Original Article
doi: https://doi.org/10.1590/1983-1447.2022.20210229.en

Analysis of access to the psychosocial care network for users of alcohol and other drugs in rural areas

Análise do acesso à rede de atenção psicossocial para usuários de álcool e outras drogas da zona rural

Análisis del acceso a la red de atención psicosocial de usuarios de alcohol y otras drogas en el área rural

Elitiele Ortiz dos Santos[a]
Leandro Barbosa de Pinho[b]
Aline Basso da Silva[c]
Adriane Domingues Eslabão[b]

How to cite this article:
Santos EO, Pinho LB, Silva AB, Eslabão AD. Analysis of access to the psychosocial care network for users of alcohol and other drugs in rural areas. Rev Gaúcha Enferm. 2022;43:e20210229. doi: https://doi.org/10.1590/1983-1447.2022.20210229.en

ABSTRACT

Objectives: To analyze the access to the Psychosocial Care Network for rural residents with problems related to alcohol abuse and other drugs.

Methods: Qualitative research, based on the Empowerment Evaluation framework. Data collection took place from March to December 2017 and was carried out through triangulation of qualitative methods with 42 Psychosocial Care Network workers in a municipality in Rio Grande do Sul, Brazil. Data analysis was performed by thematic analysis.

Results: The challenges of access are identified due to cultural issues and the lack of resources to structure the network in its connection with rural territories. Support strategies for access include articulation with other services through matrix support.

Conclusions: The access to the network is precarious for prevention and continuity of care. It is suggested a greater articulation of the network with the rural teams and an investment in the structure of the network.

Keywords: Rural areas. Drug users. Alcohol drinking. Health services accessibility. Health evaluation.

RESUMO

Objetivo: Analisar o acesso à Rede de Atenção Psicossocial para os moradores da zona rural com problemas relacionados ao uso abusivo de álcool e outras drogas.

Método: Pesquisa qualitativa, baseada no referencial da Avaliação de Empoderamento. A coleta de dados ocorreu de março a dezembro de 2017, e foi realizada através da triangulação de métodos qualitativos com 42 trabalhadores da rede de um município do Rio Grande do Sul, Brasil. A análise dos dados foi realizada pela análise temática.

Resultados: Identificam-se os desafios do acesso, devido a questões culturais e à falta de recursos para estruturação da rede na sua conexão com os territórios rurais. As estratégias de apoio para o acesso incluem a articulação com outros serviços por meio do matriciamento.

Conclusão: O acesso à rede é precário para a prevenção e a continuidade de cuidados. Sugere-se uma maior articulação da rede com as equipes rurais e um investimento na estrutura da rede.

Palavras-chave: Zona rural. Usuários de drogas. Consumo de bebidas alcoólicas. Acesso aos serviços de saúde. Avaliação em saúde.

RESUMEN

Objetivos: Analizar el acceso a la Red de Atención Psicosocial para residentes rurales con problemas relacionados con el abuso de alcohol y otras drogas.

Métodos: Investigación cualitativa, basada en el marco de *Empowerment Evaluation*. La recolección de datos se llevó a cabo de marzo a diciembre de 2017, y se realizó mediante la triangulación de métodos cualitativos con 42 trabajadores de la Red de Atención Psicosocial en Brasil. El análisis de los datos se realizó mediante análisis temático.

Resultados: Los desafíos de acceso se identifican por cuestiones culturales y la falta de recursos para estructurar la red en su conexión con los territorios rurales. Las estrategias de apoyo al acceso incluyen la articulación con otros servicios a través del apoyo matricial.

Conclusiones: El acceso a la red es precario para la prevención y continuidad asistencial. Se sugiere una mayor articulación de la red con los equipos rurales y una inversión en la estructura de la red.

Palabras clave: Medio rural. Consumidores de drogas. Consumo de bebidas alcohólicas. Accesibilidad a los servicios de salud. Evaluación en salud.

[a] Universidade Federal do Pampa (UNIPAMPA), Curso de Medicina. Uruguaiana, Rio Grande do Sul, Brasil.

[b] Universidade Federal do Rio Grande do Sul (UFRGS), Escola de Enfermagem. Porto Alegre, Rio Grande do Sul, Brasil.

[c] Universidade Federal de Pelotas (UFPel), Faculdade de Enfermagem. Pelotas, Rio Grande do Sul, Brasil.

INTRODUCTION

In the international context, the 15th World Rural Health Conference, held in 2018 in India, called on the United Nations and international governments to have as a goal "Health for all rural people", since, around the world (174 countries), 56% of people living in rural areas do not have basic health care[1].

In Brazil, the National Policy of Integral Health of the Populations of the Field and the Forest, approved in 2011, is a historic milestone in health and a recognition of the social determinants of the field and the forest in the health-disease-care process of these populations[2]. Communities and rural peoples are those whose ways of life and social reproduction are predominantly related to the field, the forest, water, agriculture and extractivism, and use natural resources for subsistence, with family labor[3].

In rural territories, a problem of relevance in public health is the drug abuse[3]. Drugs are considered substances capable of causing changes in behavior and/or perception, such as medications, cocaine, alcohol, tobacco, among others, regardless of legal status[3–4]. In rural contexts, studies draw attention to alcohol abuse, which is pointed out as a substance not only with the highest prevalence of consumption and dependence in Brazil, but also with the greatest impact on public health indicators[5–6].

Overall, 5.1% of the world's burden of disease and injuries is attributable to alcohol consumption, as calculated in terms of Disability Adjusted Life Years Lost. It is also associated with high mortality, since, worldwide, the harmful use of alcohol represents 5.3% of all deaths[4]. In rural areas, the consequences of abusive alcohol consumption are associated with involvement in situations of violence, psychiatric disorders, suicide and family burden[5–7].

Regarding rural living conditions, alcohol consumption is associated with coping with and resisting stress, insecurity and the difficulties imposed by rural environment[8]. In this scenario, easy access to the drug, the culture of alcohol consumption in the countryside, as well as marginalization and geographic distance from opportunities in the city are identified[5,8]. The social determinants of health in rural areas stem from the difficulty in accessing health, safety, transport, housing, environmental sanitation policies and programs, as well as the lack of technical assistance in the countryside[2–3,9–10].

Mental health care for the rural population is organized through the Psychosocial Care Network (PCN), which are composed of different services, such as the Family Health Strategy (FHS) teams of Primary Health Care (PHC), the Center for Family Health Support (CFHS), which are the PHC support teams in expanding their actions and resolution, in addition to these, there are also Psychosocial Care Centers (PCC type I, II, III, PCC alcohol and other drugs and PCC for children and youth), among other services, which must act in an articulated and intersectoral manner. It stands out for work in PCN, the importance of PHC, considered the gateway to the network and inserted in the users' housing territory, and PCC AD, a service aimed at caring for people with drug abuse[3,11].

Within the scope of PCN, access to mental health is an essential element, due to the aforementioned living conditions and the geographical location of the rural area, which is far from many health services. The guarantee of access goes beyond the geographical aspect, as it includes the prevention of diseases, health promotion, treatment and follow-up that happens in the network[9]. There are different barriers to accessing mental health in rural areas, due to factors related to the training of the system, difficulties in receiving health care, socioeconomic conditions of families and mental health policies being aimed at urban centers[2,12].

In this sense, the study seeks to articulate an understanding of access to health services with elements of culture, prevention, service challenges and the possibilities of articulation in the network for the care of users of alcohol and other drugs in rural areas. Thus, the study presents the following research question: how does access to PCN occur for rural residents with problems related to alcohol abuse and other drugs? The research aims to analyze access to PCN for rural residents with problems related to alcohol abuse and other drugs. The research is justified by the need to strengthen actions in the PCN that can include the needs of rural territories, minimize access barriers, and promote public policies that effectively reach this population.

METHODOLOGY

This is a qualitative research, using the theoretical and methodological framework of the Empowerment Evaluation, which is considered a participatory, qualitative evaluation, built collectively between researcher and research participants, with the objective of analyzing and qualifying the social practices and technologies[13].

The PCN of this municipality was intentionally chosen, as it is a reference in terms of care in the logic of psychosocial care and physical structuring of the PCN, being a pioneer in the implementation of PCC in the state of Rio Grande do Sul. The interest groups of this study comprise the managers and workers of PCN services. The inclusion criteria of the participants were: being a coordinator for at least one month in the network service, and, for workers, having at least six months of employment.

For data production, it was used the triangulation of qualitative methods: participant observation, semi-structured interview and open forum[13–14]. The participant observation is characterized as an important instrument that allows approach with the participants and the research context[14]. In this study, it took place from March to December 2017, with records in a field diary, seeking interaction between researcher and participants in the evaluation process. The participant observation started from the activities of PCC Alcohol and Drugs (PCC AD), in its internal dynamics and in the spaces and connections with the PCN and intersectoral network. The focus of the observations sought the meeting between the actors of the PCN, for the understanding of the way in which the network was perceived by the workers and managers, what would be the mission of the local PCN, the aspects that facilitated and hindered the work and the improvements that could be invested for the qualification of this network. These questions were also addressed in the semi-structured interview, with the objective of listening to each perception and experience of the research participants.

Semi-structured interviews were applied to 42 workers from the following network components: 18 from the Primary Health Care component: Harm Reduction (HR), central health unit, FHS and CFHS; 9 of the strategic psychosocial care component (PCC AD, PCC I, PCC for children); 1 of the urgency and emergency care component; 1 from the hospital care component (specialized chemical dependency ward; 1 from the psychosocial rehabilitation strategies component (employment and income generation service). In addition to these,3 PCN managers participated (mental health, primary care and teaching, research, and extension), 5 from social assistance (Social Assistance Department, Reference Center for Social Assistance, Specialized Reference Center for Social Assistance, Children's House and Better Early Childhood Program); and 4 of the intersectoral network: (guardian council, school, judiciary and public prosecutor's office).

The interviews were scheduled during the face-to-face contact provided by participant observation; afterwards, they were performed individually at the participant's workplace. The interviews lasted approximately 40 minutes, were recorded and later transcribed in full by the interviewer and by an academic member of the research under the supervision of the coordinating researcher. The interview script addressed semi-structured questions. For the present article, the following questions were analyzed: how do you evaluate the articulation of the service that you are inserted with the other PCN services? What are the facilities found in the municipality for network care for drug users? What are the difficulties found in the municipality for network care for drug users? The professionals interviewed were chosen because they are coordinators of the PCN and intersectoral network services, or network managers, or professionals indicated by the coordinators of these services who could contribute with relevant information related to the research object of study. This stage of the interview ended after the semi-structured interviews were performed with all the coordinators and managers of the PCN and the municipal intersectoral network that met the inclusion criteria.

Finally, the open forum (OF) was a technique used to negotiate research data, prioritize the PCN mission and planning strategies for the future, with the participation of professionals who are part of the managing collegiate: 3 managers of the PCN (Coordinator of Mental Health, Primary Care, and Multiprofessional Residency) and representative of the Network components (PCC AD III, PCC I, PCC for children and EMS). The OF was characterized as a space in which the main researcher facilitated a process of data negotiation, through the presentation of a synthesis of the empirical material collected and reflection.

This evaluation was conducted through three stages: 1) Mission construction – building the purpose of the networking, aiming to unify efforts to achieve the network's objectives; 2) Knowledge of the current situation – stage that aimed to identify the main facilities and difficulties of the local network to achieve the mission; 3) Planning for the future – elaborating and prioritizing strategies to achieve the mission[13]. In this article, data from stage two will be analyzed, referring to the knowledge of the network, from which the thematic category related to access to PCN for rural residents with problems related to the abusive use of alcohol and other drugs emerged.

Thematic analysis was used, conducted through three steps: data ordering, data classification and final analysis. In the first one, a floating and exhaustive reading of the collected material is performed. In the second, excerpts and fragments were separated, which were distributed into topics, identified as a unit of information, and then they were approximated by similarity, originating the units of meaning. Finally, the final analysis was performed with a view to interpreting the results obtained[14].

This research was approved by the Research Ethics Committee with Human Beings of the *Universidade Federal do Rio Grande do Sul*, under Opinion No. 2.322.028/2017. It is based on the principles and guidelines of Resolution nº 466/12 of the National Health Council, guaranteeing the anonymity of the participants, who are identified by the letter "T" and the interview number, accompanied by the PCN component in which they work. The letters were followed by Arabic numerals, in the ascending order of the interviews.

RESULTS

The research scenario was a small municipality in RS which, according to the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística* – IBGE), has an estimated population of 44,580 inhabitants (2017), of which approximately 50% live in rural areas. The population is of German colonization, with one of the largest concentrations of Pomeranian descendants in the world. There are five *quilombola* areas monitored by PCN and the Social Assistance Reference Center (SARC). Within the municipality, there are seven FHS with full coverage of rural territories. Among the 42 workers participating in the study, eight are psychologists, six are social workers, three are psychiatrists, two are harm reducers, one is a pedagogue, one is a prosecutor, one is a judge, one is a physical educator, one is an occupational therapist and 18 are nurses, and of these, seven are FHS nurses from the rural area. From these workers, 36 are female. Regarding the time working in the network, 11 workers have been employed by PCN for more than ten years; 11 workers have an employment relationship between 2 and 9 years; and 10 workers have a period equal to or less than one year.

Next, the thematic category related to access to PCN for rural residents with problems related to the alcohol abuse and other drugs will be analyzed, based on the analysis of three information units: culture, prevention, and access; access barriers; support services to minimize access barriers.

Culture, prevention, and access

In this category, the participants problematize aspects related to the culture of alcohol and other drug use in rural areas and the challenges faced in prevention based on the work developed by PHC, as well as access to CPN for users and families with problems due to abusive use.

When evaluating access to PCN for drug users in the countryside, one of the main difficulties faced by professionals is the prevention of the use of alcohol and other drugs in rural areas, since alcohol is part of the culture of this community:

> [...] *the German culture is very strong. And I think, too, well, that maybe a little leisure.* [...] *you will feel it more in the countryside* [...] *where we take people, for example, who work during the day in the fields,* [...] *they, in the late afternoon, go to the shops that they call it stores, and that's where they sell alcohol, there are those pool tables, and they play games, and we know there's a lot of that* (T13 Primary Care Component).
>
> [...] *the use of alcohol in rural areas has always been a problem, and here especially in the region, where the environment used for entertainment is the same as consumption* (T5 Strategic Psychosocial Care Component).
>
> [...] *I think that's the big difference* [...], *there's the whole cultural issue.* [...] *let's think about the countryside, the people who go to the fields,* [...] *do a very heavy job, it's a very tiring job, it's a job without any kind of support, they spend the day working standing, they stay in the sun, they compromise health in many ways. So, their only leisure is being able to go to the store, talk to a friend,* [...] *they get together to play cards, and then they end up, during these events, which in their minds is leisure, making use of some drink.* [...] *and then, it turns out that: "oh no, poor thing, he worked so hard, let him drink his cachaça", "let him drink his beer, he's resting" and they don't see that that could be the beginning of some dependence* (T10 Psychosocial Rehabilitation Component).
>
> *And you'll see that, in the countryside, I think it's even worse, because I think that even there, the woman, she submits and she thinks it's normal, she knows, the man thing. Here there is much more, there is a lot of drugs here, but the use of alcohol in the countryside is very strong. The man goes to the store every day, comes back late* [...] (T11 Hospital Care).

In this way, access to health services occurs when the person already presents acute clinical situations and/or difficulty living in the family and social environment:

> [...] *many times, we can only help when the problem is already installed and, especially, when it compromises clinical health as a whole. Then it's: "oh no, now I'm going to need to take care of myself because I have something else", otherwise* [...] (T10 Psychosocial Rehabilitation Component).
>
> [...] *sometimes, there are areas that don't have [Community Health Agent] and we don't know. Or when they come here, or when it's already on the limit. They will have to go and be hospitalized in psychiatry or somewhere. Then, yes, they get in touch with us: "Oh, there's a patient of yours who came straight here".* [...] (T14 Primary Care Component).
>
> *Really, like this, they seek help when it is that person who is already very, very sick, who hits, who becomes aggressive and then the family member helps, asks for help.* [...] *it wouldn't need to get to that point* (C13 Primary Care Component).
>
> *We have a lot of difficulty, usually, the cases that will come to us of alcoholism like this is when there is already*

a problem in the family context, because, usually, the woman wants to separate, the children are fighting, they are having all this issue. [...] *many times, they come because of the family. Wanting him to undergo treatment, wanting help, because of the context that has become at home, living together became difficult* (C19 Primary Care Component).

To address the use of alcohol and other drugs in rural areas, professionals emphasize networking with integrated actions between the countryside and the city, involving the participation of the FHS:

[...] *as there is this cultural issue,* [...] *we have to know a lot how to get there and what to say.* [...] *each one has its own particularity, we have to know how to identify this, because, otherwise, it often happens that the bond is totally lost and then it is difficult to recover it again.* [...] *then, you sometimes end up creating conflict between them, but then: "ah, but who called, was it you? Did you call? I shouldn't have spoken." So, it's very problematic,* [...] *that's why I like the ACS to be together* [...]*" the one who enters the house, who sits and talks".* [...] *if we create a conflict between them and we still can't do anything, it makes the situation even worse, it's more difficult, right, because they won't want to receive it again and the problem will continue there, and it will probably get worse* [...]. *What makes it difficult* [...] *not to go through everything on the net, to try to solve a case individually. Someone from the city solves a case here in the countryside, or in the countryside solves the one there, and you don't even know the reality.* [...] *we always must work in a network, it improves, we know that there is a result, and it is positive* (C14 Primary Care Component).

Access barriers

The present category refers to the barriers to accessing PCN faced by users of alcohol and drugs and the teams in the rural area. Structural barriers that interfere in users' access to services are evaluated, as well as in the work of PHC in rural territories and in the articulation of these professionals with city services. In addition, proposals for improvements to the local network are suggested.

As a barrier to accessing PCN, the participants problematize the lack of structural resources for users of alcohol and other drugs, living in the countryside, to access specialized services in the city and adhere to the proposed therapies:

[...] *they do not have a good adherence to PCC here in our unit, so we try to solve things here, because PCC works very well, but for the city area* [...]. *It's because you saw how far it is* [...]. *And buses, they are places that are once a week.* [...] *all this makes it difficult for them. So, everything that we can have a resolution here, we solve* [...], *not to mention the financial issue. The ticket becomes expensive and, sometimes, it turns out that what they were going to spend, they end up spending a lot more* [...] *they spend the whole day.* [...] *so, it ends up making this issue of access very difficult* [...] (C17 Primary Care Component).

[...] *sometimes, when I manage to send them along with hemodialysis, they go in the days, but other than that, I'll tell you very sincerely, the van is not mine, I don't have it here* [...] (C14 Primary Care Component).

Transport is also problematized as one of the access barriers in the articulation between PCC AD teams and the FHS, compromising the organization and planning of joint actions:

Yeah, I don't see the planning of actions together, in the city, yes, but those in the rural area [...] *I see it more as a support team, I think it's still lacking, I think because of the logic of the distance, but, so, always with great care, with commitment, telephone contact if necessary, one resorts to the other, but I think there is a lack of joint planning with the rural area* (T5 Strategic Psychosocial Care Component).

[...] *we end up making the most contact by phone, because there is no way to wait until we are able to meet* [...] *and when it is a more serious case, we have to meet,* [...] *then come* [...] *get dressed* (T14 Primary Care Component).

There is no matrix support in the countryside, it is the CFHS, with the team, then we talk, and, if necessary, we contact the PCC, and then we either bring the case to the PCC or it rarely happens that the PCC goes to the countryside, were few. [...] *being from the countryside, people think that transport is more difficult* (T27 Primary Care Component).

[...] *transport from PCC AD is shared with other mental health services, so when professionals need to go to a FHS in the countryside, transport is organized so that PCC I and PCC i can also enjoy the ride. However, as many locations are distant, the visit to the countryside is long, leaving the city team without transport to conduct another activity* (Field Diary).

Another point highlighted is the lack of transport for the FHS in the rural area to develop activities in the territory in its area of coverage:

> [...] *it's not even right, sometimes people come to pick us up and go out and do it,* [...] *what's closer, we do it on foot. Transport is a difficulty* (T13 Primary Care Component).
>
> [...] *it's very difficult.* [...] *like this morning, if they call me asking for a visit somewhere, whether for an emergency, for a complaint, for a bandage, I don't have transport here. It will arrive here, I think, around eleven o'clock,* [...] *if arrives, because it usually arrives later. Then, I have scheduled visits, we stay at noon, which we shouldn't, because it's for lunch, right, because it has to be done, because, later, in the afternoon, I have groups of hypertensive and diabetic, and it's all far away.* [...] *we are letting to do certain things that should be done. Sometimes patients don't like it or complain, but the transport isn't here, what am I going to do?* (T14 Primary Care Component).

One of the suggestions would be the availability of fixed transport for the FHS teams, due to the characteristics of the work they carry out in the territory.

> *We talk to a driver, talk to another, talk to the head of transport, and each one says something different* [...]. *This networking in this part is not working.* [...] *as a nurse at the unit, working in a FHS, I think there has to be a car available to the team every day of the week, as it used to be. Years ago, it was like this, before starting hemodialysis, before having PIM, before having the Happy Child. The van was here.* [...]. *The driver could stay here all morning, but there are days when there are two or three emergencies* [...] (T14 Primary Care Component).
>
> [...] *if they could get a single transport for hemodialysis, all the units go to heaven, because they all refer to the same problem of having to move the car from the unit to the city to be able to take the patients [of hemodialysis]* (T17 Primary Care Component).

Access barriers also involve limiting rural teams to communication networks with other services — telephone and internet signal, as can be observed:

> *There in the city it is possible because everything has internet, outside until they manage to get an internet* [...]. *Because we don't have internet access. Weak phone signal from [Company X] only. Not even the phone, our phone was the same team that provided it, they didn't have it either* (C17 Primary Care Component).
>
> *Here in my unit, it's a matter of* [...] *distance, right?* [...] *we are more isolated, because then there is the issue of the telephone, right? Of not having a line and not having internet* [...]. *I try* [...] *I get it there at the window, on my cell phone, and then I get what is from some professionals, which is easier* [...], *then I talk like that, more on my own* (C15 Primary Care Component).

Support services to minimize access barriers

In this category, professionals evaluate services that act as a support resource to minimize barriers to accessing PCN and qualify care in psychosocial care for users and families with problems related to the use of alcohol and other drugs.

In rural areas, the CFHS is a support resource for the teams, as it participates in monitoring the activities carried out by the FHS:

> *That's how our work together with the CFHS works well.* [...] *It's great. They come more than twice a month, agents have direct follow-up, groups, team meetings;* [...]. *They are part of the team,* [...] *the professionals we have more contact with* (T15 Primary Care Component).
>
> *I think that the CFHS team itself was a facilitator,* [...] *mainly, for people from the countryside* [...] *sometimes, we go in one day and bring things here in the city that the team cannot get out of there to solve, small things,* [...] *referral, document* (T28 Primary Care Component).

HR is another support device mentioned. In a shy way, this service has been participating in the discussions of rural cases and inserting itself in the network:

> [...] *in the countryside, there is a little lack of harm reduction work,* [...] *we participate in hypertensive and diabetic groups, so we try through harm reduction. "Oh, how much are you drinking, what time do you drink? But does it make you any good? Who knows if you drink at another time? Change that drinking routine"* (T27 Primary Care Component).
>
> *Here, there was a time, but now the harm reduction people changed a lot* [...] *they stayed for two years and left, then I don't know how it turned out. It started this past month at FHS X, and then they said that people will come here to work* [...]. *It is, to work, even once a*

month with the staff, with the team of health agents (T19 Primary Care Component).

The professionals also reinforced the need to put into practice the matrix support schedule between rural teams and PCC AD.

The PCC has each technical professional responsible for two units. So, once a month, we go to the unit, whether rural or urban area, and we discuss cases, when we cannot go, with some difficulty, because time is limited or because of transportation difficulties, we make telephone contact, but we do not give up this contact [...]. *So, oh, with primary care it can improve, there are professionals who invest more time in these discussions* (T1 Strategic Psychosocial Care Component).

[...] *we have a reference in each PCC, and then, in fact, it was supposed to come, this reference was supposed to come once a month, for us to talk, discuss cases, but it's not happening anymore* [...] (T15 Primary Care Component).

I feel a little guilty, I haven't been to the BHU since June and I think it really happens, then it's horrible for you to say, but I think it's the same with my colleagues (T3 Strategic Psychosocial Care Component).

DISCUSSION

The PCN aims to expand and promote access to psychosocial care for the population. However, one of the challenges is the effectiveness of its actions in the national territory, in contexts of different cultures and different urban and rural locations, borders and spaces of difficult access, mainly where the infrastructure conditions (roads, transport, health services) hinder a qualified performance of services[3].

In this study, the participants evaluate the challenge of working to prevent the exacerbated use of alcohol and other drugs in rural communities of Pomeranian and German ancestry, where residents have as a culture the frequent use of alcohol associated with leisure, socialization, entertainment, and reward for tiring work of the field. Due to cultural values, excessive use is not associated with possible health problems and chemical dependency. In this way, the cases that reach the FHS already present acute situations, such as cardiovascular diseases, violence and/or difficulty in living in the family environment, work accidents, and, in some cases, psychiatric hospitalization is indicated.

Such analysis is also evidenced in another study, which presents the influence of the social context (culture, socioeconomic issues, work, socialization networks) on drug abuse, in which close contact with people who use drugs becomes a life style considered normal and acceptable, since, in addition to the pleasure of the drug, there is a link with socially constructed values, motivations for use, ways of life and social relationships[6].

Alcohol use is part of many cultural, religious, and social practices. However, it is noteworthy in the Pomeranian culture in which the excessive use of alcohol is also associated with situations of violence, disorders related to alcohol use and suicide, as observed in other studies[5,7]. This evidence suggests investing in prevention strategies of alcohol use linked to sociocultural aspects, in order to reduce communication barriers with this population.

According to an American study, residents of rural areas commonly suffer from a lack of accessible and understandable information about drug abuse and the availability of health services[15]. It is suggested that there is a lack of backup for health professionals, especially regarding formal networks, arising from health policies and other social protection equipment[10]. Furthermore, a study carried out in the United States shows that there are many people and families who even perceive the need for treatment, but do not always seek it, for fear of being seen negatively by the community, due to stigma and prejudice[16].

In Brazil, the difficulties in organizing care actions aimed at the rural area permeate different factors, including the absence of policies to guide the work. In the most recent public policy aimed at the comprehensive care of rural and forest populations, there is no reference to mental health, either to indicate territorial, social and cultural particularities, or to guide the planning of PCN[3].

In the international literature, it is possible to identify that successful interventions in rural contexts involve strategies aimed at regions and specificities, strengthening family and social networks, inclusion of local, religious leaders and local caregivers who can be trained to create bonds between professionals and the community[12].

In the present study, the potential of the FHS to work within the scope of the local culture is identified, mainly through the contributions of the Community Health Agent (CHA). As they are close to the territories and have a bond with the families, these teams know the values, knowledge and dynamics of relationships. In this sense, they are strategic services to organize care based on the articulation of knowledge and technologies present in the network[3]. Scientific evidence shows that a health system that has comprehensive primary care is more effective and efficient in terms of results and costs[1]. In addition, users are satisfied to be assisted in local services, because they are more accessible and less

stigmatizing than specialized mental health services, as observed in a research carried out in Norway[17].

Regarding access barriers to PCN, in the present study, the limitation of structural resources for the countryside resident to access the specialized services of the city and to adhere to the therapies is analyzed. The difficulty of financial resources to pay for transport to the city, the lack of transport from the city hall and the geographical distance of the services to the territory of the population are identified. Rural communities, historically, suffer from a lack of resources that allow them to circulate in the spaces of the city where most of the health equipment is located. The PCC has the characteristics of an urban service, which, for rural residents, may be out of reach, as it requires investment, such as money and transport, resources considered decisive for access to this service[3].

Research participants also point out the lack of transport as a difficulty to the articulation between the teams from the countryside and the city for shared care in spaces for team meetings, home visits and other joint actions. Without these strategies, mental health care in rural areas runs the risk of being limited to spontaneous demand, that is, when a situation is already aggravated.

Another issue highlighted is the limited access to the city hall car. The absence of this resource impairs the team's work in the territory, especially families who live in areas distant from the unit that do not have their own means of transport or have financial difficulties to provide it. It is noteworthy that the FHS involves programmed and articulated actions in community spaces, such as churches, schools, and community centers, as well as the possible need for evaluation in psychiatric crisis situations, which may require transport at any time.

The difficulty of structural resources in rural areas is not limited to transport, but also involves access to communication networks, such as telephone and internet signal, since these resources are not yet available to the teams under study. The professionals use their own resources, such as the internet, cell phone and personal telephone number, for communication, and, depending on the location, the telephone and internet signal do not work. Studies corroborate the innovation in the use of telemedicine, and the guarantee of access to communication networks is the central axis for structuring this work[1,18].

A study conducted with the rural American population identified that the use of telemedicine was associated with greater receipt of face-to-face outpatient services for drug use disorders. Although the study recognizes telemedicine as a promising tool, in practice it is still underused due to infrastructure and technology factors[18]. In Brazil, it is necessary a situational diagnosis of technological barriers in rural contexts . Furthermore, it should be considered that, for this use, technical support and training for the teams are essential[1].

When analyzing the aforementioned access barriers, we realize that, despite the growth of PCN, specifically PCC throughout Brazil, the reality of mental health care in the countryside remains with fragilities[3]. It is seen in this study that the expansion of the PCN must be followed by mechanisms that enable its connection, especially in rural areas, where the expansion of coverage does not reflect on the guarantee of access. It is observed that there was an expansion of the PCN in its structural component, such as the creation of the FHS in rural areas with full coverage, the Better Childhood Program of "Happy Child", the CFHS and the matrix support for the teams in the rural environment; however, this expansion is not followed by adequate planning of structural resources, such as transport, internet network and telephone signal.

As support strategies, the rural teams, the professionals in this study, highlight support from the CFHS and the HR program. The presence of the CFHS in the FHS helps the team feel supported in its actions and as a support bridge to connect with some services in the city. The partnership with harm reduction, on the other hand, is perceived as a powerful strategy that needs more investments, and an organization to systematize the activities conducted together.

The CFHS and the HR are part of the Primary Health Care component within the PCN and have shown support for the teams' work by expanding the scope of actions and monitoring of cases. In practice, the main challenge is the integration of these services for the coordination of care, understanding as the integration of many points of the PCN and accountability for cases. In the case of rural populations, the lack of this coordination increases the difficulty of access, as it fragments care, leaving access to the service marked by acute crisis assistance[11].

In this sense, it is understood that rural primary care actions lack support services, such as HR and extension programs[8], as well as innovative health treatment options, which may include the use of mobile clinics, and consultation via videoconference, text message as support, in order to reduce the distance and allow contact between interdisciplinary teams, as observed in the trend of international studies conducted in Europe and the United States[8,19].

Regarding specialized support in mental health (matrix support), it is identified the need to improve the articulation between PCCad and rural teams. The professionals' statements demonstrate that this matrix support work has already been agreed upon, but in practice, it has not been happening systematically. The problems identified in this study require

investment both linked to health management and the organization of work processes and professional training. With the support of the scientific literature, it is observed in the international experience that, in PHC, teleconsultation models with specialized services can be possible paths for the qualification of teamwork. The use of telehealth can provide access to rural regions and increase the availability of specialized professionals for substance use treatment. Such strategies must be added to the expansion and qualification of workers in rural areas[19].

Another issue is that health management and work in the Brazilian context must consider the social determinants of the rural population, where many still live in extreme poverty. That is, investing in drinking water, food, resources for work in the field, social assistance programs and reducing domestic violence, and health education for users[20]. In addition, professional training is essential to change this scenario, for this, it is suggested investment in health training, including subjects on health in rural areas in the undergraduate and postgraduate curriculum. Investment in scholarships and other educational subsidies can help recruit and retain professionals in rural areas[20]. Therefore, the limitations of mental health care in rural areas demonstrate the need to re-signify work technologies and build new care modes that bring teams closer to rural territories, facilitating the inclusion of people in PCN care actions.

FINAL CONSIDERATIONS

In the present study, it was identified that, for rural residents, access to PCN in prevention actions and adherence to mental health treatments for problems related to alcohol abuse are extremely difficult, due to factors related to the adequacy of interventions that consider the cultural issues of the rural territory and the organizational dynamics of the PCN, which does not have sufficient resources to facilitate users' access to actions. In the rural context, it is evident that access barriers are imposed by the weaknesses of human resources in preventive work and structural transport resources, financial and technological deficiencies that bring teams closer to rural territories. These barriers must be treated as priorities in network management.

Regarding the strategies to support access to PCN in rural areas, the articulations of the FHS professionals with the HR and CFHS teams and the matrix support with the PCC AD are listed as potential. This support qualifies the gateway to PCN in preventive actions and can guarantee the continuity of care that follows access to the network. In this sense, according to the findings of the present study, it is suggested as a possible solution a greater articulation of managers and professionals of the specialized services of the PCN with the teams of the rural territories, in order to support and, above all, prioritize innovative technologies of care for rural contexts. In addition, an investment is suggested in the structuring of PCN within the scope of the SUS, with adequate logistics of resources for users and professionals, qualification of teams and work instruments defined as the systematic spaces of articulation between the teams.

A limitation in this study was the inclusion of only coordinators, managers, and professionals from the PCN and the intersectoral network in the semi-structured interviews. Other evaluative studies with the participation of PCN users and family members are suggested, contemplating their needs, perceptions, and suggestions for possible strategies in the construction of PCN in rural contexts. It is shown as a contribution of the study the indication for managers and workers to include in the organization of their PCN strategies to facilitate the access of alcohol users residing in rural areas, prioritizing actions of approaching the local culture, investment in prevention and resources that sustain connections between professionals and communities. In this sense, the study presents ways to build more accessible and resolute networks at the local and regional scope, and contributions to the strengthening of public policies aimed at rural territories and to the qualification of PCN actions in the care for alcohol and drug users.

REFERENCES

1. World Organization of Family Doctors. 15 thWorld Rural Health Conference; 2018 Apr 26-29; Nova Delhi, India: Wonca; 2018 [cited 2022 Fev 05]. Available from: https://www.globalfamilydoctor.com/conferences.aspx
2. Dantas CMB, Dimenstein M, leite JF, Macedo JP, Belarmino VH. Território e determinação social da saúde mental em contextos rurais: cuidado integral às populações do campo. Athenea. 2020;20(1):e2169. doi: https://doi.org/10.5565/rev/athenea.2169
3. Dimenstein M, Leite J, Macedo JP, Dantas C. Condições de vida e saúde mental em contextos rurais. São Paulo: Intermeios; 2016.
4. Pan American Health Organization [Internet]. Washington: PAHO; 2019 [cited 2021 Aug 01]. Alcohol; [about 6 screens]. Available from: https://www.paho.org/en/node/4825
5. Jaeger GP, Mola CL, Silveira MF. Alcohol-related disorders and associated factors in a rural area in Brazil. Rev Saude Publica. 2018;52 Suppl. 1:8s. doi: https://doi.org/10.11606/S1518-8787.2018052000262
6. Guimarães AN, Schneider JF, Nasi C, Camatta MW, Pinho LB, Ferraz L. Alcoholism in rural areas: biographical situation of relatives of patients admitted to a general hospital. Esc Anna Nery. 2019;23(4):e20190040. doi: https://doi.org/10.1590/2177-9465-EAN-2019-0040
7. Potratz TF, Costa AA, Jardim AP. Pomeranos e violência: um estudo fenomenológico. Braz J Forensic Sci. 2015;4(2):162-76. doi: https://doi.org/10.17063/bjfs4(2)y2015162

8. Csák R, Szécsi J, Kassai S, Márványkövi F, Rácz J. New psychoactive substance use as a survival strategy in rural marginalized communities in Hungary. Int J Drug Policy. 2020;85:102639. doi: https://doi.org/10.1016/j.drugpo.2019.102639
9. Arruda NM, Maia AG, Alves LC. Desigualdade no acesso à saúde entre as áreas urbanas e rurais do Brasil: uma decomposição de fatores entre 1998 a 2008. Cad Saúde Pública. 2018;34(6):e00213816. doi: https://doi.org/10.1590/0102-311X00213816
10. Macedo JP, Dimenstein M, Silva BIBM, Sousa HR, Costa APA. Social Support, Common Mental Disorder and Abusive Use of Alcohol in Rural Settlements. Trends Psychol. 2018;26(3):1139-53. doi: https://doi.org/10.9788/TP2018.3-01En
11. Cirilo Neto M, Dimenstein M. Desafios para o cuidado em saúde mental em contextos rurais. Gerais Rev Interinst Psicol. 2021;14(1):e15627. doi: https://doi.org/10.36298/gerais202114e15627
12. Moody L, Satterwhite E, Bickel WK. Substance use in rural central Appalachia: current status and treatment considerations. Rural Ment Health. 2017;41(2):123-35. doi: https://doi.org/10.1037/rmh0000064
13. Fetterman DM, Kaftarian SJ, Wandersman A. Empowerment evaluation: knowledge and tools for self-assessment, evaluation capacity building, and accountability. New York: Sage; 2015.
14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11. ed. São Paulo: Hucitec; 2008.
15. Mojtabai R, Chen LY, Kaufmann CN, Crum RM. Comparing barriers to mental health treatment and substance use disorder treatment among individuals with comorbid major depression and substance use disorder. J Subst Abuse Treat. 2014;46(2):268-73. doi: https://doi.org/10.1016/j.jsat.2013.07.012
16. Ali MM, Teich JL, Mutter R. Reasons for not seeking substance use disorder treatment: variations by health insurance coverage. J Behav Health Serv Res. 2017;44(1):63-74. doi: https://doi.org/10.1007/s11414-016-9538-3
17. Ruud T, Aarre TF, Boeskov B, le Husvåg PS, Klepp R, Kristiansen SA, et al. Erratum to: Satisfaction with primary care and mental health care among individuals with severe mental illness in a rural area: a seven-year follow-up study of a clinical cohort. Int J Ment Health Syst. 2016;10:40. doi: https://doi.org/10.1186/s13033-016-0072-8
18. Creedon TB, Schrader KE, O'Brien PL, Lin JR, Carroll CD, Mulvaney-Day N. Rural-nonrural differences in telemedicine use for mental and substance use disorders among. Psychiatr Serv. 2020;71(8):756-64. doi: https://doi.org/10.1176/appi.ps.201900444
19. Ali MM, Nye E, West K. Substance use disorder treatment, perceived need for treatment, and barriers to treatment among parenting women with substance use disorder in US rural counties. J Rural Health. 2022;38(1):70-6. doi: https://doi.org/10.1111/jrh.12488
20. Pessoa VM, Almeida MM, Carneiro FF. Como garantir o direito à saúde para as populações do campo, da floresta e das águas no Brasil? Saúde Debate. 2018;42(spe 1):302-14. doi: https://doi.org/10.1590/0103-11042018S120

Acknowledgment:
To the Coordination for the Improvement of Higher Education Personnel (*Coordenação de Aperfeiçoamento de Pessoal de Nível Superior* – CAPES) for granting a postgraduate scholarship to the first author.

Authorship contribution:
Conceptualization: Elitiele Ortiz dos Santos.
Formal analysis: Elitiele Ortiz dos Santos., Leandro Barbosa de Pinho, Aline Basso da Silva, Adriane Domingues Eslabão.
Investigation: Elitiele Ortiz dos Santos.
Methodology: Elitiele Ortiz dos Santos.
Project administration: Elitiele Ortiz dos Santos, Leandro Barbosa de Pinho.
Supervision: Leandro Barbosa de Pinho.
Validation: Leandro Barbosa de Pinho.
Writing-original draft: Elitiele Ortiz dos Santos Leandro Barbosa de Pinho, Aline Basso da Silva, Adriane Domingues Eslabão.
Writing-review & editing: Elitiele Ortiz dos Santos, Leandro Barbosa de Pinho, Aline Basso da Silva, Adriane Domingues Eslabão.

The authors declare that there is no conflict of interest.

Corresponding author:
Elitiele Ortiz dos Santos
E-mail: elitielesantos@unipampa.edu.br

Associate editor:
Carlise Rigon Dalla Nora

Received: 08.02.2021
Approved: 12.30.2021

Editor-in-chief:
Maria da Graça Oliveira Crossetti