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Original Article

Matrix support in the care network to people with needs by the use of alcohol and other drugs[1]

O apoio matricial na rede de atenção às pessoas com necessidades decorrentes do uso de álcool e outras drogas

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Abstract

The study focuses on the relationship between the Centers for Psychosocial Care Alcohol and other drugs (CAPS AD) and Basic Care through the Matrix Support. The objective of the study was to identify difficulties and facilitators of the matrix support, based on the perspective of the professionals who receive the matrix support and the professionals who offer the matrix support and analyze the work dynamics of these professionals through the Matrix Support bias. We opted for qualitative research. Data collection took place through two focus groups. One group had eight CAPS AD professionals who offer the matrix support and the other had seven UBS (basic healthcare units) professionals who receive the matrix support. The data were analyzed using the thematic analysis technique that allowed the identification of the analysis categories: Difficulties and facilitators of the matrix support and Specificities that permeate care strategies of alcohol and drug problematic users. The results indicate that the professionals recognize that the Matrix Support methodology presents potential not yet achieved but in constant construction. A warm, non-stigmatizing, and resolutive work ethic is necessary, overcoming the logic of specialization and the fragmentation of mental health actions.

Keywords: Mental Health, Primary Health Care, Drug Users.

[1]The current ethical processes were respected. The master's research project was submitted to the UFSCar Human Research Ethics Committee, approved on 04/18/2016, under number 1,505,113, and submitted to the Municipality of Campinas, through CETS (*Centro de Educação dos trabalhadores da Saúde*), approved on 12/15/2015, under number 083/2015.

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Resumo

O estudo tem como foco a relação entre os Centros de Atenção Psicossocial Álcool e outras drogas (CAPS AD) e à Atenção Básica por meio do Apoio Matricial. O objetivo do estudo foi identificar dificuldades e facilitadores do apoio matricial, com base na perspectiva dos profissionais matriciados e matriciadores, e analisar a dinâmica de trabalho destes profissionais pelo viés do Apoio Matricial. Optamos pela pesquisa de abordagem qualitativa. A coleta de dados se deu por meio da realização de dois grupos focais, um com os oito profissionais matriciadores dos CAPS AD e outro com os sete profissionais matriciados das UBS, participantes da pesquisa. Os dados foram analisados com base na técnica de análise temática que permitiu a identificação das categorias de análise: Dificuldades e facilitadores do processo de apoio matricial e Especificidades que permeiam as estratégias de cuidado com pessoas que fazem uso problemático de álcool e outras drogas. Os resultados apontam que os profissionais reconhecem que a metodologia do Apoio Matricial apresenta potencialidades ainda não alcançadas, mas em constante construção. Faz-se necessária uma ética de trabalho acolhedora, não estigmatizante e resolutiva, superando a lógica da especialização e da fragmentação das ações de saúde mental.

Palavras-chave: Saúde Mental, Atenção Primária à Saúde, Usuários de Drogas.

1 Introduction

At the same time as the process of making SUS a policy in Brazil, the National Mental Health Policy was structured with its discussion starting with the Psychiatric Reform movement in the late 1970s and 1980s. The National Health Policy Mental Health was achieved through a set of knowledge and practices, Programs, Laws, and Ordinances, but specifically through the implementation of the Psychosocial Care Network (RAPS) throughout the national territory. RAPS aimed to consolidate an open, territorial, and community-based care model (Brasil, 2013) to the detriment of the asylum treatment.

RAPS was instituted on December 23, 2011, through Ordinances 3088/GM/MS and 3089/GM/MS, to structuring the care network for people with psychological distress and with needs by the use of crack, alcohol and other drugs, within the scope of the Unified Health System (Brasil, 2011a).

Historically, the theme of the use of alcohol and other drugs is culturally associated with criminality and dangerousness, resulting in treatments inspired by models of excluding and isolating users from social life. Until the 1990s, there was no policy of wide access to alcohol and drug users in national scope, within the public health area.

The persistent strengthening of the discourse and the conception that drugs are the great evil of today produce the concentration of efforts in their elimination and their fight, resulting in gaps between the needs of users and the care offered. The dichotomy between the discourse on the war against drugs opposed to the discourse of those who are in favor of them provides a limited understanding of the theme, excluding

determining factors for this discussion such as the poverty, unemployment, violence, the lack of access to prevention drug actions, racism, among others (Souza, 2013).

On the other hand, municipal, state, and federal policies that adopted the Harm Reduction strategy as a care policy for the care of people with needs by the use of alcohol and other drugs are in line with scientific evidence, showing more effective and efficient results in health. As an example, there is the "*De Braços Abertos*" Program, created in early 2014, by the mayor of São Paulo, Fernando Haddad (PT) and collective, inspired by successful experiences in the United States and Canada. The Program was born in the region of Luz, also known as *cracolândia*, in the center of the city of São Paulo, aimed at care in the territory, enabling people with needs by the use of alcohol and other drugs to live, eat, work and health care (São Paulo, 2016).

The Program is a reference in the World Congress on Drugs at the United Nations as one of the best harm reduction policies. However, it was interrupted by the subsequent management, with the election of João Dória (PSDB). The new and current program adopted, called "*Recomeço*", is based on the promotion of drug abstinence and designed by the State Government of Geraldo Alckmin. The program proposes the admission of people with needs by the use of alcohol and other drugs, directing care to this population, against the precepts proposed by the Psychiatric Reform (São Paulo, 2016).

It is important to emphasize that in the political moment we are experiencing, the Federal Government is also moving towards absenteeism models, with the strengthening of three main forces: biomedical psychiatrization through hospitalizations, the judicialization of care through security forces and the moralization of treatments through the strengthening of Therapeutic Communities (mostly religious) (Gomes-Medeiros et al., 2019).

From the health point of view, some of the general effects of this process are the withdrawal of users of Primary Care and specialized services and the ineffectiveness of clinical practices. Also, beyond the health borders, the effects of this process are the overcrowding of penitentiaries and the creation of new prisons, resulting in a crisis of a prison system never seen before in Brazil. The prison context is one of the results of the drug war. The Executive, Legislative and Judiciary powers must propose new concepts and new practices to this crisis (São Paulo, 2016).

Our concerns appeared amid this theme but specifically, they are focused on the practice of the Matrix Support in the care network for people with needs by the problematic use of alcohol and other drugs. The research questions that guided this study were:

- How has the Matrix Support been carried out in the care network for people with needs by the use of alcohol and other drugs? What is the perception of the professionals of Primary Health Care and CAPS AD about the Matrix Support? What are the singularities of the Matrix Support methodology in this context?

To answer these questions, this study aimed to identify the difficulties and facilitators for the development of the matrix support, based on the perspective of professionals who receive and offer the matrix support, in the care network for people with needs by the use of alcohol and other drugs. The study also sought to analyze the work dynamics that are established among these professionals in the Matrix Support.

2 Reconfiguration of the Alcohol and other Drugs and RAPS Policy

The most recent expansion of the care network for users of alcohol and other drugs occurred within the context of the "crack epidemic" in 2012. The media reinforced the idea that the "crack" problem should be treated as an epidemic, distorting the real issue of approaches that strengthened the understanding of the phenomenon as something pathological, which spread uncontrollably. Even before this, in 2001, at the III National Conference on Mental Health, the Harm Reduction strategy was already pointed out as one of the guidelines to be consolidated by Mental Health policies, inaugurating the mainstreaming path to the integration of Mental Health and STD/ AIDS actions. Thus, the Harm Reduction Programs migrated from the exclusive area of STD/AIDS and became part of the Mental Health Care, articulating the Ministry of Health's Policy for Comprehensive Care for Users of Alcohol and other Drugs (Brasil, 2003; Souza, 2007).

The articulation of the Harm Reduction actions in the territories with the Alcohol and Drug Policy in Brazil was a pioneer in the city of Santos, between 1989 and 1994. In 1989, the sanitary doctor Fábio Mesquita (coordinator of the STD/AIDS Program), along with David Capistrano Filho (health secretary of Santos and one of the main militants of the Brazilian Sanitary Reform) were responsible for these first Harm Reduction actions in Brazil (Souza, 2007).

In Campinas, Gastão Wagner de Souza Campos, then secretary of health, made the Harm Reduction an official policy in 2001, paving the way for the expansion of the project, and the Harm Reduction Program was created in 2002. Ordinance 1,028, of July 2005, regularized the Harm Reduction actions in the national territory, expanding the care directed to people with needs by the use of alcohol and other drugs, and the proposals exclusively based on the prohibitionist paradigm. Also, in July 2005, a financial incentive through Ordinance 1,059/GM was allocated to the promotion of harm reduction actions in CAPS AD. In 2002, through Ordinance 816/GM, the National Program of Integrated Community Care for Users of Alcohol and Other Drugs was created within the scope of the Unified Health System, developed jointly by the Ministry of Health and by the State Health Departments, Federal District, and municipalities. The Program organizes actions to promote, prevent, protect the health, and educate people with needs by the use of alcohol and other drugs (Brasil, 2005).

Thus, in the same year, when characterizing the different types of Psychosocial Care Centers, Ordinance 336 includes CAPS AD as one of the central services in the organization of the new substitute care network for users of alcohol and other drugs. In this, the Federal Government's initiatives related to the care offered to people with needs by the use of alcohol and other drugs, such as the Emergency Plan to Expand Access to Treatment and Prevention in Alcohol and other Drugs in the Unified Health System - SUS (PEAD), instituted by Ordinance 1190, of June 4, 2009; and the Integrated Plan to Combat Crack and Other Drugs (PIEC), instituted by Presidential Decree 7179, of May 20, 2010. Through these initiatives, the Ministry of Health started to finance through SUS, Projects Street Offices, Transitional Shelters (CAT), and Harm Reduction Schools. In addition to CAPS AD, this fact has enhanced the emergence of experiences of diversification and expansion of assistive devices (Brasil, 2009).

In this scenario of encouraging projects aimed at people with needs by the use of alcohol and other drugs, the Ministry of Health instituted Ordinance 3,088 in 2011,

establishing the Psychosocial Care Network for people suffering or with mental disorder and with needs by the use of crack, alcohol and other drugs, within the scope of the Unified Health System, strengthening Law 10,216 by updating the proposal for a substitute mental health care network (Brasil, 2011b).

In this context, mental health practices in Primary Care are formally strengthened, including care for people with problematic use of alcohol and other drugs.

Considered as an important demand in primary care, mental health actions are essential if we observe the problems related to this phenomenon that affect large population groups that are still insufficiently welcomed by public policies in general. According to Bertagnoni et al. (2012), the mental health care should take place in a network and include the participation of users and family members as protagonists in the construction of unique therapeutic projects and, for the effectiveness of this network, the articulation of specialized care and primary care is centrally determinant.

In this process, with the implementation of matrix support actions and the consolidation of the Family Health Support Centers (NASFs), the intention was to expand the care network, improve the functioning of the current equipment and train professionals at both levels of care, aiming at the resoluteness and universality of access to services and mental health care. The articulation between mental health and primary care is essential and cannot be postponed, implying profound changes in institutionalized health practices (Brasil, 2010).

The Matrix Support model emerged as a methodology for health work management proposed by Campos (1999), which aims to guarantee a specialized back-up, able to offer both technical-pedagogical and assistance support. Mental health actions in primary care through this methodology seek to promote appropriate responses to users' needs to combat ways of violence and stigma, expanding clinical efficacy and interventional possibilities (Brasil, 2003; Campos, 1999).

The research for this article was developed in the city of Campinas – SP. Since the 1990s, this city has developed actions that are politically and socially committed to the implementation of SUS. The public network in Campinas initiated the Paideia methodology for co-managing institutions and health care, which was an important experience for systematizing the practice of matrix support. Developed by Campos et al. (2014) over the past 25 years, this device has been widely used in health policies and practices in Brazil, as an instrument strongly incorporated by mental health networks.

Based on this reference, mental health, primary care and hospital services of the Unified Health System of Campinas underwent organizational changes, new groups, innovative management, and work process devices. Thus, they sought the institutional democratization and qualification of services to the population (Campos et al., 2014).

Based on these findings and considering that studies exclusively about alcohol and other drugs matrix are scarce in the literature, we proposed to carry out this study, which is part of a broader master's research, aimed to understand the Matrix Support process from the perspective of CAPS AD and Primary Care professionals, specifically in the care network for people with needs by the use of alcohol and other drugs.

3 Methodology

This is a cross-sectional, descriptive, exploratory study with a qualitative and participatory approach. Thus, it is based on the conception of reality and the subject-object relationship characteristic of the qualitative approach to social relationships. In qualitative research, subject and object are related so that the researcher's worldview permeates his approach to the object, and also the researcher is considered a key instrument for understanding the reality to be studied (Minayo, 2010).

Concerning the participatory aspect of the research, Campos & Castro (2014) and Furtado (2001) highlight the importance of health knowledge production as a process by the partnerships between researchers and people affected and involved by the research theme such as network professionals, users, family members, and managers. The authors argue that the choice for participatory research is justified by a political and ideological position, based on ideals of social justice and democracy.

The researcher responsible for this research was also a worker in one of the CAPS AD, who participated in the study at the beginning of the research and, currently, she is the manager of a CAPS AD also participating in the study at the time. Experiencing matrix support processes and the relationship between primary care and CAPS AD as a worker, she enhanced the sensitivity to understand the focus groups, facilitating the data analysis process.

In the case of this research, in particular, the participation of professionals in research on the matrix support process is central to describing, analyzing and transforming these practices since these participants direct care to people with needs by the use of alcohol and other drugs, allowing space for enunciation and reflection on difficulties and potentialities found in daily care actions.

The research had 15 health professionals, in which 8 were professionals from three CAPS AD and 7 were from the Basic Health Units in the city of Campinas, with technical, medium and undergraduate levels, working in the Matrix Support process in the care network for people with needs by the problematic use of alcohol and other drugs, in their roles of professionals receiving or offering matrix support. The data collection period was from February to June 2016.

The inclusion criteria of the participants in the study were voluntarily signing the Free and Informed Consent Form and working for at least six months in Matrix Support practices (as professionals receiving or offering matrix support), aimed at the support network for alcohol and other drugs.

The context of the study was the health network established among the three CAPS AD that assists the health demands of the population in problematic use of alcohol and other drugs in the city of Campinas and the UBSs (Basic Health Unit) that articulate with these CAPS AD from the perspective of Matrix Support. The three CAPS AD participating in the study work together with the Municipality of Campinas, and with the Health Service Dr. Cândido Ferreira.

For this study, only CAPS-AD were listed as potential units of AD care offering matrix support for ABSs because the municipality does not have other matrix support strategies, such as the Health Support Centers of Family (NASF). NASF was recently implemented in the Municipality in which Matrix Support actions already existed.

To locate the participants, the managers of the CAPS AD were initially contacted to identify the professionals who perform Matrix Support and in which UBS these professionals perform it. After this first contact, a date was scheduled for initial contact with the CAPS AD enrolling professionals offering matrix support. This contact took place in team meetings, in which the project, the objectives, location, and date of data collection were presented to the professionals. At that time, nine professionals were interested in participating in the research in the three CAPS AD, knowing that the first CAPS AD has a staff of 42 professionals, in which 07 of them performed Matrix Support actions. The staff of the second CAPS AD had 31 professionals, in which 08 of them performed Matrix Support actions and the last CAPS AD had 24 professionals, in which 08 of them performed Matrix Support actions.

Among the CAPS AD surveyed, two are type II CAPS, and one is a type III CAPS, that is, with availability for eight-night beds. One of these CAPS covered the Northwest and Southwest Districts and hosted the CAPS AD team responsible for the Northwest district, which is the only CAPS AD in the municipality of Campinas with the municipal administration.

Workers from 4 UBSs indicated by offering the matrix services participated in the research. Campinas has 63 UBSs that are responsible for primary health care in the municipality. They are supported and backed by district and central technical teams from the Municipal Health Department and have a local Health Council, with representatives of the user population, health workers, and the Municipal Health Department.

The professionals offering matrix support have technical or medium undergraduate who are in specialized service teams such as CAPS, and who perform Matrix Support actions; the professionals receiving the matrix support also have medium or technical undergraduate training but are part of the Primary Health Care and perform Matrix Support actions. The professionals offering the matrix support provide specialized support to the Primary Care teams; however, this movement should not be understood as a vertical process since the construction in the Matrix Support process is circular; the exchange of knowledge is horizontal and dynamic in search of a stitched network, thread by thread, by the hands of professionals who offer and receive matrix support and users of the mental health network.

We used three instruments for data collection: the professional information protocol, containing information about personal data and related to the length of service and experience in mental health; the service information protocol, containing specific information on the functioning dynamics; and a script for the development of the focus group. The instruments were developed by the researcher based on the theoretical material on the theme and submitted to analysis and validation by specialists in the area.

All professionals participating in the study signed the Free and Informed Consent Term, authorizing the use of the material produced in the research, keeping confidentiality, respecting the prerogatives of Resolution 466/12 of the National Commission for Ethics in Research (CONEP).

For data collection, we used the focus group technique. According to Westphal et al. (1996) and Gatti (2005), this is a data collection technique in which people who share common features deepen discussions on a specific issue. Through this, it is possible to

reach a larger number of people at the same time and obtain data with a certain level of depth in a short period.

Two focus groups were created lasting approximately two hours each, as provided in the literature. The focus group with CAPS AD workers included eight professionals who offer matrix support and the focus group with UBS workers with seven professionals receiving the matrix support, totaling 15 participants. The development of the focus groups was audio-recorded and later transcribed.

The researcher recorded the observations in a field diary. The researcher assumed the role of observer of the focus groups, performing the complete and accurate record of the observations, personal experiences of the professional/researcher, their reflections and comments, and the record of reactions, feelings, behavior of the participants through a field diary. To conduct the focus groups, the team of the Paideia Research Group of the Faculty of Medical Sciences (FCM) of UNICAMP was contacted, in which the researcher participated during 2015 and the professionals who were interested in the theme were invited to participate. Two professionals accepted the invitation to moderate the Focus Groups.

The recording transcriptions respected the veracity and originality of the speeches and the preservation of the identity of the authors of the speeches, as well as the description of the observations. The data from the services' information protocol were analyzed descriptively. The Thematic Analysis proposed by Bardin (2009) analyzed the data from the focus groups, used as one of the techniques of Content Analysis. Based on this approach, the transcripts were read to identify the nuclei of meaning. Afterward, the themes were identified and aggregated into thematic categories.

Before the focus groups and after contacting service managers and coordinators, and filling out the information protocol, we characterized the services based on information collected from the three CAPS AD managers and the four UBS coordinators. Seven services of CAPS AD and Primary Care to which the participating professionals are linked participated in the study. The services were identified from letter A to letter G, keeping the service names confidential. To maintain confidentiality in the participants' identities, those of the CAPS AD were identified by the letter P plus a number and the acronym CAPS, and the Primary Care participants were identified in the same way, by the letter P plus a number and the letters AB.

After analyzing the material collected through the focus groups, the following analysis categories were listed:

- Difficulties and facilitators of the Matrix Support process;
- Specificities that permeate the care strategies for people who make problematic use of alcohol and other drugs;
- Matrix Support Conceptions and Actions;
- Powers and limits of the Matrix Support;
- Management pact or political-institutional aspects.

We will deal only with the first two categories in this article.

The Human Research Ethics Committee approved the project with code 1,505,113, and by the Health Workers Education Center (CETS) approved it by number 083/2015.

4. Results and Discussion

4.1 Matrix support work dynamics

This item shows the results referring to the CAPS AD work dynamics for matrix support actions.

Table 1. Work dynamics of CAPS AD - Matrix Support Actions.

Institution	Existence period of the Matrix Support	Matrix Support Actions performed	Service organization to offer Matrix Support	Units receiving matrix support
A	Since 2012	Case discussions, shared home visits, shared individual and group visits.	Matrix Support is part of the professionals' monthly actions. The team is divided by territorial reference by the UBSs.	15 UBS and 01 Shelters
B	Since 2011	Monthly meetings between the reference couple for the basic health unit. Home visits together, discussions of topics related to the harm reduction policy.	After agreeing on a team and health district, the coordinators agree periodically and the spaces/times they will give Matrix Support.	09 UBS
C	Since 2007	Monthly and occasional meetings with reference UBS, shelters of social assistance, and UAT.	The team is organized around the demand for the basic network and also the internal demand for specialized services.	07 UBS; 08 Shelters; LGBT Reference Center; SOS Rua; UAT

Source: The author – 2019. UBS - Basic Healthcare Units. LGBT - Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transgender. UAT - Transitional Reception Unit.

As shown in Table 1, the Matrix Support goes beyond the borders of the health sector, also occurring in an intersectoral way with assistance services. Thus, it is necessary to facilitate communication between different specialists and professionals and to set up a system that produces a sharing of responsibilities for cases and practical and systematic action, according to each specific therapeutic project, so that interdisciplinarity occurs and contribute to increasing the effectiveness of interventions. It is important that the role of each instance, of each professional, is very clear (Campos et al., 2014).

The matrix support and reference team increase the possibilities of carrying out an expanded clinic and dialogical integration between different specialties, professions, and sectors, facilitating communication between different specialists and professionals, sharing the responsibilities for cases and practical action, and fostering interdisciplinarity

and increasing the effectiveness of interventions (Campos & Domitti, 2007). Table 2 shows the work dynamics of Primary Care professionals to perform Matrix Support.

Table 2. Work dynamics of AB professionals Matrix Support Actions.

Institutions	Period of the existence of the Matrix Support	Matrix Support Actions performed	Service organization to offer Matrix Support
D	Since 2001	Meetings with teams, or groups for projects and shared services/assessments.	Each professional is a reference for 2 ESF, one within the UBS, and one from another UBS of the reference.
E	Not informed	Mental Health Meetings with CAPS III and CAPS AD; Local psychologist of the Mental Health Team and psychiatry at Hospital Escola.	The CAPS and the Psychologist of the Mental Health Team perform Matrix Support in team meetings, with the psychiatry of Hospital Escola held in one period during the week.
F	Not informed	Discussion of cases, construction of individual and collective therapeutic projects.	Discussions held at reference team meetings. Each mental health professional enrolls one or more health teams. The theme of mental health is also addressed in the expanded meetings with CAPS, CAPSij, Community Center, CAPS AD, and schools in the region.
G	Not informed	The Mental Health Team has monthly meetings with two UBSs. Visit and shared actions with CAPS AD.	The team meets weekly with the registered UBS, and the mental health team professionals are divided to attend each UBS. The psychiatrist has an agenda for the three UBS.

Source: The author – 2019. UBS - Basic Healthcare Units. ESF - Family Health Strategy. CAPS - Centers for Psychosocial Care. CAPS AD - Centers for Psychosocial Care Alcohol and other drugs.

Matrix support actions are identified in different ways by different managers

In general, we identified that some coordinators define this support based on their effectiveness groups, such as the meetings between professionals from different services in the network, for example. Other managers identify the support based on matrix strategies (such as sharing cases and PTS building). Although in these definitions the role of the support to promote the inseparability between management and clinic, between clinical and pedagogical aspects is implicit, these roles are not explicitly stated by the managers.

Regarding the services in the Family Health Strategy (ESF), a hybrid group in the municipality of Campinas stands out for these data, which includes minimal mental health teams in the ABS in some units. In these units, the matrix support groups have different shapes in the units that are exclusively receiving matrix support by the CAPS.

The results from the focus groups point out that the professionals receiving the matrix support (ABS) perceive this insertion as a facilitator of the Matrix Support

process, while the professionals offering the matrix support share an opinion regarding the Mental Health teams formally inserted in Primary Care: some highlight that the presence of these teams at the UBS facilitate the Matrix Support process due to the more intensive presence of these professionals in the daily service, and others point out that their presence hinders the Matrix Support process since the potential for mental health demands/offers located in these professionals are great.

Mental Health teams have been established in the Campinas AB network since the 1970s, which were markedly expanded during the implementation of the Matrix Support project. The Mental Health teams have professionals with specific training in psychiatry, psychology, and occupational therapy. At the time of this implementation, about 1/3 of the UBS teams had mental health professionals (Campinas, 2006).

Today, four of the participating units have minimal teams and two have the mental health support exclusively offered by CAPS.

Comparing the two tables above, the CAPS ADs are organized for the Matrix Support process differently from the Abs because each CAPS AD professional is a reference for one or more UBS, a factor facilitating communication and personalizes the matrix support relationship. Another difference in the format of matrix support offered by CAPS AD is that they carry out matrix support actions and health actions, involving intersectoral articulation through territorial logic. The logic of matrix support established by the professionals of the mental health teams of AB occurs through the referral of each professional of the mental health team to at least two ESFs, at least one within the UBS and another UBS of the reference.

The great challenge is replacing the asylum logic, especially in the latest institutional political setbacks, going beyond replacing psychiatric hospitals. Primary Care (AB) has a potential to face this challenge, since it approaches, almost inevitably, the demands of mental health in its daily context, providing new approaches that can avoid unnecessary referrals to specialized services (Figueiredo & Campos, 2008).

Thus, it is necessary to sensitize Primary Care professionals about the power of care to be offered at this care level, understanding that the profile of CAPS AD users is different from people with needs by the use of alcohol and other drugs that are in the territory.

4.2 Difficulties and facilitators of the Matrix Support process

From the focus groups, the professionals mentioned difficulties for the Matrix Support actions in general, such as the high turnover of professionals, the absence of a psychiatrist, the insufficient human resources in the network, the absence of services that cover the specifics of the cases and assistant perspectives of the Matrix Support.

Regarding the specific aspects of the matrix support in the care of AD problems, issues of the prevention and the articulation of care were identified.

The establishment of partnerships between professionals from AB and CAPS AD and building bonds between professionals and people with needs by the use of alcohol and other drugs is favorable for the construction of Matrix Support, mentioned by professionals from AB, increasing the support network for both the user and the general professional, as shown in the statements below.

> *I feel that the basic units use CAPS as a substitute for the affective bonds in the building professional partnerships* (P11 AB).

> [...] *but if you ask like that, who is your reference in CAPS, he knows the name. He knows that if he needs, we act and the person will either receive there or go to the Health Center, so we have been achieving, more recently, we have managed to get CAPS to work together and it works great. We have a lot more difficult today when we call CAPS III and need a bed, right, even at CAPS AD, the reception is different, right, because we know each other* [...] (P12 AB).

Rigotti (2016) states that investing in the establishment of bonds between professionals is matrix support to be established. Thus, identifications are born among professionals, both from the support teams and from the primary care teams, favoring the feeling of belonging to both teams. In this sense, the actions are seen as producing co-responsibility, and the interventions of the professionals who offer the matrix support are not felt as control over the Primary Care teams.

When the matrix support methodology is perceived and used through affections becomes much more powerful. For example, when professionals who offer the matrix support perceive the moral aspects involved in the discussion of a case, and the discomfort or desire, these aspects must be used by the team and not denied, as a bridge for communication, exchanging knowledge and collective construction of care guidelines to people with problems by the use of alcohol and other drugs.

Some CAPS AD and UBS professionals perceive the specificity of Alcohol and other drugs as an element of resistance for resolving care to users, both for access to the service and the reception and offer of care, as shown in the following reports.

> [...] *because I think that in the AD, it is difficult even for users to access the CS, but also to the CAPS, I think that people at CAPS get a very small percentage of people who would demand care in the area* [...]. *Speaking directly of the CAPS AD, of this AD thing, for me, this resistance of the AB starts when they start the conversation saying to the CAPS that "we don't have AD cases in this territory* (P1 CAPS).

> [...] *it is this perspective that I wanted to ask, this thing that we understand as a public health problem, yes, the AD* (P12 AB).

If, on the one hand, this element that is around the process of stigmatizing people using alcohol/drugs, is pointed out as a hindrance to the operationalization of support, on the other hand, it allows maturing and reflecting on the challenges of universality access and comprehensive care, seen in limit situations in the case of this population. Knowing that the experience with drugs is a stigmatized social practice, sometimes results in prejudice, discrimination, and criminalization, creating real barriers to access, and the maturing of the care practice of these people can lead to a democratization of institutions of care for the population in general (Tedesco & Souza, 2009; Souza, 2013).

The people who need the care offered by AD policies are a challenge to the *contrafissura* movements.

Lancetti (2015) understands the concept of *contrafissura* as a social symptom from prohibitionism and its failure, favored by a media current that potentiates the desperation to resolve immediately and in a simplified way aspect related to the use of alcohol and other drugs, focusing on drugs and not on the person who uses them. The author states that *contrafissura* is the first barrier faced by managers and caregivers. This barrier can be understood based on the limits of common sense and, as a social symptom, continues to be reaffirmed, even though its low clinical effectiveness and questionable efficacy. Thus, the *contrafissura* also appears in each caregiver as a certain resistance when linked to the topic of alcohol and other drugs.

The effectiveness in the treatment of problematic use of alcohol and other drugs depends almost exclusively on the user's desire, motivation, and commitment to stop or decrease its use. Then the health professionals are responsible for assisting them in identifying their difficulties and planning changes, always following their expectations and possibilities. This process is built based on a therapeutic relationship of trust and commitment from both parties, and also from a theoretical basis on care methodologies, such as harm reduction, recognized and based on scientific research from institutions responsible for science and ethic. The care given to people who use drugs requires specificities based on subjectivity and respect for the users' choice of care.

The authors Figueiredo & Campos (2009) explain that to change paradigms, it is necessary to qualify teams to incorporate in their performance repertoire, other dimensions of the subject, and their biological facet, valuing their subjectivity and the set of social relationships that determine desires, interests, and needs.

4.3 Specificities of the care strategies for people who use alcohol and other drugs

The item specifically shows care strategies mentioned in the focus group discussions. They mentioned in the narratives, elements such as the perspective of care through the harm reduction and abstinence bias, and the alcohol and other drugs policy. Most professionals who offer the matrix support perceive effective care through the perspective of harm reduction, while some professionals who receive the matrix support specify the care for users of alcohol and other drugs mainly due to the abstinence bias, as shown in the following reports of the professionals of the CAPS AD.

> [...] *yes, and so, currently in the matrix support that I do, in addition to this process of establishing partnerships, it has been a big investment for the reduction of damages in the territory, and in one of the Health Centers that agree with this matrix support, there is a harm reduction area that happens there every time a week* [...] (P1 CAPS).

> *It is those basic discussions, right, of harm reduction, that I think we, right, in AD already work with them in some way, but in Primary Care is still a long way to go. Sometimes, you are discussing the case with this paradigm with someone who is intending to abstinence all the time, and then it makes it very difficult*! (P2 CAPS).

> *But then, it is a lot you can see! The CAPS have to discuss, the CAPS have to talk about alcohol and drug policy, I know that it is our place and such, but only the people who have to talk about it, man, it's exhausting*! (P3 CAPS).

Thus, also through the matrix support, it is necessary to expand the discussions for the practice of harm reduction, which seeks to encourage people with needs by the use of alcohol and other drugs to become protagonists of their relationship with drugs and treatment, promoting self-care with health and the search for rights, which result in public policies.

Unfortunately, the current national view does not go in this direction. The Policy of Integral Attention to Users of Alcohol and Other Drugs supported by Ordinance 1,059/GM, of July 4, 2005, of the Ministry of Health, which intended a financial incentive for the promotion of harm reduction actions in Health Centers. Psychosocial Care for Alcohol and other Drugs, an important policy built from the Psychiatric Reform, implemented more fully through Law 10,216, and in the recognition of the importance of respecting the human dignity of people in problematic drug use (Brasil, 2005) has been at risk since Law 13,840, of June 5, 2019, sanctioned by the Federal Government. With the new Law, the hospitalization of the drug user may be requested by a family member, public worker in the health area, Social Assistance, or public bodies that are part of the National System of Public Policies on Drugs (Sisnad) and will be formalized by medical decision. In addition to these setbacks and threats to the achievements with PNAD, the new law does not recognize Harm Reduction as care for people with problematic use of alcohol and other drugs, recognizing only Abstinence as the only treatment (Brasil, 2019).

This Law also redirects financial investments, stimulating the admission of people with problematic use of alcohol and other drugs in Therapeutic Communities (TCs). CAPS AD are still insufficient and need investment for their expansion and maintenance. However, this fact cannot be justified for directing public resources without bidding, to hire places in private and religious-oriented institutions as most TCs, without fulfilling norms equivalent to those submitted to the services that give health care. Thus, scientific evidence is necessary for these institutions to prove their effectiveness and the numerous investments provided by this new law.

The contexts in which users are on the street, involved with drug trafficking and comorbidities with sexually transmitted diseases were also elements shown by the professionals offering the matrix support as specificities commonly present in the AD network. Such questions launch professionals to share care actions in the network against the limits of the clinic or take the clinic to its potential limit, highlighting the limited situations of these professionals, as shown in the statements below.

> [...] *we started with a very serious case, prostitution, homeless person, exchanging the body for the intense use of crack, full of STDs* [...] (P5 CAPS).

> [...] *there, people who are willing to deal with boundary issues, street situations, and the aspects that AD brings are very dramatic, situations of people attending people in street situations and that* [...] (P2 CAPS).

> [...] *they had many doubts about harm reduction, many ACSs were afraid to approach the territory because some users were drug dealers and some users were in TB* [...] (P1 CAPS).

> *I had the opportunity to offer matrix support to two UBSs, one in the Southwest and the other in the Northwest, and it was interesting that they had very different realities, a more collective use, a very vulnerable and very voluminous dynamic of girls who use them there, not only them but their customers too* [...] (P7 CAPS).

The reports showed the need to approach and clarify the issue of the use of alcohol and other drugs, a fact that directs care to people with such a problem. Drug use is a complex phenomenon, involving other areas than the health area, such as public security and social assistance, for example. It is necessary to understand this phenomenon and care for people from the perspective of complexity, as well as the social representation of the use, the user, and the care. It is urgent to implement public policies from the perspective of an interdisciplinary and intersectoral approach to a comprehensive approach to the individual to qualify access and network bond.

Lancetti (2015) and Souza (2013) highlight that it is necessary to cross the discursive surface on drugs, overcoming the stagnation of roles and restricted relationships between people who use drugs destructively and those who are supposed to cure drug addicts.

The reports of professionals from CAPS AD and AB show that the perception of care for people with needs by the use of alcohol and other drugs is not limited to the issue of substance use:

> [...] *a more comprehensive understanding of the individual, right, the use of the substance and such and that he can also have the care in AB* (P5 CAPS).

> *I think that, sometimes, it is very negative in the matrix support, the user beat the elderly mother or that good boy is now using drugs and then do not generalize, you know, the professional gets these moral judgments, the thing is not the drugs, it is the unemployment, the lack of access to basic things in the territory* (P6 CAPS).

> *Cases, by CAPS AD. You can observe the AD patient from two perspectives today, as a public health problem, a disease, which is what we as health professionals work on, or the path of criminality and everything, you know, that for me it is where the prejudice comes* (P11 AB).

Varanda (2009) discusses the reference to general prejudiced criminality in the homeless population and drug users highlighted by the homeless and users, considering the way they evaluate they are perceived due to the inability of ordinary citizens to distinguish who represents a threat in the context of urban violence.

The understanding of the problematic use of alcohol and other drugs must go beyond the criminal and coercive context. Interventions for people in problematic use should be valued for free care and not by stigmatization.

Little is discussed about the need to modify the reality that determines and co-produces the phenomenon of drug use. It is urgent and necessary to implement public policies that are not based on the understanding that people who use problematic drugs are a

problem, but it is the result of a series of relationships that determine the place that these people occupy in the world.

It is important to realize, for example, that one of the ways of conceiving drug use, which is far from the conventional, is to perceive it as an effort to question, denounce and react to the impoverished forms of existence of oppressed and denied people of a neoliberal capitalist society that emphasizes individual profit and denies the rule of law.

Professionals who receive matrix support revealed prejudice, threats, fears, moral judgments elements in their narratives for the care of users of alcohol and other drugs:

> *Prejudice is a matter of practice, we do it, right, by bandits. You know, they are* "*bandits*" [...] *I see threats to Cândido's employees, to me, you know*? (P15 AB).

> *Harm is a matter of practice, we do it, right, for bandits. You know, they are* "*bandits*" [...] *I see threats to Cândido's employees, to me, you know*? (P15 AB).

> *They threaten. They threaten many professionals at the Health Center* (P14 AB).

> *There is always that thing, you know, I don't feel a willingness to go after it by the people and there is prejudice, right* [...] (P13 AB).

> *And the drug addict is a very different thing than the alcoholic addict, you know. The alcoholic addict is not directly connected with crime, the drug addict is* (P15 AB).

Souza (2013) points out that, after the implementation of Public Policies on drugs in Brazil, the health area was equipped with a political, institutional, and legal arsenal capable of producing clashes and changes over hegemonic drug policies in the Brazilian State. Thus, the problem of drugs could be faced with the expansion of coverage and the invention of new care devices, with a change in looking at this phenomenon to overcome the licit-illicit duality that stigmatizes, mainly, illicit drug users.

Given the statements above, there is still a long way to go to fully overcome the prejudiced in care practices.

This category discussed the specificities of care with users of alcohol and other drugs. Some Primary Care professionals understand the care for these people mainly by the abstinence bias, while the CAPS AD professionals, in general, propose care through the Harm Reduction bias, being able to use abstinence strategies when they are necessary in the evaluation and construction of each singular case.

The participants pointed out factors such as fear, threats, prejudices, and the absence of specific training related to the care of users of alcohol and other drugs.

5 Final Considerations

Primary Care and CAPS AD professionals recognize that the Matrix Support methodology has potentialities not yet reached, but under constant construction. CAPS AD professionals identify that the harm reduction perspective is still little used by Primary Care, and professionals who receive matrix support have difficulties in referring users to some CAPS AD.

The specificities of Matrix Support in the AD network stand out among the themes that emerged in the focus groups, such as the moral aspects and producers of stigmas present in the reports of some participants. Some Primary Care professionals presented speeches showing prejudice and fear for people with needs by the use of alcohol and other drugs. Professionals perceived the matrix support as a means for them to feel appropriate to do qualified listening, reducing anguish and suffering, enabling a collective and cross-sectional construction.

Although the results and discussions produced by the research have been consolidated based on a municipal study, we think that the city of Campinas, as being the birthplace of the matrix support tool concept and its pioneering spirit in the mental health area, has the potential to produce diagnoses of limits and strengths of the matrix support practices that can certainly contribute to the qualification of these practices in other territories.

We understand that the research provided elements that explain the importance of CAPS AD, Primary Care, and matrix actions. A welcoming, non-stigmatizing, and resolving work ethic is needed, overcoming the logic of specialization and fragmentation of mental health actions. It is urgent to consolidate a care network, willing to act in the perspective of transforming the modes of care and care in mental health, especially in the dismantling scenario of SUS and the threat to the sustainability of the basic principles of SUS.

However, the current political scenario full of controversial care proposals in which scientific research is no longer paramount to the care models proposed in mental health, and specifically, to the care of people with problematic use of alcohol and other drugs, significantly weakens changes in the paradigm in which health teams, both in primary care and those of CAPS AD, have been working on the construction of co-responsible care and valuing subjectivity. This resistance is shown in the daily care offered to people, in the dissemination of the effectiveness of care and the demand for preserved human rights.

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Paula de Fátima Oliveira Faria: Text design, organization of sources, and analysis. Sabrina Helena Ferigato: Text review and writing. Isabela Aparecida Oliveira Lussi: Conception of the text, Writing of the text and text review. All authors approved the final version of the text.

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