a territorial network of relations [46,47]. However, it is a dimension that faces many difficulties due to the lack of relations between the network's facilities and the healthcare providers' difficulty in being in the territory to strengthen the established bonds. This emphasizes the need for the family's involvement through associations and social centers, as well as the connection to educational institutions (especially for adolescents). Still, these actions do not take place in the services studied here either. The closest thing is the work by healthcare providers in the NASF and the community health agents [48,49].

Therefore, the lack of policies for work and income, housing, associations of users and families, and territory-based cultural initiatives in which users are protagonists, as well as violent incursions in the territory by the public powers constitute the main barrier, an obvious limit on building autonomy by the networks to which the facilities belong. And if we consider building autonomy as a process, we identify a gap in it. As proposed by Jervis [50] and Sena [34], the development of full citizenship takes place in the community and society in which people live and in which they are marginalized.

This gap increases significantly with the absence of continuous training in health under the principles and actions of the psychosocial paradigm, especially harm reduction, preventing for example the development of harm reduction workshops [51,52]. This also results in the lack of a critical view by healthcare workers vis-à-vis the centrality of diagnoses and the "War on Drugs" notion, resulting in turn in users' objectification and the focus on detox treatment and abstinence [53,54]. This obviously also results from the difficulty in working in teams with limited numbers of healthcare professionals and in precarious services, as identified by Bittencourt et al. [37] and Conejo [55].

Finally, the development of bonds with shared responsibility, namely effective participation by users, cited in 13 studies, strengthens the notion of therapeutic process, as proposed by Ongaro-Basaglia [56] and Basaglia [57]. As it decreases the difference in power between users and healthcare

workers, it also promotes the building of contractual power, that it, reclaiming values to build greater self-confidence to develop relations, even outside the "treatment spaces". However, the development of external relations, the dimension of citizenship and social rehabilitation, with participation in processes of collective exchanges – economic, political, and affective – is limited by the difficulties discussed above.

Thus, these limitations often prevent a practical transformation of users' lives, making them dependent on the CAPS and health units, exacerbating the so-called "revolving-door" process or career of institutionalization [21], that is, the lack of a network of services and professionals prepared to continue therapeutic processes and the lack of transformation of conditions for reproduction of the users' daily lives, such that they often return to the same treatment site with the same demands [58,59,60,61].

These difficulties obviously limit the development of the entire psychiatric reform project, since the reform with its practical and conceptual foundations, such as the psychiatry of deinstitutionalization [20,50], seeks to create and foster the development of a territorial network with various facilities spread across the city, such as shelters, work cooperatives, and associations for sociocultural production and political expression. Such elements, according to Rotelli [21], are the invented institution's objective and practice, seeking "*reentry into the social body, consumption, and production, exchanges, new roles, other material ways of being for the other, in the eyes of the other*" [21] (p. 95).

The difficulties also place constraints on harm reduction, which is based on the development of peer help groups and self-care interventions performed in the territories by users themselves, as harm reduction is developed in other countries. These and other actions are highlighted in a global study on harm reduction by the Dutch institution Mainline [62]. These actions feature the need to fight poverty, violence against users, and precarious access to housing and the supply of counseling services and safe use [44,62].

Final remarks

The results of this review reveal a set of contradictory and diffuse strategies for building autonomy. Some actions build autonomy, while others reaffirm control over users. Although this review is current and addresses various services in a new paradigm of care for drug users, the results indicate that biomedical rationale still controls what is considered deviation, lack of self-control, and madness.

The review identified users' lack of participation in the organization of services, which impose rules, even when there is a certain autonomy for participation in groups and workshops, besides unique treatment plans. In addition, the activities for building autonomy are all carried out inside these facilities. That is, there are virtually no inter-sector activities or participation in community and political spaces such as users' associations or health and social assistance councils. The literature consulted here shows that there is still a veiled and organized predominance of the individual dimension, even with the idea of therapeutic treatment to the detriment of shared responsibility and especially of social and political participation.

Even though the Brazilian network includes some services with temporary sheltering and social rehabilitation beyond the CAPS, such as Social Centers and Shelter Units, they are not being developed and used as recommended by the policy of care. Such services are crucial for building autonomy and combatting drug users' stigmatization and marginalization, but this review has not identified their inclusion, pointing to the lack of effective inter-sector action by the RAPS itself. Therefore, the central role of the CAPS AD, namely of performing inter-consultation with other services, has not happened as recommended by the country's mental health and drug policy.

Even so, the specific activities developed by CAPS AD and primary care services prove to be essential for beginning to reclaim users' autonomy and self-worth in the face of their stigmatization and marginalization. The work by the NASF teams, community-based health agents, and street clinics allow a kind of care that is much closer to the reality of users and their families, guaranteeing certain rights, mediating family conflicts, and sometimes sheltering based on harm reduction. This set of actions allows follow-up in health which can otherwise be hindered by users' fear of accessing

services simply because they use drugs (which shows the intensity of the prejudice and stigma they still face in their daily lives).

Care is performed in the internal institutional space, in addition to the lack of inter-sector collaboration, reinforcing the dependence created by the policy itself for users of specific services. The space of reclusion that was reserved for individuals that were considered addicts was expanded, but it remained separate from social contact, and the psychiatric institution still dictates the words and acts with which individuals are allowed to speak and live. The needs of persons in treatment are addressed in a fragmented way rather than comprehensively as recommended by the health system, leading the RAPS to promote capillarization in the forms of control, partly perpetuating the chronicity-based logic of total institutions.

This review clearly shows that the guideline of a strategy for building autonomy requires greater investment in the RAPS to truly combat the marginalization of individuals with abusive drug use. In addition to the CAPS AD and health units, investment is necessary in services that allow health promotion, with quality housing, employment, and possibilities for embracing what the individual human being has already produced, beyond lives marked by the impacts of a society that produces illness.

It is necessary to support the construction of this logic of care at the social level, with a society that receives and builds the material conditions together with excluded individuals for them to rebuild their lives. The services and actions of care should not only extend outside the white-tiled and insurmountable walls of total institutions, but must be part of social transformation, constantly in search of autonomy.

Contributors

M. E. R. Martins elaborated the article's content. F. Büchele and C. C. Bolsoni contributed to the article's review. All authors contributed to the final approval.

Additional informations

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References

1. Ministério da Saúde. A política do Ministério da Saúde para atenção integral a usuários de álcool e outras drogas. Brasília: Ministério da Saúde; 2003.
2. Soares CB. Consumo contemporâneo de drogas e juventude: a construção do objeto na perspectiva da saúde coletiva [Professorship Thesis]. São Paulo: Departamento de Enfermagem em Saúde Coletiva, Escola de Enfermagem, Universidade de São Paulo; 2007.
3. Machado l, Boarini M. Políticas sobre drogas no Brasil: a estratégia de redução de danos. Psicol Ciênc Prof 2013; 33:580-95.
4. Souza DR, Oliveira MAF, Soares RH, Domanico A, Pinho PH. Resistências dos profissionais da atenção psicossocial em álcool/drogas à abordagem de redução de danos. J Nurs Health 2017; 7:16-24.
5. Medeiros PFP, Garcia LSL, Kinoshita RT, Santos PS, Hayashida G. Rede de Atenção Psicossocial no Sistema Único de Saúde (SUS): Eixo Políticas e Fundamentos. Brasília: Secretaria Nacional de Políticas sobre Drogas; 2017.

6. Santos V, Soares CB. O consumo de substâncias psicoativas na perspectiva da saúde coletiva: uma reflexão sobre valores sociais e fetichismo. Saúde Transform Soc 2013; 4:38-54.
7. Brites C. Política de drogas no Brasil: usos e abusos. In: Bokany V, organizadora. Drogas no Brasil: entre a saúde e a justiça. Proximidades e opiniões. São Paulo: Editora Fundação Perseu Abramo; 2015. p. 119-42.
8. Passos E, Souza T. Redução de danos e saúde pública: construções alternativas à política global de "guerra às drogas". Psicol Soc 2011; 23:154-62.
9. Teixeira M, Ramôa ML, Engstrom E, Ribeiro JM. Tensões paradigmáticas nas políticas públicas sobre drogas: análise da legislação brasileira no período de 2000 a 2016. Ciênc Saúde Colet 2017; 22:1455-66.
10. Hornstein C. Guerra às drogas: "por que não tentar diferente depois de tanto fracasso?". Carta Maior 2014; 14 may. https://www.cartamaior.com.br/?/Editoria/Direitos-Humanos/Guerra-as-drogas-por-que-nao-tentar-o-diferente-depois-de-tanto-fracasso-/5/30923.
11. Gomes-Medeiros D, Faria PH, Campos GWS, Tófoli LF. Política de drogas e Saúde Coletiva: diálogos necessários. Cad Saúde Pública 2019; 35:e00242618.
12. Paim JS, Almeida Filho N. A crise da saúde pública e a utopia da saúde coletiva. Salvador: Casa da Qualidade Editora; 2000.
13. Buss PM. Promoção da saúde e qualidade de vida. Ciênc Saúde Colet 2000; 5:163-77.
14. Campos GW, Barros RB, Castro AM. Avaliação de política nacional de promoção da saúde. Ciênc Saúde Colet 2004; 9:745-9.
15. Czeresnia D. O conceito de saúde e a diferença entre prevenção e promoção. In: Czeresnia D, Freitas CM, organizadores. Promoção da saúde: conceitos, reflexões, tendências. Rio de Janeiro: Editora Fiocruz; 2003. p. 43-58.
16. Fleury-Teixeira P, Vaz FA, Campos FC, Alvares J, Oliveira V, Aguiar R. Autonomia como categoria central no conceito de promoção de saúde. Ciênc Saúde Colet 2008; 13 Suppl 2:2115-22.
17. Kinoshita RT. Contratualidade e reabilitação psicossocial. In: Pitta A, organizador. Reabilitação psicossocial no Brasil. 2ª Ed. São Paulo: Hucitec Editora; 2001. p. 55-9.
18. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. Agir em saúde: um desafio para o público. 2ª Ed. São Paulo: Hucitec Editora; 2002. p. 71-112.
19. Amarante PDC. Avaliação dos novos serviços de saúde mental: em busca de novos parâmetros. Saúde Debate 1996; 52:74-83.
20. Basaglia F. As instituições da violência. In: Basaglia F, organizador. A instituição negada. Rio de Janeiro: Edições Graal; 1985. p. 99-134.
21. Rotelli F. A instituição inventada. In: Rotelli F, Leonardis O, Mauri D, Risio C, organizadores. Desinstitucionalização. São Paulo: Hucitec Editora; 1990. p. 89-99.
22. Ribeiro FML, Minayo MCS. As mudanças na política brasileira de drogas: o avanço da lógica da justiça sobre a saúde. Revista Cultura y Droga 2020; 25:17-39.
23. Massuda A. Mudanças no financiamento da atenção primária à saúde no sistema de saúde brasileiro: avanço ou retrocesso? Ciênc Saúde Colet 2020; 25:1181-8.
24. Silva T, Soares AN, Lacerda GA, Mesquita JF, Silveira DC. Política Nacional de Atenção Básica 2017: implicações no trabalho do agente comunitário de saúde. Saúde Debate 2020; 44:58-69.
25. Ercole FF, Melo LS, Alcoforado CC. Revisão integrativa versus revisão sistemática. REME Rev Min Enferm 2014; 18:9-12.
26. Souza MT, Silva M, Carvalho R. Revisão integrativa: o que é e como fazer. Einstein (São Paulo) 2010; 8:102-6.
27. Soares CB, Hoga LA, Peduzzi M, Sangaleti C, Yonekura T, Silva DR. Revisão integrativa: conceitos e métodos utilizados na enfermagem. Rev Esc Enferm USP 2014; 48:335-45.
28. Stetler CB, Morsi D, Rucki S, Broughton S, Corrigan B, Fitzgerald J, et al. Utilization-focused integrative reviews in a nursing service. Appl Nurs Res 1998; 11:195-206.
29. Minayo MC. O desafio do conhecimento: pesquisa qualitativa em saúde. 11ª Ed. São Paulo: Hucitec Editora; 2008.
30. Ministério da Saúde. Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União 2013; 21 may.
31. Yasui S. Rupturas e encontros: desafios da reforma psiquiátrica brasileira [Doctoral Dissertation]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2006.
32. Onocko-Campos R, Campos GWS. Co-construção de autonomia: o sujeito em questão. In: Campos GWS, Minayo MCS, Akerman M, Drumond JM, Carvalho YM, organizadores. Tratado de saúde coletiva. São Paulo: Hucitec Editora/Rio de Janeiro: Editora Fiocruz; 2006. p. 669-88.
33. Amarante P, Lancetti A. Saúde mental e saúde coletiva. In: Campos GWS, Minayo MCS, Akerman M, Drumond JM, Carvalho YM, organizadores. Tratado de saúde coletiva. São Paulo: Hucitec Editora/Rio de Janeiro: Editora Fiocruz; 2006. p. 615-34.
34. Sena J. Produção do cuidado no Centro de Atenção Psicossocial de Fortaleza – CE: limites e desafios na construção da autonomia do usuário [Masters Thesis]. Fortaleza: Universidade Estadual do Ceará; 2010.
35. Borges CD, Schneider DR. Trajetória do cuidado e o percurso ao CAPSad: com a palavra os usuários. Cadernos Brasileiros de Saúde Mental 2018; 10:224-49.

36. Londero M, Ceccim R, Bilibio L. Consultório de/na Rua: desafio para um cuidado em verso na saúde. Interface (Botucatu) 2014; 18:251-60.
37. Bittencourt M, Pantoja PVN, Silva Júnior PCB, Pena JLC, Nemer RCB, Moreira R. Consultório na Rua: as práticas de cuidado com usuários de álcool e outras drogas em Macapá. Esc Anna Nery Rev Enferm 2019; 23:e20180261.
38. Paula M, Jorge MB, Vasconcelos M, Albuquerque R. Assistência ao usuário de drogas na atenção primária à saúde. Psicol Estud 2014; 19:223-33.
39. Saraceno B. Libertando identidades: da reabilitação psicossocial à cidadania possível. Rio de Janeiro: Instituto Basaglia/Te Cora; 2001.
40. Junqueira A, Carniel IC, Mantovani A. As assembleias como possibilidades de cuidado em saúde mental em um CAPs. Vínculo 2015; 12:31-40.
41. Godoy MC, Viana A, Vasconcelos K, Bonvini O. O compartilhamento do cuidado em saúde mental: uma experiência de cogestão de um centro de atenção psicossocial em Fortaleza, CE, apoiada em abordagens psicossociais. Saúde Soc 2012; 21 Suppl 1:152-63.
42. Martins J. CAPS AD III entre a cor cinza da técnico-burocracia e as cores vibrantes que articulam clínica e política [Masters Thesis]. São Cristóvão: Universidade Federal de Sergipe; 2015.
43. Tibiriçá V, Luchini E, Almeida C. Perspectiva do usuário de drogas sobre seu tratamento e a rede de atenção psicossocial. SMAD, Rev Eletrônica Saúde Mental Álcool Drog 2019; 15:1-9.
44. Gomes T, Vecchia MD. Estratégias de redução de danos no uso prejudicial de álcool e outras drogas: revisão de literatura. Ciênc Saúde Colet 2018; 23:2327-38.
45. Vasconcelos SC, Frazão I, Vasconcelos E, Cavalcanti A, Monteiro E, Ramos V. Demandas de autocuidado em grupo terapêutico: educação em saúde com usuários de substâncias psicoativas. Rev Enferm UERJ 2013; 21:79-83.
46. Lacerda A. Redes de apoio social no Sistema da Dádiva: um novo olhar sobre a integralidade do cuidado no cotidiano de trabalho do agente comunitário de saúde [Doctoral Dissertation]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2010.
47. Peiter P, Belmonte P, Teixeira M, Cobra G, Lacerda A. Homeless crack cocaine users: territories and territorialities in the constitution of social support networks for health. Soc Sci Med 2019; 227:111-8.
48. Oliveira EM, Santos NTV. A rede de assistência aos usuários de álcool e outras drogas: em busca da integralidade. In: Santos LMB, organizador. Outras palavras sobre o cuidado de pessoas que usam drogas. Porto Alegre: Conselho Regional de Psicologia do Rio Grande do Sul; 2010. p. 71-86.
49. Cardoso MP, Agnoll R, Taccolini C, Tansini K, Vieira A, Hirdes A. A percepção dos usuários sobre a abordagem de álcool e outras drogas na atenção primária à saúde. Aletheia 2014; (45):72-86.
50. Jervis G. Manuale critico di psichiatria. Milano: Feltrinelli; 1975.
51. Coelho HV, Soares CB. Práticas na atenção básica voltadas para o consumo prejudicial de drogas. Rev Esc Enferm USP 2014; 48:111-9.
52. Engstrom EM, Teixeira MB. Equipe "Consultório na Rua" de Manguinhos, Rio de Janeiro, Brasil: práticas de cuidado e promoção da saúde em um território vulnerável. Ciênc Saúde Colet 2016; 21:1839-48.
53. Rosenstock KIV, Neves MJ. Papel do enfermeiro da atenção básica de saúde na abordagem ao dependente de drogas em João Pessoa, PB, Brasil. Rev Bras Enferm 2010; 63:581-6.
54. Lima A, Dimenstein M, Macedo JP. Consumo de álcool e drogas e o trabalho do psicólogo no núcleo de apoio à saúde da família. Psicol Pesq 2015; 9:188-97.
55. Conejo SP, Lisboa VC, Oliveira A, Garcia MR. Contribuindo para a construção da autonomia com profissionais que atuam com usuários de drogas: uma análise de dois projetos de intervenção no maior polo manicomial do Brasil. In: Garcia MV, Conejo SP, Melo TM, organizadores. Drogas e direitos humanos: caminhos e cuidados. Holambra: Editora Setembro; 2017. p. 17-44.
56. Ongaro-Basaglia F. Rovesciamento istituzionale e finalità comune. In: Basaglia F, organizador. L'istituzione negata. Milano: Baldini Castoldi; 2018. p. 321-35.
57. Basaglia F. A utopia da realidade. In: Amarante P, organizador. Escritos selecionados em saúde mental e reforma psiquiátrica. Rio de Janeiro: Garamond; 2010. p. 225-36.
58. Wandekoken K, Quintanilha B, Dalbello-Araujo M. Biopolítica na assistência aos usuários de álcool e outras drogas. Rev Subj 2015; 15:389-97.
59. Lacerda C, Fuentes-Rojas M. Significados e sentidos atribuídos ao Centro de Atenção Psicossocial Álcool e outras Drogas (CAPS AD) por seus usuários: um estudo de caso. Interface (Botucatu) 2017; 21:363-72.
60. Silva L, Almeida A, Amato T. A perspectiva dos profissionais sobre o processo de alta de pacientes do Caps-AD: critérios e dificuldades. Saúde Debate 2019; 43:819-35.
61. Sanches L, Vecchia M. Reabilitação psicossocial e inclusão social de pessoas com problemas decorrentes do uso de álcool e outras drogas: impasses e desafios. Interface (Botucatu) 2020; 24:e200239.
62. Rigoni R, Breeksema J, Woods S. Speed limits – harm reduction for people who use stimulants. https://idpc.net/publications/2018/09/speed-limits-harm-reduction-for-people-who-use-stimulants (accessed on 20/Nov/2018).

63. Ribeiro JP, Gomes GC, Mota MS, Ortiz E, Eslabão AD. Strategies of care for adolescent users of crack undergoing treatment. Invest Educ Enferm 2019; 37:e12.
64. Lago RR, Bógus CM, Peter E. An exploration of the relational autonomy of people with substance use disorders: constraints and limitations. Int J Ment Health Addict 2020; 18:277-92.
65. Vasconcelos MP, Paiva FS, Vecchia MD. O cuidado aos usuários de drogas: entre normatização e negação da autonomia. Gerais (Univ. Fed. Juiz Fora) 2018; 11:363-81.
66. Subrinho Queiroz L, Sena E, Santos V, Carvalho P. Cuidado ao consumidor de drogas: percepção de enfermeiros da Estratégia de Saúde da Família. Saúde Soc 2018; 27:834-44.
67. Galhardi C, Matsukura T. O cotidiano de adolescentes em um Centro de Atenção Psicossocial de Álcool e outras Drogas: realidades e desafios. Cad Saúde Pública 2018; 34:e00150816.
68. Santos JM, Baptista JA, Nasi C, Camatta MW. Responsabilização e participação: como superar o caráter tutelar no centro de atenção psicossocial álcool drogas? Rev Gaúch Enferm 2018; 39:e20180078.
69. Paula ML, Jorge MB, Lima L, Bezerra I. Experiências de adolescentes em uso de crack e seus familiares com a atenção psicossocial e institucionalização. Ciênc Saúde Colet 2017; 22:2735-44.
70. Silveira M, Rosa D, Silva M, Farias FL, Moniz AS, Ventura J. Autonomia e reinserção social: percepção de familiares e profissionais que trabalham com redução de danos. Ciênc Cuid Saúde 2017; 16:34299.
71. Lago RR, Peter E, Bógus CM. Harm reduction and tensions in trust and distrust in a mental health service: a qualitative approach. Subst Abuse Treat Prev Policy 2017; 12:12.
72. Nasi C, Olivieira G, Lacchini AJ, Camatta M, Everling EM, Schneider JF. O trabalho da equipe orientado pelas motivações dos usuários no capsad: estudo fenomenológico. Rev Pesqui (Univ. Fed. Estado Rio J.) 2015; 7:3239-48.
73. Zanatta AB, Garghetti FC, Lucca SR. O centro de atenção psicossocial álcool e drogas sob a percepção do usuário. Rev Baiana Saúde Pública 2012; 36:225-37.
74. Moura FG, Santos JE. O cuidado aos usuários de um centro de atenção psicossocial álcool e drogas: uma visão do sujeito coletivo. SMAD Rev Eletrônica Saúde Mental Álcool Drog 2011; 7:126-32.
75. Giffoni FA, Santos M. Terapia comunitária como recurso de abordagem do problema do abuso do álcool, na atenção primária. Rev Latinoam Enferm 2011; 19:821-30.
76. Oliveira E, Oliveira MAF, Claro HG, Paglione HB. Práticas assistenciais no Centro de Atenção Psicossocial de Álcool, Tabaco e outras Drogas. Rev Ter Ocup 2010; 21:247-54.
77. Pinho PH, Oliveira M, Vargas D, Marilia A, Machado A, Silva A, et al. Reabilitação psicossocial dos usuários de álcool e outras drogas: a concepção de profissionais de saúde. Rev Esc Enferm USP 2009; 43:1261-6.
78. Moraes M. Modelo de atenção integral à saúde para tratamento de problemas decorrentes do uso de álcool e outras drogas: percepções de usuários, acompanhantes e profissionais. Ciênc Saúde Colet 2008; 13:121-33.
79. Souza J, Kantorski LP, Mielke FB. Vínculos e redes sociais de indivíduos dependentes de substâncias psicoativas sob tratamento em CAPS AD. SMAD Rev Eletrônica Saúde Mental Álcool Drog 2006; 2:1-7.

Resumo

Os arcabouços teórico-práticos que compõem o paradigma psicossocial no campo das drogas, tais como a redução de danos e a promoção da saúde, trouxeram foco ao sujeito em sofrimento na relação com a realidade social. Eles valorizam a singularidade de usuários e profissionais para compreensão do processo saúde-doença e a construção das políticas de saúde. Conceito que embasa e agrega essas características é o de construção de autonomia. Entretanto existem acepções e ações distintas relativas à autonomia, pluralidade intrínseca ao desenvolvimento da política de saúde mental e drogas no país. O objetivo deste artigo é descrever as estratégias para construção de autonomia para pessoas que fazem uso abusivo de drogas. O método utilizado foi a revisão integrativa, buscando-se, nas bases PsycInfo, PubMed, Biblioteca Virtual de Saúde (BVS) e Web of Science, estudos que analisaram o processo de cuidado a usuários de drogas. Foram sistematizadas ações que constroem autonomia e as barreiras para o cuidado. Foram selecionados 22 estudos, sendo 18 pesquisas em Centros de Atenção Psicossocial Álcool e Drogas (CAPS AD) e quatro em serviços de atenção primária. Sobressaíram ações realizadas na dimensão do resgate de valor social, como planos terapêuticos singulares e oficinas de redução de danos. Representam barreiras a exigência da abstinência, a falta de ações intersetoriais, falta de reinserção social por vínculos de trabalho e não participação em instâncias comunitárias e políticas. Evidencia-se um conjunto de práticas contraditórias e difusas, havendo as que constroem autonomia e as que impõem o controle sobre o usuário. Ainda assim, as ações dos CAPS AD e atenção primária demonstram ser fundamentais para o resgate de autonomia frente à estigmatização e marginalização.

Autonomia Pessoal; Serviços de Saúde Mental; Abuso de Drogas

Resumen

Los andamiajes teórico-prácticos que componen el paradigma psicosocial en el campo de las drogas, tales como la reducción de daños y la promoción de la salud, se centraron en el sujeto que padece el problema en relación con la realidad social. Ellos valoran la singularidad de consumidores y profesionales de la salud para la comprensión del proceso salud-enfermedad, así como la construcción de políticas de salud. El concepto que fundamenta y agrega esas características es el de construcción de autonomía. No obstante, existen acepciones y acciones distintas, relacionadas con la autonomía, pluralidad intrínseca al desarrollo de la política de salud mental y drogas en el país. El objetivo de este artículo es describir las estrategias para la construcción de autonomía para personas que consumen abusivamente drogas. El método utilizado fue la revisión integradora, donde se buscaron estudios, en las bases PsycInfo, PubMed, Biblioteca Virtual en Salud (BVS) y Web of Science, que analizaron el proceso de cuidado a consumidores de drogas. Se sistematizaron acciones que construyen autonomía, así como barreras para el cuidado. Se seleccionaron 22 estudios, siendo 18 investigaciones en Centro de Atención Psicosocial de Alcohol y otras Drogas (CAPS AD) y 4 en servicios de atención primaria. Sobresalieron las acciones realizadas en la dimensión de rescate de valor social como planes terapéuticos singulares y talleres de reducción de daños. Representan barreras la exigencia de abstinencia, la falta de acciones intersectoriales, falta de reinserción social por vínculos de trabajo y la no participación en instancias comunitarias y políticas. Se evidencia un conjunto de prácticas contradictorias y difusas, existiendo las que construyen autonomía y las que imponen el control sobre el usuario. No obstante, las acciones de los CAPS AD y atención primaria demuestran ser fundamentales para el rescate de la autonomía frente a la estigmatización y marginalización.

Autonomía Personal; Servicios de Salud Mental; Abuso de Drogas

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