Gaining Autonomy & Medication Management (GAM) as a psychosocial care device in primary care and support to mental health care[1]

Gestão Autônoma da Medicação (GAM) como dispositivo de atenção psicossocial na atenção básica e apoio ao cuidado em saúde mental

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Abstract

This study discusses the construction of devices for the production of psychosocial care, which are based on the proposal of Gaining Autonomy & Medication Management in Primary Health Units in São Paulo, where groups were formed based on co-management and sharing of experiences, formed by psychiatric medication users. Workers moderated these groups and attended weekly support workshops for 15 months. This process has given visibility to a complex problematic condition in which the increasing mass prescription of psychiatric drugs over the years in primary care and the concentration of health responsibility on mental health in specialized care services are combined. The construction of these devices allowed a common production of care and support outside the field of medicalization, which destabilized barriers to autonomy, posed by the verticality of health team practices, the workers' domination relations over users and the power relations built around specialized knowledge. The common ground established by users and workers in these collective processes has broadened the notion of support in the Brazilian public health field.

Keywords: Medicalization; Psychiatric Medication; Mental Health; Autonomy.

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Resumo

Discute-se a construção de dispositivos para produção de atenção psicossocial, que são baseados na proposta de Gestão Autônoma da Medicação em Unidades Básicas de Saúde em São Paulo, onde foram constituídos grupos com base em cogestão e compartilhamento de experiências, formados por usuários de medicação psiquiátrica. Os trabalhadores moderaram esses grupos e participaram de oficinas de apoio semanais durante 15 meses. Este processo deu visibilidade a uma condição problemática complexa na qual se conjugam a crescente prescrição maciça de drogas psiquiátricas ao longo dos anos na atenção básica e a concentração da responsabilidade sanitária em saúde mental nos serviços de atenção especializada. A construção destes dispositivos permitiu uma produção comum de cuidado e de apoio fora do campo da medicalização, que desestabilizou barreiras à autonomia, postas pela verticalidade das práticas das equipes de saúde, pelas relações de dominação dos trabalhadores sobre os usuários e pelas relações de poder construídas em torno do saber especializado. O campo comum estabelecido por usuários e trabalhadores nestes processos coletivos tem ampliado a noção de apoio presente no campo da saúde pública brasileira.

Palavras-chave: Medicalização; Medicação Psiquiátrica; Saúde Mental; Autonomia.

Introduction

This research followed construction processes of Gaining Autonomy & Medication Management (GAM) devices in primary health care units, with workers and users, in a field in which the increasing mass prescription of psychotropic drugs is combined with the lack of care spaces and psychosocial care and the concentration of sanitary responsibility on mental health in specialized care services. This orientation towards specialization of care and drug prescription is inserted in a contemporary context of the increasing medicalization of health and life (Zorzanelli; Ortega; Bezerra Júnior, 2014). In the field of mental health, it is driven by the centrality of psychiatry and psychopharmacology and the global expansion of prescription and continued use of psychotropic medication in a context of increasing influence of neuroscientific knowledge on the constitution of lifestyles (Rose, 2013).

Research on the topic of medicalization in the field of mental health fits into a complex global scenario. Whitaker (2017) makes a detailed census of the invention of psychopharmacology in pharmaceutical industry laboratories in the 1950s, involving the creation of a new psychiatry based on the composition of market interests and the medical corporation, in a field of truth production consisting of mass communication, (Food and Drug Administration), scientific journals, government and mental health agencies (National Institute of Mental Health). Thus was created the notion of "mental illnesses" as disorders caused by neurochemical imbalances that could be corrected or compensated for by the action of drugs on neuronal synapses. In this perspective, since 1953, a cataloging of these symptoms-based "disorders" has been built, which constitutes the Diagnostic and Statistical Manual of Mental Disorders produced by the American Psychiatric Association, a standardization tool for psychiatric prescription, currently in its fifth edition, with more of three hundred diagnoses.

According to the World Health Organization, the use of psychiatric drugs has become a habit in the lives of hundreds of millions (Folha..., 2018).

In Brazil, in 2007 the National System for Controlled Product Management (SNGPC) was developed and implemented to monitor and control the abuse and indiscriminate consumption of psychotropic drugs (Anvisa, 2010). In 2015, the Forum on Medicalization of Education and Society (FMES) released consolidated SNGPC data on psychoactive drug use in Brazil. From 2008 to 2014, this report records a 296% growth in Ritalin consumption and, from 2009 to 2013, a 531% growth in Clonazepam consumption (FMES, 2015).

Given this global scenario, since the late twentieth century strategies have been created to enable alternative forms of action and care – Open Dialogue (Kantorski; Cardano, 2017); Hearing Voices Movement (Kantorski et al., 2017); Gaining Autonomy & Medication Management – based on the construction of dialogic spaces in a network that contradict the growing medicalization in the field of mental health.

Gaining Autonomy & Medication Management

The GAM was first formulated in Quebec in 1993 from the mobilization of mental health service users and workers and academics concerned with respect for human rights, citizenship and the protagonism of people taking psychiatric medication (Rodriguez Del Barrio; Poirel, 2007). In this context, GAM constituted a strategic positioning in the health area that advocates autonomy – individual and collective – and the active participation of users in decisions about the use and non-use of psychiatric medication; a position that bets on expanding the network of existential connections (Merhy; Feuerwerker; Silva, 2012) and on the shared management relations of collective health processes (Passos et al., 2013).

The GAM strategy was initially built and researched, both in Quebec and in Brazil, with users considered to have "severe and persistent mental disorders" (Brasil, 2002). The Brazilian version of the *GAM Guide* was adapted from a multicenter survey (Onocko-Campos et al., 2012a) in Psychosocial Care Centers II (CAPS II), a specialized mental health care service. The *GAM Guide* consists of a set of questions to problematize the relationship with psychiatric drug use and autonomy in mental health care processes (Onocko-Campos et al., 2012b).

In ten years, a continuous process of research and implementation of GAM in the Psychosocial Care Network (Renault, 2015; Silveira; Moraes, 2018; Zambillo; Palombini, 2017) has led to recent trials in various network services – CAPS Children and Youth (Caliman et al. al., 2018); CAPS Alcohol and Other Drugs and Primary Care (Caron, 2019). In the research addressed here, processes of construction of GAM devices were accompanied in Primary Health Units (UBS) that provided a service training and support work and the experimentation of shared care practices with workers, users and academics, which can contribute for community psychosocial care practices in primary care. These experiences constituted a capillarization process of the GAM strategy in 2017 and 2018 in the city of São Paulo, in the Vila Brasilândia neighborhood, in two UBS and one CAPS III Alcohol and Other Drugs (Caron, 2019).

Methodological procedures: a support-research

We consider this to be a support research, in which the academic researcher, besides studying the construction of GAM as a device, was also a supporter of the workers, administrators and user collectives in four meeting spaces: regional meetings; general team meetings; support workshops with workers and administrators; GAM groups with users and workers. Workers in the area covered by the Technical Health Supervision (STS) of the Freguesia do Ó and Vila Brasilândia neighborhoods who were interested in getting to know GAM participated in a joint initial training. A portion of them organized to start building the device locally and the researcher-supporter was invited to facilitate support workshops in each unit and to follow up on the GAM groups with users.

1. Regional meetings: held bi-monthly or monthly. These meetings brought together workers – community agents,

pharmacists, nurses, social workers, psychologists, doctors, technicians – unit and STS administrators, interns and professors from the Pontifical Catholic University. Thus, in each territory, a space for evaluating the device's construction processes was constituted. After the constitution of the GAM groups in the units, users started to participate in the regional meetings.

2. General team meetings: In each unit general meetings were held with the entire team to address GAM issues within the unit, without definite frequency. These meetings, with 40 to 60 workers, addressed problems related to psychiatric medication in the work routine at UBS and in its area of coverage. The general meetings deepened the team's relation with the GAM proposal and became a space for discussion and knowledge about the territory and work.
3. Support Workshops: In each unit, weekly meetings were held with a group of workers and eventually the administrators of the units, setting up a collective support for workers and problematizing psychosocial care in those territories. The workshops were a collective transdisciplinary device for producing a common plan around the GAM strategy. Initially, the territory was analyzed, notably the relationships between the service, professionals and users regarding the prescription and use of psychiatric medication, which allowed us to formulate a design of the problems around the use of psychiatric drugs and a local project based on the GAM perspective. From this formulation, users were invited to participate in weekly meetings. These workshops, then, constituted a space for monitoring the processes brought by the device.
4. GAM groups with users and workers: in each unit, weekly workers were moderators of a GAM group with psychiatric medication users about medication use and user autonomy. Participants could make ancillary use of a specific tool – *the GAM Guide* (Onocko-Campos et al., 2012b). In these groups, the participants were in a circle and a laterality position was cultivated with each other; the proposed relationship mode was sharing and co-management (Melo et al., 2015).

The workers participating in the research were: administrator, pharmacist, general practitioner or family doctor, nurse, social worker and high school workers – community agents, nursing technicians and assistants and a reception worker – and, together with the users, they were invited to be researchers of a shared investigative process of GAM experimentation at each unit, but such participation was not required to be part of the GAM group. The names of the participant-researchers are the authors of studies presented at events and proceedings and were certified by those responsible for the research, which was authorized and registered with local and regional management bodies approved by the Research Ethics Committee (REC) of the Municipal Department of Health of São Paulo – Certificate No. 62652516.6.3001.0086 – and REC of the School of Public Health of Universidade de São Paulo – Certificate No. 62652516.6.0000.5421.

Elements of a problematic field

At the first general meeting in one of the units, a female worker, rapporteur of the meeting, wrote the word **demindcalization** on sheets of paper pinned to the wall. This act drew participants' attention to the match between the written word and the term "demedicalization" that had been quoted by a meeting participant. In the form of a lapse, a sense of demedicalization of the **mind** emerged in that collective, heralding a field of GAM-related un-psychiatry and un-psychopathology. When discussing the prescription of psychiatric medication in daily work, a statement came out of the usual sense that destabilized the limits of the mental health field regarding the medicalization of life and care.

Over the years, a population of psychiatric drug users has accumulated on the agenda of both units. In UBS pharmacies, the register of users of psychotropic medication is scattered and there is no consolidated data on the number of users. In one UBS, it was estimated that seven to nine thousand users regularly took psychotropic drugs from their pharmacy. In another, three thousand users of benzodiazepines were raised.

Once the user receives a prescription – often at a specialist care facility with a referral to UBS – the subsequent prescriptions are made by the primary care physician or family doctor, who only repeats the prescription. Thus, successively, the same prescription with a new date is issued in batches with dozens of users who periodically attend UBS for "prescription exchange", a procedure in which there is no objective or time for consultation and evaluation. According to a unit administrator,

> *there is a kilometric list of patients taking psychotropic drugs, who come to UBS in search of prescription exchange, without evaluation, without consultation, without dialogue. We are giving medicines without knowing why.* (UBS administrator)

Doctors complained about the short duration of consultations (15 minutes), reduced listening, sparse dialogue, and pointed to the problem of continued prescription of limited-use protocol drugs. One doctor said that over the course of 15 years at the same UBS, he prescribed psychoactive drugs to thousands of users, seeking to alleviate patient symptoms without thinking that this could become a serious problem. They were intimidated when users aggressively demanded the drug. During periods when there was a shortage of medicines at UBS, community agents were threatened by users to obtain psychiatric drugs.

Workers reported that users often distributed drugs to others, or used more drugs, and the medication quota was insufficient. Nurses and community agents reported that psychiatric drugs were being sold in the informal illicit drug market. One user who attended the GAM group reported that she bought the medication in the informal market for a lower price than in pharmacies.

A problematic field was delimited around the chronification caused by the indiscriminate use of psychiatric drugs, in which thousands of users in the areas covered by the units gave the medicines their trajectories and uses without accompaniment or spaces for attention and care. The workers' narratives gave visibility to an omission regarding the living conditions and needs of these users of psychiatric medication in the UBS work routine. An invisibility of mental health in primary care could then be seen and coupled with the mass consumption of psychotropic medication, both sustained by a routine of continual prescription renewal, constituting a problematic condition that was not addressed by teams and mental health support strategies.

Support workshops and displacement of knowledge centers

In the space opened by general meetings and support workshops, there was a large influx of workers, mobilized by a desire for training and action in mental health care. Many community agents, technicians and nursing assistants appropriated the GAM construction space. This high participation of workers with high school education was a sign of a shift in the action of specialized knowledge centers of higher education in that space.

Although there were regular meetings with the support of CAPS, CAPS for Children and Youth and CAPS Alcohol and Drugs, and there were also follow-ups with a Family Health Support team, which are of fundamental importance for mental health work in primary care, these strategies did not address the issues at hand.

In addition, there were antagonisms and mutual criticism between the basic unit and support teams. The usual spaces of support were, therefore, insufficient in view of the needs of training and action in the field of mental health care.

Cogestive practices in support workshops

The willingness to participate in a common production around the GAM proposal, which encouraged many workers, contrasted with a work routine tied to a *repetitive scheme*, in which the relationship with the user was described by the workers as *conditioned*, and which resulted in loss of sensitivity and enthusiasm for work. Thus, the criterion of autonomy in drug management, brought in the debates promoted by the GAM, showed power problems in the service's routine and gained importance concerning other control practices, including diabetes and hypertension follow-up.

The cogestive practice in support workshops quickly opened the possibility for workers to express their implication with the theme of autonomy and health. The discussion about the right to participate in treatments, information about procedures and medications, and the decision about the conduct was configured as a moment of sharing experiences. One participant stated that *at Family Health team meetings we cannot talk about the problems we have suffered, we can only talk about the patients' cases, at GAM we can talk about what we have been through* (Community Health Agent). In the support workshops, the field of mental health entered through the path of sharing life experiences.

Obstacles and resistances

At first there was a resistance from family health teams to open a dialogue with users about their needs and medication use. The community agents pointed out that the physician and nurse, who are the authority on the teams, were not responsible for the implementation of the GAM and thus weakened the invitation to users. The reason for the hesitation to make the invitation was that the user needed the medicine for health reasons, could not be without it and that, then, GAM was recommended only for those who would be advised to *change their medication* (Community Health Agent).

Initially, users were invited during home visits. On these occasions, the usual way for Family Health Strategy teams to call on users to come to the UBS was described as "giving a message" that included explaining the purpose and reason for attending. That is, the usual way in which the professional speaks and guides while the user listens and follows. This message was sufficient when the user wished to schedule a procedure or an exam, but had no effect as an invitation to join an unknown group. The invitation to the GAM required dialogue, an unusual openness to the user experience, listening to the person being invited, and an interest in their needs.

The main hindering factor in joining the GAM group was the lack of access to mental health care other than prescription renewal (if that can be called care). It was then sought to invite users who came to the unit for this purpose. In these moments, it was possible to create a space for these people to express their needs and experiences with the use of medication and to contextualize the invitation to the GAM group.

Repercussions and experiences of displacement in the dialogical field

People who came to the unit periodically just to renew their prescription could talk about their lives, be heard and seen. Worlds previously imperceptible gained visibility, displacing the point of view (and listening) of those workers, who felt helpless before those narratives, of which we transcribe some excerpts:

> José never leaves his home, he lies on the couch, he's very afraid. He has been using drugs that are no longer effective for 11 years and has asked the group for help in *changing the medicines*.

> In the first crisis, Gilmar began to break everything around him during work. He constantly hears voices that speak offensive things against him. He came to the group because he never had the opportunity to participate in a group of people.

Jonas drank a lot until he had a *mental problem.* He stopped drinking and became *addicted to medicines.* He is very afraid and only goes out accompanied by his sister. He wants to get rid of this *drug addiction.*

Lucia separated from her husband, who treated her *like a prostitute.* She injures herself by cutting her skin and imagines that when lying in bed, she is lying on knives.

Alda says *the medicine is my drug*, and she comes to UBS for a prescription just as *a drug addict goes to the crack house.*

Lizete lives alone and often does not leave the room, does not take care of her hygiene or the house. She feels *robotic by the medicine.* She takes medicine to try to avoid seizures in which she struggles on the floor. She says: *I do not understand what people say. I listen, but I forget.*

When someone comes to her house, Iracy stays in the room with a very bad feeling. She feels her life is *controlled by medicines* and wants *to have her life back.*

In the context of disconnection between work in primary care and psychosocial care, lack of spaces for conversation about suffering and use of psychiatric medicine, participating in GAM was configured as an unprecedented experience.

The narratives collected gave light to the invisible place of abandonment of those suffering people, which caused much discomfort to workers. Some thought that these users should be referred to specialized care. The misconception reappeared as to who should provide adequate care to these "patients" seen as "mentally ill" and classified by the health system as having "severe and persistent mental disorders" (Brasil, 2002), a term that condenses a problematic spectrum.

Surprised, a nurse assistant said she had been visiting at a user's home for three years and *had never heard the things she said there at the very first meeting* (Nursing Assistant). This contrast is significant: at the very first meeting, there was room for the person to say what in three years the worker did not hear. In those meetings, when opening space for expression and listening in mental health, it was shown that the usual work in primary care and Family Health teams was not sensitive to the needs of those users, and that the sharing provided by co-management and the perspective of autonomy offered other possibilities for work.

Another point that contributed to the discomfort of the moderators was the shift of the professional from the command position. Moderators felt deep discomfort not knowing what to respond to users' narratives. So, the automatic, conditioned reaction was to say something that diverted listening from what the person was saying. The usual way to intercept listening was to give an answer, an explanation, to speak a generality that fixed codes to that existential territory and deprived the other's speech of its difference and strength. Thus, the moderators updated automatisms that actively conserved and produced the group in the subjected position.

Another form of subjection could also be imposed by the lack of attention. When one user reported that she was getting worse when she remembered that as a child she was abused by her older sister, and at the group meeting reported which abuses were, the moderators did not listen, did not give the moment a time of silence, or the attention to what had been said, and quickly changed the subject.

Such subjectivity forces by subjection were always active. The moderators, supporter, and academics were able to experience how difficult it was to listen and stay connected, rather than intercepting the dialogical field, either by responding reactively or by dropping the listening demands expressed in the narratives. Sustaining the communicational field required dealing with the forces that retained the constraints and restricted desubjectivation movements. We understand "desubjectivation" as displacements of subjective position in which one goes through a zone of confusion, one outside oneself, and experiences a temporality of transit and change (Pelbart, 2013).

It should be noted that those forces that conserve constraints, or those that produce subjection, are centripetal, because they refer to a center, a certain identity, the preservation of a status that was being destabilized by the call for autonomy in sharing put into action in that collective. They were reactive forces that pointed to the conservation of stabilized positions in ourselves. So, working in the group was also a strength relationship with oneself, with one's own ways of seeing and saying, thinking and reacting.

The communicational field constituted in those meetings was not centered around structured knowledge nuclei, which left the members less protected by a rationality that, in explaining, dominates the object. The narrated experiences escaped from a diagnosed place, there was no behavior to be understood as a symptom, pathology to be classified, nor subject to be explained. It can be said that these encounters were less limited by scientific rationality, the "mindcalization", the medicalization of the mind, and in this condition the members of the group could be more directly affected by the narratives.

Collective autonomy and harm reduction

Throughout the meetings, it was visible and commented in the group that something changed. Jonas, who previously only came to UBS accompanied by his sister, because he was very afraid of leaving home, now comes alone; He said he was going for walks and going to the town square to exercise. Gilmar brought his wife to the GAM meeting because he wanted to introduce her to the group he was meeting weekly with and that was doing him good. Lucia was now managing joy in the group, listening carefully to others, meeting Alda during the week, and returned to her work. Alda, who had come to the group to get the prescription she wanted, was now experimenting with sleeping without medication and decreasing the antidepressant during the day. Because they met in the GAM group, Alda went with Lizete to the salon. Lizete, who often didn't even leave her room, went to a party with Alda. Leaving that place where she "didn't understand" and "forgot" what others said, Lizete started to pay attention to the group.

At each meeting, numerous small gestures of autonomy expansion were produced in the midst of a multiplicity of care needs. In one of the units another name was given to the device: Autonomy in Life. A space of mental health care was affirmed for the constitution of enriched existential territories that favored greater autonomy in life. We are dealing with a notion of autonomy that goes beyond the scope of the individual, although, as we saw in the processes narrated above, there was also an expansion of individual autonomy.

We discuss here with the concept of vital normativity, proposed by Canguilhem (2009), as an inherent capacity of every living being to construct norms of life, so that the greater the amplitude of relationships, the greater the individual's network of connections, the greater autonomy in their living. In order to broaden this notion in the collective plan, beyond an individual normative capacity, we add the notion of transversality proposed by Guattari (1985). This notion proposes a dimension of the collective that goes beyond the pair of coordinates – verticality and horizontality –that regulates relationships in the form of hierarchies and identities. A dynamic dimension that produces displacement, traffic, destabilizes the boundaries given by a certain mode of organization and brings into play the undetermined and the out of sense. For Guattari (1985), it is in this zone of indetermination that new existential possibilities emerge. These two notions – vital normativity and transversality – help us to conceive autonomy as a possibility of collective action and the expansion of normative capacity in the common plan, which, in this case, included the worker and the academic, as well as the user.

In this network sharing plan, new modes of existence emerged, which gave the device a new visibility in a perspective that we call "harm reduction", a term that has its origin in the field of integral health care of people who use or abuse alcohol and other drugs. The incursions with the GAM proposal into a CAPS Alcohol and Drugs pointed out that the contraction of groupality and cogestive sharing produced effects of a safety net with potential for harm reduction and increased

autonomy in relation to psychoactive substance use (Caron, 2019).

Closer to the original meaning of the term "harm reduction", the GAM device assists the invention of ways to reduce harm produced by the use of psychiatric medicines and other drugs. The discussions proposed in the *GAM Guide* and co-management practices place a political field in the constitution of a contractual power of these users, primarily in relation to rights in the health area. Further on, this political field extends to the constitution of a citizenship that includes the defense of human rights against stigma, social segregation and physical and moral abuse. The device helps to destabilize the status of "mentally ill" and "mental illness" and thus promotes a reduction of iatrogenic damage produced by relationships in the field of medicalization of health and life.

But, above all, the contraction of groupality in a communicational field in which the different participants were side by side provided a qualification in the ways of walking in life. Each in their own way was the inventor of that damage-reducing territory and reaped its effects on life. An affectability involved the participants in those meetings. As positions fixed by rules and coordinates regulating relationships were shifted, then an affective connectivity that took place in a communicational field sensitive to experiences began to intensify. In this open field of sensitivities, there were gestures of care for each other. The cogestive practice allowed the protagonism of users in sharing care, a comprehensive way of being together with each other in a harm-reducing experience.

From this perspective we operate a repositioning of the term "harm reduction" both in the care of users of alcohol and other drugs, and in health work in a broad way.

Final considerations: formation in conjunction and support in movement

The experience addressed here dialogues with a field of production of theoretical and methodological contributions that has contributed with public policies of academic formation and permanent health education in the perspective of the emergence of new practices and the integral care proposed by the Brazilian Health Reform. A vast field of problematization in which we only draw a few lines on the theme of support for care practices (Campos, 2000; Merhy, 2010; Merhy et al., 2014; Novos..., 2014; Passos; Barros, 2006; Pereira; Feuerwerker, 2018).

We saw that these meetings profoundly affected workers and changed their views and conduct at work. In the field opened by the device a support to the worker's activity was operating that far exceeded the support function performed by the supporter.

Moderating physicians, general practitioners, approached mental health not through the door of psychiatry or psychopathology, but by reducing the iatrogenic damage caused by conduct. One of the doctors shared that his listening in appointments had changed and he was treating people in another way. He says he is now *beginning to understand the Psychiatric Reform* and *how mental health patients can get attention at primary attention* (General Practitioner).

These were processes in which all participants were in training. We started from a proposal, an idea, but no one knew what that idea could be, no one knew a priori how to make GAM, and that was exactly the common reason that catalyzed the varied desires of participation of academics, administrators, workers and users: know, learn, try a psychosocial care proposal. This opening, which was an initial condition of not knowing, later proved to be a quality that favored the realization of the device and encouraged participation in the shared process of care and knowledge production.

Training and support were gestated and practiced in a common plan which, as a plan, is open and centerless. It was a process of formation and support in which experience itself was the focus of formation. The formative process was a movement that took place when it was possible to dwell on experience, when questioning the experience and allowing ourselves to reap its effects.

This attention to the experience was an invitation to a multiplicity of looks and visibilities, which facilitated the access to transversality, helped to escape the frameworks that stabilize the field of relationships and provoked transits in which new ways of thinking, existing and caring were possible.

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Authors' contribution

Both authors conceived, wrote and approved the manuscript.

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