Cogitare Enfermagem

ORIGINAL ARTICLE

ACTIONS DEVELOPED IN THE TERRITORY FOR USERS OF PSYCHOACTIVE SUBSTANCES: CARE IN FREEDOM?

HIGHLIGHTS

1. Understand care actions in the territory.
2. Challenges in promoting care in freedom for users.
3. Informal support, religiosity, and spirituality are positive in treatment.
4. Challenges in validating Therapeutic Communities.

Daiana Foggiato de Siqueira[1]
Priscila de Melo Zubiaurre[1]
Fernanda Demetrio Wasum[1]
Júlia Oliveira Silveira[2]
Mara Regina Caino Teixeira Marchiori[2]
Keity Laís Siepmann Soccol[2]

ABSTRACT

Objective: To understand the care actions provided by health workers to users of psychoactive substances in the territory. **Materials and Method:** Qualitative, descriptive, and exploratory research. It was carried out in two Family Health Strategies in a municipality in Rio Grande do Sul, Brazil. Semi-structured interviews were conducted with health workers, and thematic content analysis was used. **Results:** The data was organized into two categories: actions in the territory and care in freedom. And the frailties of the territory. It was noted that workers face challenges in promoting care and freedom for users, such as the fragility and setbacks of public policies. **Final considerations:** It is important for workers to resist setbacks and to strengthen other care strategies in the territory, promoting free and comprehensive care for users of psychoactive substances.

KEYWORDS: Primary Health Care; Substance-Related Disorders; Mental Health Assistance.

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[1]Universidade Federal de Santa Maria, Departamento de Enfermagem, Santa Maria, RS, Brasil.
[2]Universidade Franciscana, Departamento de Enfermagem, Santa Maria, RS, Brasil.

INTRODUCTION

The paradigm of the Brazilian Psychiatric Reform, which is still in progress, puts on the agenda the debate about the need to promote care in freedom in mental health in the face of the scenario of violence committed in asylums against people suffering from mental illness. It bets on an important break with the way of understanding the human experience based on psychiatric rationality, proposing the psychosocial model of care[1-2].

This model considers how people live and manage the complexity of life, making it necessary to create a network of decentralized services that can assist them in their territory. In this sense, the Psychosocial Care Network (RAPS, in Portuguese)) enables the creation of a new dimension to the set of mental health actions in the public health system. It is responsible for broadening the population's access to psychosocial care, based on different levels of complexity: primary, secondary, tertiary, and residential[2-3].

With this redirection, the Psychosocial Care Centers (CAPS) became the main service in the RAPS, making up the secondary level of care. Established by Ordinance 336/02, CAPS are oriented towards care in freedom and operate in different modalities, with a community base and open door to demands. The CAPS alcohol and other drugs (AD) is the specialized service responsible for meeting the demands of users with harmful consumption of psychoactive substances (PAS). In this way, the CAPS AD must guarantee the protection and rights of people with problems resulting from the consumption of PAS, as a social and health policy[4-5].

In line with this proposal, in 2004, the Ministry of Health published the Comprehensive Care Policy for Drug Users. This policy encourages specialized services to focus on the rehabilitation and reintegration of PAS users, providing care preferably through out-of-hospital resources, centered on the person, and associated with the social and health network[6-7]. From this perspective, Primary Health Care (PHC) plays the role of the mental health user's gateway to the RAPS. It welcomes users, identifying their needs related to the breakdown of social ties and coordinating actions with specialized services[3,6].

However, it is known that there are still practices that violate the human rights of people suffering from mental illness, especially those who make harmful use of PAS. The use of PAS is commonly perceived as something negative, associated with crime and violence, implying the stigmatization of the user. As a result, a conflict has arisen over how to care for users, led on the one hand by prohibitionist policies, which focus on repression and criminalization, and on the other by policies for care in freedom, reducing harm to people's health and social life[8-9].

Against this backdrop, the new advances, and setbacks in public mental health policies in Brazil, this research aims to understand the care actions provided by health workers to users of psychoactive substances in the territory.

METHOD

This is a descriptive and exploratory qualitative study carried out in two Family Health Strategies (ESF) located in a municipality in the central region of the state of Rio Grande do Sul, Brazil. Eleven health workers took part in the study, including three nurses and eight nursing technicians. They were selected according to the following inclusion criteria: they had been working in the ESF for at least six months, and they directly assisted people who used psychoactive substances. Workers on sick leave for health-related reasons during the data production period were excluded. It should be noted that there were four workers

on leave for this reason. Data were collected using the open interview technique. Initially, information was collected on the characterization of the participants: age, schooling, and time spent working. Then the interview began, guided by the following questions: How is care provided to users of psychoactive substances? What care activities are carried out for users of psychoactive substances here in the territory? What care activities do you carry out for users of psychoactive substances?

The researcher received training from the researcher responsible for collecting the information, as she had no previous experience. In addition, the researcher responsible for the data collection stage had no links with the workers in the health services where the information was collected. Before the interview, the researcher introduced herself to the participants during a team meeting with each of the health teams, mentioning her background, ties to the university, the objectives of the research, data collection procedures, possible risks and benefits, and feedback on the data.

The interviews were carried out individually according to the order in which the workers were invited (randomly) and according to their availability, taking place interspersed between the two FHSs. Data production was interrupted when data sufficiency was reached so that the participants could be interviewed.

The interviews were carried out between January and June 2021, in a reserved room at the FHSs, to guarantee the confidentiality of the information, as scheduled in advance. They lasted an average of thirty-five minutes and were recorded on a digital media device, with the consent of the participants. The recorded material was transcribed in full using the Microsoft Word® text editor and submitted to the thematic content analysis technique.

Data analysis followed three stages: the first was pre-analysis, which corresponded to pre-exploration of the material, in which floating readings were carried out to choose the composition of the corpus of analysis and clippings from the text. In the second stage, called exploration of the material, categories were defined by identifying recording and context units, thus enabling categorization. The last stage enabled the results to be processed and then interpreted considering the relevant scientific literature[10]. Thus, the following categories were created: actions in the territory: care in freedom? And weaknesses of the territory.

The study was approved by the Franciscan University Research Ethics Committee under approval number 4.503.333. The workers who agreed to take part in the study signed an Informed Consent Form. To ensure anonymity, the letter "A" was used, followed by the number of the interview in the order in which it was conducted.

RESULTS

Actions in the territory: care in freedom?

Some of the actions taken to care for PAS users in the territory, according to the workers, are referrals to community institutions, such as churches. These institutions end up taking the user in and, in some cases, referring them to farms (Therapeutic Communities). Clinical examinations and consultations are carried out at the unit when necessary. In addition, groups, psychotherapy, and individual appointments are offered with resident mental health professionals based at the unit.

We have the church here on the avenue. [...] Or he also takes them to the farms; the church refers to them. (A1)

In addition to all the health care, exams, and consultations, people who want to do something are also offered psychological care, which we also have here for mental health (Residence). Here, we have group and individual care. (A2)

Among the actions taken to care for users in PHC, the workers mentioned actions to promote health and prevent the use of PAS, such as groups aimed at users' mental health, and social projects developed by religious people.

Here, the sisters (social project) are the ones who work a bit more on (health promotion and drug use prevention). (A2)

We had the health group, and it helped their mental health and ours too. (A10)

According to the reports of some workers, users monitored by the unit who want to stop using drugs are referred to a specialized service (CAPS AD).

We make referrals to specific CAPS, alcohol, and drugs, but usually, when we do, it's because they already wish to leave. (A8)

I take the person who is a drug user to the clinic. The doctor gives them a certificate stating that they are drug users and can refer them to a clinic. (A11)

Frailties of the territory

Some workers pointed out the fragility of care actions in the area for PAS users. The lack of community actions, institutions, or strategies means that these people end up being referred to other services in the care network. Sometimes CAPS AD ends up being the only alternative. However, according to the workers, users often find it difficult to adhere to treatment.

Here at the unit, we don't have anything specific. As it's the gateway, the first access, we make referrals to the network according to need. (A5)

There isn't much here in the community that we can do anything about. In the past, the agents would even bring us the groups they had precisely to treat this type of user. If it's not CAPS, there's no other one (service). And they often don't want to go to CAPS. It's difficult. (A11)

Workers experience challenges in visualizing the possibilities of effective care actions for substance users and access to treatment strategies.

Yeah, I don't have much to do. Generally, it's not just the drug that affects the drug user. We make appointments. But when it's drugs, it's difficult to do anything but refer them to CAPS. But they don't go there either; it's no use. (A6)

DISCUSSION

The analysis of the interviews revealed that the main mechanism used by workers was to refer PAS users to community institutions, especially religious ones. As a result, they are directed by these institutions toward therapeutic communities. In addition, weaknesses in the RAPS were pointed out, including the lack of community actions and strategies and the difficulty users have in adhering to treatment.

PHC workers said they carry out some territorial care actions for PAS users, including referrals to community institutions, such as churches. According to the interviewees, churches welcome the public who use PAS and work on aspects related to spirituality and religiosity. It is understood that working on spirituality and religiosity during treatment can facilitate the process of achieving positive results, such as improving the quality of life and reducing the risk of relapse to the use of PAS[11–12].

It is understood that churches make up the users' informal social support network. It represents the relationships that the person establishes beyond the RAPS in the various contexts of their daily life, such as relationships with family, friends, the community, and, in this case, churches. However, it is understood that PHC must fulfill the important role of emphatically working on users' links with the components of the formal social support network, that is, with the services of the health network and the professionals. It is known that both social support networks are important when it comes to comprehensive, humanized health care. However, health professionals are expected to seek to enhance the quality of the relationships that users establish with RAPS services[13-14].

Spirituality and religiosity can help positively with the results of the recovery process for users who abuse PAS. However, these aspects carry with them an important distinction. Spirituality is linked to the way a person wants to live and is inherent. Therefore, it does not necessarily depend on a specific religion. It is defined by the relationship established with what is sacred, or transcendent. Religiosity, in turn, is characterized by an organized system of beliefs, practices, and symbols developed to facilitate the approach to the sacred, commonly found in churches. Through religiosity, people are led to discover meaning in their lives. Those who discover it are motivated by a third party to maintain religious practices internally or collectively[12,15].

People who experience significant situations of suffering often turn to religion to find guidance and strength to regain their emotional and psychological balance, to (re)construct the meaning of their lives[16]. Both religiosity and spirituality are known to reinforce positive emotions, such as well-being, optimism, and a sense of control over one's own life. In addition, they are characterized as facilitating aspects in the process of abstinence and adherence to treatment for the use of PAS[12,16].

The churches that receive PAS users in the area, mentioned above, usually refer them to the TCs they are linked to. It is known that the treatment offered in these institutions is based on three essential elements: work, discipline, and spirituality - although religiosity takes precedence over the latter. It is understood that this form of treatment aims to maintain abstinence and the recovery of the user through the individual moral, spiritual, and religious reform of the people being treated. In this sense, the person is taught that the use of PAS is something that belongs to the individual sphere and is associated with sin and the interference of evil forces. In addition, the asylums, and the lack of ways to deinstitutionalize users at the end of treatment stand out[16-17].

It is worth noting that the TCs became part of the RAPS with the introduction of Ordinance 3.088/11, as a transitional residential care service, and received funding from the federal government for their proper functioning[18]. Since then, the policies that ensure these institutions have been strengthened. In 2017, Ordinance No. 3,588/17 was launched, idealizing TCs as services capable of promoting the social reintegration of users with harmful use of PAS. In line with this ordinance, the involuntary hospitalization of PAS users in TCs is ensured by Law No. 13.840/19. Since its enactment, involuntary hospitalizations can be requested by public agencies, family members, or legal guardians, as well as public health or social assistance workers[19-21].

Although there are currently standards and regulations for the work of TCs in Brazil, there are still major challenges for their validation within the RAPS. There is a need to establish universal guidelines and scientifically validated therapeutic approaches so that they can function properly. However, the set of legislative changes that have taken place

recently serve to facilitate and strengthen its operation. In addition, the prohibitionist and criminalizing elements present in the legislative changes allow the national drug policy in the country to become even more rigid[16,22].

In contrast to the proposal for TCs, it is important to note that the Adult Reception Unit (UAA, in Portuguese) services, which are still little known by the population, offer reception to people with needs arising from the abusive use of PAS. Established by Ministerial Order 121/12, the UAAs work with a focus on prevention and health promotion, treatment, and reducing the risks and damage caused by substance abuse. Unlike TCs, UAAs are territorially based and follow the logic of psychosocial care, working with the subjectivity and context of each user. In addition, they work with different strategies for the treatment of harmful use of PAS, since they are based on issues related to the way people inhabit the social space, considering the inequality and marginalization suffered by people [9, 23–24].

Also, in the territorial actions offered by the PHC, according to the workers, there are groups, psychotherapy, and individual consultations with resident mental health professionals allocated to the unit. The fact that there are residents in the PHC to work in mental health practices is fundamental to the construction and maintenance of actions developed by the team. By being part of the work processes, residents sometimes end up taking on the demand for mental health care actions in the service, making it possible for workers and residents to exchange knowledge about new working methods[25].

Beyond PHC, strategies such as health promotion and prevention of PAS use end up happening through religious people or institutions. This shows that in PHC there are no specific programs to assist PAS users, but only individual interventions, counseling, and referrals to other services[6].

Among these services is CAPS AD, which, according to the workers, is the mental health service to which they refer users of harmful PAS who want to stop using. It is known that the CAPS AD should be a leading service in user care, as it is responsible for organizing the demand for mental health and harmful use of PAS. With a territorial and community base, it provides continuous care that considers the complexity of the user's life and relationships, offering comprehensive and intersectoral care. To this end, its actions should be based on Harm Reduction (HR), promoting the formation of bonds and, thus, the social reintegration of the person[16,26].

The HR policy is a care strategy that goes against the prohibitionist policy on the use of PAS, given that repressive actions have not contained consumption, understanding that this phenomenon is associated with people's life experiences. By demystifying the use of abstinence as a means of care, HR proposes listening to life experiences and proposing adaptations of actions to reduce the risks of using PAS[27-28].

Despite the existence of policies that guide this service to work with HR, it is known that some of them do not work with therapeutic strategies other than abstinence, that is, the total interruption of PAS use. Treatment based on abstinence points to care based on moral treatment and illness, making it difficult to take a broad and therefore comprehensive view of the phenomenon of harmful use of PAS. In this sense, to think of abstinence as the sole goal of care is to focus only on the drug, suspending the relationship and meaning of the experience of using PAS. Although abstinence-based care is positive for some users, for many it is synonymous with abandoning treatment and relapsing[26-28].

Due to the fragility of care actions in the territory, referral to the CAPS AD is often the only care alternative seen by PHC health workers. However, according to the workers, users often have difficulties adhering to treatment. It is known that several factors interfere with adherence to treatment for the harmful use of PAS, including individual motivation for behavioral change and the illusory idea that they will only be offered medication[29].

The fragility of care actions in the territory aimed at PAS users has intensified with the current dismantling of public policies in Brazil, especially strategic devices such as CAPS AD and UAAs. The current regulations point to a return to the asylum paradigm, relying on public funding for prolonged hospitalization and, thus, the deprivation of liberty of people who use harmful psychoactive substances[16].

Considering the current scenario of public policies aimed at PAS users, the separation between care practices in freedom and those of repression is becoming blurred. However, it is of the utmost importance for health workers to resist new setbacks and to strengthen community strategies aimed at providing users with comprehensive care in freedom.

Between advances and setbacks, the Brazilian Psychiatric Reform movement has highlighted the need for discussions to emerge about care in freedom in everyday health practices. Caring for freedom is an ethical requirement for health workers, as it means recovering autonomy and creating co-responsibility, respecting the subjectivity of the person who presents themselves. In this sense, it means respecting the other person's wishes and their ability to manage their care based on where they live and the social support resources, they have[1,11].

Care in freedom can be a challenging process, which is constantly under construction and involves changing the way we think about and manage care in health services, regardless of how they operate[11]. In this sense, since the Brazilian Psychiatric Reform, PHC has taken on the role of caring for users suffering from mental illness and/or harmful use of PAS, becoming the gateway for users to the RAPS. PHC must develop actions aimed at preventing use, early diagnosis, care for possible problems and referral to other services in the care network[6].

It is worth mentioning that the study's limitations lie in the fact that only professional nurses and nursing technicians took part in the research and that only two ESFs were investigated. As such, there is a need to investigate this issue with other professional classes and other primary care health services.

FINAL CONSIDERATIONS

This research made it possible to understand the care actions developed by health workers for users of psychoactive substances in the territory. It was noticed that PHC workers have been facing important challenges when it comes to promoting care in freedom for PAS users, a fact that strengthens strategies for working with informal social support networks, involving religious and spiritual aspects.

It is understood that working with informal support networks and aspects such as religiosity and spirituality in the care of PAS users can lead to positive results in their treatment. However, caution is needed, as these strategies reinforce the idea of maintaining abstinence and of people's moral, spiritual, and religious reform. It is known that these strategies are incorporated into the functioning of TCs, an institution that has grown significantly recently, receiving funding from the Federal Government.

Although the TCs are currently part of the RAPS, there are still major challenges to validating them as a service that promotes mental health care, with guidelines and therapeutic approaches based on scientific evidence. On the other hand, there are other strategies for providing care and guaranteeing rights and dignity to mental health service users. These may be strengthened on the ground in this scenario of dismantling public mental health policies, such as actions within the scope of PHC with teams of residents, the HR policy, and the UAAs.

This study pointed to some movements to dismantle public mental health policies in the Brazilian scenario, experienced in the period from 2019 to 2021, going back to the asylum paradigm. However, it is hoped that the study will contribute, in an informed way, to the qualification of health workers and the academic community in general to produce care freedom for PAS users.

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Corresponding author:
Priscila de Melo Zubiaurre
Universidade Federal de Santa Maria (UFSM)
Av. Roraima, nº 1000 Cidade Universitária – B. Camobi
E-mail: zubiaurrepriscila@gmail.com

Role of Author:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Siqueira DF de, Zubiaurre P de M, Wasum FD, Silveira JO, Marchiori MRCT, Soccol KLS.** Drafting the work or revising it critically for important intellectual content - **Siqueira DF de, Zubiaurre P de M, Wasum FD, Silveira JO, Marchiori MRCT, Soccol KLS.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Siqueira DF de, Soccol KLS**. All authors approved the final version of the text.

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