Original Article

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Primary Health Care and users of psychoactive substances: possibilities and challenges of care

Atenção Primária à Saúde e usuários de substâncias psicoativas: possibilidades e desafios do cuidado

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Abstract
Objective: to know the possibilities and challenges of care provided by health workers to users of psychoactive substances in the territory. Materials and methods: Qualitative, descriptive and exploratory research conducted with 11 health workers from two Family Health Strategies. The open interview was used and the data treatment occurred through the thematic content analysis technique. Results: some workers still resist working under the logic of harm reduction, producing comprehensive and person-centered care in the face of the possibilities that the devices and care strategies in the territory offer. Conclusion: the care actions provided by health workers to users of psychoactive substances in the territory suffer from the setbacks of public policies aimed at this public.
Keywords: mental health; primary health care; substance-related disorders; mental health care; drug users
Resumo

Objetivo: conhecer as possibilidades e os desafios do cuidado prestado pelos trabalhadores de saúde aos usuários de substâncias psicoativas no território. Materiais e métodos: Pesquisa qualitativa, descritiva e exploratória, realizada com 11 trabalhadores da saúde de duas Estratégias Saúde da Família. Utilizou-se a entrevista aberta e o tratamento dos dados ocorreu por meio da técnica de análise temática de conteúdo. Resultados: alguns trabalhadores ainda resistem em trabalhar sob a lógica de redução de danos, produzindo o cuidado integral e centrado na pessoa diante das possibilidades que os dispositivos e estratégias de cuidado no território ofertam. Conclusão: as ações de cuidado prestadas pelos trabalhadores de saúde aos usuários de substâncias psicoativas no território, sofrem com os retrocessos das políticas públicas voltadas a este público..
Palavras-chave: saúde mental; atenção primária à saúde; transtornos relacionados ao uso de substâncias; assistência à saúde mental; usuários de drogas

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Introduction

The Brazilian Psychiatric Reform is an important milestone regarding the establishment of the protection and rights of people suffering from mental disorders and disorders resulting from the use of psychoactive substances (PAS). It proposes the change of the hospital-centered and biomedical model of care to a model based on a thematic and priority network in mental health, composed of community and territorial care services[1].

Thus, the new model of mental health care is now ordered by the so-called Psychosocial Care Network (PSCN). Established by Ordinance n. 3.088/11, it implements the integral care prioritized by the Unified Health System. It consists of different levels of complexity (primary, secondary, tertiary and residential), in order to enable greater social integration, autonomy and protagonism to the subjects assisted[2].

In this sense, Primary Health Care (PHC), as a primary level of care, becomes part of the PSCN, characterizing itself as its gateway. Its role is to break with the traditional model of care, expanding the clinic of psychosocial care. Regarding the care of PAS users, PHC plays an important role, due to its capillarity and its ability to achieve the reality of life in the territory. It performs, through its multidisciplinary team, prevention and health promotion actions, early diagnosis, treatment under the logic of harm reduction, care for complications, and the construction of extended therapeutic projects[3-5].

As a secondary level of mental health care, there are the Psychosocial Care Centers (PSCC) in the form of alcohol and other drugs (ad), responsible for assisting PAS users. Considered as a central articulating device of PSCN, PSCC ad aims to offer preventive care, focusing on rehabilitation, strengthening health protection factors, perform clinical follow-up and social reintegration through work, leisure, strengthening family and community bonds, and in the exercise of citizenship of the assisted subject[2,6].

To complement the devices and care strategies offered to PAS users, the Comprehensive Care Policy for Drug Users was instituted in 2004, highlighting the need for user-centered care and working on the social reintegration aspect with interface in the community and in the health network. Thus, the use of PAS is seen as a complex and heterogeneous public health problem in which there are social, psychological, economic and political implications related to the problem. However, historically, the consumption of PAS is strongly associated with crime and treatment offers under the logic of exclusion and segregation, increasingly strengthening the social stigma suffered by these users[4,7].

The policies aimed at PAS users suffer great challenges regarding the establishment of a policy that prioritizes in fact the integral attention to consumer health. In 2006, Law n. 11.343/06 was enacted establishing the National System of Public Policies on Drugs (NSPPD) and prescribes measures to prevent misuse, attention and social reintegration of PAS users and dependents, in addition to establishing rules for repression of unauthorized production and illicit drug traffick[8]. This and other laws end up being amended in 2019 by Law 13,840/19, which brings changes on NSPPD and the conditions of attention to PAS users, in addition to dealing with the new financing of drug policies, allowing the embracement of PAS users in Therapeutic Communities.

Faced with the constant struggle to establish policies that can actually promote the comprehensiveness of care to users of PAS[7] and ensure their rights and protection, the possibilities and challenges that health workers face, especially those who work in the territory, in their daily practices in relation to the care of PAS users is questioned. Thus, driven by this concern, this research aims to know the possibilities

and challenges of care provided by health workers to users of psychoactive substances in the territory.

Materials and Methods

Qualitative, descriptive and exploratory research, which allows the understanding and dimensioning of the singularities and meanings inherent to behaviors, practices, forms of relationship and institutional structures of the research scenario[8]. It was performed in two Family Health Strategies (FHS), but included three teams, since one of the scenarios had two teams working in the same space. The FHS are located in a municipality in the central region of the state of Rio Grande do Sul.

The inclusion criteria for the participants were: all workers in the health team with a relationship with the FHS for at least six months and who directly assisted people using drugs. The exclusion criteria were workers on leave for health-related reasons. At the time of data collection, there were four workers on leave for these reasons.

Workers who agreed to participate in the study signed the Informed Consent Form (ICF) in two copies: one for them and the other for the researcher.

The production of data was through the technique of open interview, and the researcher received training from the researcher responsible for the collection of information, as she had no previous experience. Prior to the interview, the researcher introduced herself to the participants, citing her training, link with the university, the objective of the research, the procedures of data collection, possible risks and benefits and data devolution.

During the interview, initially, information was collected about the characterization of the participants: age, education and time of professional activity. After, the interview began, which was guided by the following questions: How do you visualize the care provided to users of psychoactive substances? What are the possibilities of care for users of psychoactive substances in the territory?

The interviews were conducted individually according to the order in which the workers were invited and according to their availability. Data collection occurred interspersed between the two FHS. Data production was interrupted upon reaching data sufficiency, being closed after the eleventh interview that did not bring new information. There was only one refusal, however, there were no withdrawals. The researchers responsible for the data collection stage did not have any type of relationship with the health services workers in which the participants' information was collected.

The interviews were conducted between the months of January and June 2021, in a room reserved in the FHS where the participants work, from previous scheduling by telephone or personal contact. The researchers' first contact with the participants was in person, when they introduced themselves for the participants during a team meeting with each of the health teams, and explained the reason for their presence. From this, they invited to participate and the interviews were scheduled. The interviews were conducted in private rooms that ensured the confidentiality of the information.

The interviews lasted about 35 minutes and were recorded with the aid of digital media devices, with the consent of the participants. The recorded material was transcribed in its entirety, with the aid of the Microsoft Word text editor, and submitted to the technique of thematic content analysis[9]. Data processing followed three steps. The first, the pre-analysis, corresponded to the pre-exploration of the material, in which fluctuating readings were performed to choose the composition of the analysis corpus and clippings of the text. In the second stage, called exploration of the material, the definition of the categories was carried out, through the identification of units of record and context, thus allowing categorization. The last step allowed the

treatment of the results and their interpretation.

Data analysis originated two categories: Mapping users of psychoactive substances and two questions about the care of the user of psychoactive substances. After, the categories were analyzed in the light of the relevant scientific literature.

To ensure anonymity, the letter W for health workers was adopted, followed by the interview number according to the order of its performance. The research complied with Resolution 466/2012 of the National Health Council. The project was approved by the Research Ethics Committee of the Franciscan University through the Certificate of Presentation for Ethical Appreciation n. 40454820.0.0000.5306, on January 19, 2021.

Results

The study included 11 health workers, being three nurses and eight community health agents. The participants were mostly female, and aged between 35 and 53 years. As for the time of work in the FHS, it comprised between five and 20 years.

Mapping users of psychoactive substances

Community Health Agent in the territory

Health workers perceived, in the figure of the Community Health Agent (CHA), a powerful way to access PAS users. The approach of the community agent with the territory and the bond formed between agent-user end up facilitating the necessary opening for the user to bring questions regarding the use of substances. In addition to bonding, CHAs also have a "record" as a work tool that allows the mapping/identification of users of psychoactive substances, among other health issues.

> "He gets here and speaks. And there is a questionnaire (Community Health Agents form) at the first visit. And there he asks: do you use alcohol? Do you use drugs? And he says. And even though sometimes he doesn't say it, we've lived here for almost 30 years and we know he uses." (A1)

In other cases, the question of the use of PAS ends up becoming a question of difficult approach with the user. However, the approach of the CHA to the community ends up facilitating the identification of those who use psychoactive substances, either by knowing the history of the community and those who inhabit it, or through reports from other residents.

> "In all consultations I do, the question is whether you are a drug user. Both when doing prenatal care, when collecting CP [cytopathological], any service that is done, there is the question if you are a user." (A7)

According to reports, some PAS users are identified at the time of initial embracement in the service. In this, usually, the user already has some physical and mood signs due to the use of some substance. Moreover, the interviewees pointed out that, when the PAS user seeks PHC in order to get help regarding the use, this is already perceived as something harmful.

> "It's in the embracement, when they come here. They usually come after using the drug, with mood, eye changes." (A9)
> "And through the Community Health Agent, who knows the community, knows how to identify them. They don't seek here that much. They come when they really need it." (A5)

Two questions about the care of the user of psychoactive substances

The counter fissure

It was possible to observe that health workers are concerned with the immediate resolution of the problem of the use of PAS.

The insistence and frustration when perceiving negative responses of the user and his/her absence in the actions offered are noticeable in the following statements.

> "I invited them to participate when there was something there at the post, I invited them, but it was no use. They simply don't go. It goes in and out their ears. But I guide a lot." (A7)
> "[...] Sometimes you can't act right away. You get a little lost, in the feeling of "what to do? What do we do?" There's nothing we can get, you know? Everything needs contact for a possible hospitalization, but everything takes time." (A10)

Workers report trying to talk about the harms of PASs in the life of the subject, carry out guidelines and insert him/her into collective activities.

> "We try to embrace the user when he comes with a complaint. Try to talk about the harms it causes in his life, try to see some group... some activity that he may join." (A4)
> "If they give you the opportunity to talk, we talk a lot. I was always saying: talking to whatshername, you have to think about her, for the sake of your daughter..., but, no matter how much I advised, it was no use." (A3)

Care comprehensiveness

The reports of the interviewees unveiled the look and the integral care of the health worker for the PAS user. During listening in the unit, guidance is provided on the use, sharing of syringes and the risk of contracting sexually transmitted infections (STIs), as well as ways to access the specialized service to seek treatment.

> "We say that there is treatment, that there is the PSCC, which has this doctor and the team to receive them. It offers a quick test that nurses and technical staff perform." (A1)
> "We guide the care they have to take in this type of sharing, condom use, because it ends up increasing the risk. We have the PEPs (Post Exposure Prophylaxis to HIV) here that we offer. There are these types of care that we end up disclosing to them." (A2)
> "We advise on the issue, when they are syringe users, on sharing syringes because of STIs, and then do the quick tests. Provide guidance on sharing, if they want syringes we have them here, we even provide them to some." (A9)

Workers realize the importance of the damage-reducing agent in PHC units. This fact seems to facilitate the access of the PAS user population to the unit to take care of issues related to use. In addition, workers report that the engagement of family and social care professionals are also relevant to the care of the user.

> "When we had the Harm-Reducing agent [...] the kids would come to the field, we had kits, we distributed kits." (A1)
> "It's a joint effort, both the family's work and the center that is trying to help him, and trying to see these issues, like with social care [...]." (A4)

Discussion

Among the multiplicity of nuclei that make up the PHC team, the presence of community health agent (CHAs) stands out. The role developed by CHAs is a powerful way to access PAS users and thus map the territory they inhabit. Cartography, in this sense, refers to the origin of its meaning, which is related to geography and maps. This method allows the visual representation of the geographical space demarcated and conditioned by the history[1,10].

In this sense, CHAs develop the role of cartographer in the PHC scenario and act as a link between the health service and the community, inhabiting the same territory where they work. They provide the population assisted the guarantee of bond and cultural identity before the service offered. At the same time, they are configured as a channel of communication, between team-territory, on the needs and priorities of the area, and thus build bonds

of trust with the community. These bonds are fundamental for the development of their activities and to build affinity with the assisted population, which facilitates the identification and care of users of PASs[11].

However, the role of CHAs can also be challenging. As a member of the community, they are part of the same networks of health determination of the assisted users, being responsible for producing knowledge about these determinants. By living in the territory where they develop their activities, they end up extending their work activity beyond the established limits, compromising their personal life. In moments of leisure, CHAs remain in their workplace and continue to produce knowledge about the territory. Commonly, the other residents of the locality take reports about health issues to the figure of the worker. In this case, in particular, there are reports of residents who consume PAS, a fact that also facilitates the identification and care of these users[11-12].

On the other hand, the mapping of users also happens in the unit when they are assisted by other workers to perform some procedure. However, even before doing so, users go through the initial embracement to identify their needs. The PHC began to embrace people in mental distress and play the role of gateway to PSCN since the changes in the mental health care model proposed by the Brazilian Psychiatric Reform. Since then, as this service has a multiprofessional team, it must be able to perform the recognition of PAS users, as well as to monitor the demands that are beyond the symptoms related to the use of the substances[4].

The embracement began to be characterized as a strategy of organization and planning of practices in PHC. From the moment the user accesses the service, the embracement is already carried out, and can happen through any health professional exercising his/her function. It is seen as an important device for providing qualified listening to users, analyzing the demand and possible referrals, as well as building the singular therapeutic project for them[13-14].

At embracement, some users are identified as consumers of PAS because they present some physical and mood signs that indicate the recent use of some substance. There are many cases of harmful use of PAS in the territory. However, these do not usually seek the health unit for problems directly associated with substance use, which hinders the identification of the demand and planning of the actions aimed at this public. In this case, the family ends up playing an important role. By bringing complaints to the health service about the consumption of substances in the intrafamily environment, it ends up contributing to the team in identifying users who need help[4].

Multiple factors hinder the user's search for access to health services. One of the most common factors ends up being the association between the use of PAS and crime, socially constructed and crossed in some health workers, a fact that hinders the view of the reality experienced by the consumer. The strengthening of this social stigma ends up contributing to the non-admission of the damages that the substance implies to the user's life, and thus the non-recognition of the need to seek help regarding the losses caused by PAS[4,15].

Another factor that is characterized as a barrier to access health services by the PAS user is associated with excessive bureaucracy and protocols to start treatment. The lack of knowledge about the services that offer treatment for harmful use of substances, such as PSCCad, is common among users. Moreover, the excess of medicines and the fear of their side effects, especially when associated with the use of other PAS, are part of the list of factors that hinder users' access to health services[16].

According to the workers, PAS users look for the health service to obtain assistance in relation to substance use, usually when they realize that consumption is being harmful. At this time, when seeking treatment due to the use of substances and

the consequent complication to the health situation, the user reveals his/her moment of life, bringing past experiences related to the use of the present moment. A fact that consists in the establishment of a transitional and dynamic process, which reconsiders the user's current situation and realizes the commitment of his/her health in the long term, especially of an emotional order. In this case, the user seeks the service for the suspension or for the reduction of the use of the substances[6].

Several factors can encourage the subject to start using PAS, and the most common among them is the search for an immediate sense of pleasure. However, although PASs offer pleasurable moments to the subject, they can compromise brain structures, leading to psychological, interpersonal, social, occupational and legal consequences[17-18].

Over time, due to the use of PAS, the social context of the subject can be considered as an emerging problem, which, in contrast, contributes to increased consumption. The increase in consumption may also be due to suffering associated with lack of citizenship, difficulty in accessing material goods and social values, unemployment, social vulnerability, lack of family support, because there is no adequate professional follow-up, among others. With this, there are chances of poisoning by the use of PAS, and thus provide even more damage to the health of the user, such as damage to organs and systems. The subject may present aggressive behavior towards him/herself and others, engaging in episodes of social and intrafamily violence, car accidents and falls, for exemple[18-19].

The use of PAS can achieve intergenerational patterns, with periods of discontinuity of use and relapses. There are different patterns of use of PAS. However, the continuum model seems to be the most appropriate to describe the process that implies its dependence. This model is associated with the frequency and intensity of use, characterized as harmful use of PAS that causes physical and/or psychic losses, which can increase according to the pattern of consumption[18-20].

When the user in harmful use of PAS accesses the PHC service, after the embracement, according to the workers, some care actions are offered. In this sense, the embracement is characterized as facilitating not only the user's entry into the service, but also the permanence, adherence to treatment and access to the service network. Moreover, it is an excellent strategy for the creation and strengthening of bonds, which enables the gradual inclusion of the user in the treatment of PAS consumption[14,21-22].

At this moment, two questions about the care of the PAS user in the territory emerge: the counterfissure and the integral care to the user. The analysis of the interviews revealed the anguish presented by health workers facing certain need for immediate resolution of the problem of chemical dependence. In order to terminate it immediately, the worker tries insistently with the subject to perform the treatment. The worker guides about the harms of substances and proposes some possible actions existing in the territory, and beyond it. The worker focuses on the substance and symptoms it implies in the life of the subject, facing it through prohibitionism. However, there is the path of suffering and the complex plan of life to be taken into account. When it comes to complexity, the words destabilization, risks, challenges and uncertainties are present in the same plane[1].

When faced with the destabilization and uncertainties of the user, who in turn refused to adhere to the treatment that was insistently offered, the worker ends up frustrated. In this sense, workers often create a conception of the PAS user as the problem that causes their care strategies to be ineffective. This attitude, in addition to triggering the search for a culprit for treatment failure, ends up strengthening social discourses that build obstacles in access to care[15].

This insistence on solving immediately and in a simplified way the

question of harmful use of PAS is characterized by the phenomenon of counterfissure. This is the movement to fight the user's craving, in the impulse to solve a problem of such complexity immediately through abstinence[23]. Meanwhile, the drug addict occupies a place of subject without voice, without rights and without desires.

This form of resolution, besides being reductionist, is directly allied to prohibitionist policies. These are understood as a simplified form on the model that governs the performance of States in relation to the consumption of PAS, linking to punishment and criminalization of users. In addition, they become one of the main factors responsible for the large-scale creation of Therapeutic Communities[5,23].

It is worth noting the current setback that mental health policies have suffered over the years, especially concerning alcohol and other drugs policy. In 2011, Ordinance GM/MS 3,088/11 was established, which brings a new dimension of PSCN and the set of actions in Mental Health in the UHS. In it, the TCs became one of the points of the network in the residential care of transitory character, receiving budgetary incentive of the Federal Government for their strengthening. Subsequently, this change was reaffirmed by Ordinance n. 3,588/17, idealizing the TCs as equipment capable of promoting the social reintegration of chemical dependents. Moreover, in 2019, Law 13,840 was enacted, which allows PAS users to be embraced in TCs[2].

These legislative changes, in addition to going against the precepts of the Brazilian Psychiatric Reform movement, hurt basic human rights of people suffering from chemical dependence. Thus, they reinforce institutionalization and standardization, defending a reductionist, moralistic and uncritical rationality on the consumption of PAS[2,24].

In contrast to the issue of counterfissure, prohibitionist policies and their consequent setback, health workers put on the agenda another issue about the care of PAS users: the integrality of care. This is one of the basic principles of the UHS and concerns the guarantee of the right of access to all levels of health care. In this sense, care ceases to be isolationist or moral treatment, and becomes a care of creation of possibilities and production of sociabilities. The actions move from the axis of substance use and symptom treatment to embrace the existential reality of the subject[1,25].

The present study showed that workers carry out guidance to users from the perspective of harm reduction strategy, such as about sharing syringes, not using condoms and the consequent risk of contracting STIs. This strategy allows workers to carry out a systematization of the needs to be met, associating them with their cultural environment and the community surrounding them. In addition, it is characterized as a new perspective of care for PAS consumers, as it is unrestricted to abstinence, respects their autonomy and reduces the damage that the substance can cause in their health[15,26].

Harm reduction is a less costly and more efficient way of caring for PAS users when compared to traditional approaches that are usually found in health services. One of the most relevant points of the practice is to consider the plane of the singularity of the subjects and recognize them as citizens. Thus, it seeks possibilities of social inclusion and offers conditions to (re)think their relationship with substances, having their protagonism in the process of improving quality of life and health[27].

Recognizing harm reduction as a powerful care strategy in the territory, the workers brought reports about the importance of the damage-reducing agent in the PHC units. According to them, the role developed by the damage-reducing agent facilitates the access of PAS users to the unit to take care of issues directly related to the use. This professional works by carrying out educational, cultural activities of health promotion and prevention, facilitating and

mediating users' access to territorial health services. Thus, this strategy carried out by the harm-reducing agent allows the establishment of a better worker-user relationship, reducing barriers to access health services, and also strengthening family engagement in care[28].

In addition to the action of the harm-reducing agents, the workers mentioned the importance of engagement of the family and social care professionals in the care of PAS users. The family is considered as an important support in the care of the PAS user, especially in the process of rehabilitation and social reintegration. Therefore, it should be included in health services and practices, so that it is co-responsible for the care of the user. However, this family also needs to be taken care of due to the overload of problems experienced due to the use of PAS in the intrafamily environment. By understanding it as part of the process, extending care to it, it becomes more participatory in the resumption of the user's quality of life[29].

As for the engagement of social care professionals, placed on the agenda by workers, it is important regarding the integrality of care. Social inequalities and economic vulnerability are producers of mental illness processes, as well as obstacles to the exercise of citizenship. Factors commonly worked by the social worker, in addition to those related to social rights, the strengthening of bonds and family care[30-31].

In order to actually offer subsidies to face the vulnerability of people in general, especially those who use PAS, it is necessary to integrate individual and collective protective factors, and to enhance institutional prevention actions. Therefore, it is necessary to change the paradigm from "sick" to citizens with autonomy, rights and desires in front of their own lives and health[7].

Conclusion

This research provided the knowledge of the possibilities and challenges of care provided by health workers to users of psychoactive substances in the territory from the report on their daily practices in PHC services. There is need to work under the logic of harm reduction, producing comprehensive person-centered care before the possibilities that the devices and care strategies in the territory offer. Moreover, there is the power of the CHA's performance in the territory, who, despite the challenges inherent to his/her figure, produces breaks in the barriers of access to the health service, embracing the demand of PAS users.

The care actions provided by health workers to PAS users in the territory suffer from the setbacks of public policies aimed at this public. Finally, this study is believed to contribute to the identification of challenges and possibilities of care for PAS users in the teams of the participating services. In addition, it is expected to contribute, in a grounded way, to the qualification of care to PAS users in the city, with health services and with the academic community in general.

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