PSICOLOGIA EM ESTUDO

Psicologia em Estudo
ISSN: 1413-7372
ISSN: 1807-0329
Universidade Estadual de Maringá

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SAÚDE MENTAL E REDUÇÃO DE DANOS NA ATENÇÃO PRIMÁRIA: CONCEPÇÕES E AÇÕES1

Psicologia em Estudo, vol. 24, e44697, 2019
Universidade Estadual de Maringá

DOI: https://doi.org/10.4025/psicolestud.v24i0.44697

Disponível em: https://www.redalyc.org/articulo.oa?id=287162798040

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ARTICLE Doi: 10.4025/psicolestud.v24i0.44697

MENTAL HEALTH AND HARM REDUCTION IN PRIMARY CARE: CONCEPTIONS AND ACTIONS[1]

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ABSTRACT. The aim of this article was to present the conceptions and actions of mental health of the workers of the Family Health Attention Center (NASF) of the city of Fortaleza (State of Ceará) in the field of Mental Health. Particularly, with regard to the interventions carried out in the problem cases of use of crack, alcohol and other drugs in the Primary Health Care (PHC). To do so, a semi-structured interview was applied, composed of five sections: 1) Professional profile of interviewees; 2) Moral Conceptions; 3) Knowledge about Drugs; 4) Harm Reduction (HR) Actions; 5) Perceptions of the interviewer. Descriptive data analysis was performed using the Statistical Package for the Social Sciences (SPSS), v. 20. The results reflect the coexistence of moral and traditional conceptions, guiding and sustaining moral values and medical models, making difficult the adoption of a HR orientation.

Keywords: Family health attention center; harm reduction; social psychology.

MENTAL HEALTH AND HARM REDUCTION IN PRIMARY CARE: CONCEPTIONS AND ACTIONS

RESUMO. O objetivo deste artigo é apresentar as concepções e ações de saúde mental dos trabalhadores dos Núcleos de Atenção em Saúde da Família (NASF) da cidade de Fortaleza-Ceará, sobretudo às intervenções realizadas nos casos problemáticos de crack, álcool e outras drogas na Atenção Primária em Saúde (APS). Para tanto, fez-se uso de entrevista semiestruturada, composta por cinco partes:1) perfil profissional dos entrevistados; 2) concepções morais; 3) conhecimentos sobre drogas;4) ações de Redução de Danos (RD); 5) percepções do entrevistador. Os dados foram submetidos a uma análise descritiva por meio do *software Statistical Package for the Social Sciences* (SPSS), v. 20. Os resultados assinalaram a coexistência de concepções morais e tradicionais, orientadores e mantenedoras de modelos moral e médico, que dificultam a adoção de uma atuação voltada para a RD e faz com que estes profissionais assumam posicionamentos que descaracterizam e impeçam o desenvolvimento de ações de RD nos serviços.

Palavras-chave: Núcleos de atenção em saúde da família; redução de danos; psicologia social.

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SALUD MENTAL Y REDUCCIÓN DE DAÑOS EN LA ATENCIÓN PRIMARIA: CONCEPCIONES Y ACCIONES

RESUMEN. El objetivo de este artículo es presentar las concepciones y acciones de salud mental de los trabajadores de los Núcleos de Atención en Salud de la Familia (NASF) de la ciudad de Fortaleza-Ceará. Específicamente en lo que se refiere a las intervenciones realizadas en los casos problemáticos de crack, alcohol y otras drogas en la Atención Primaria de Salud (APS). Para ello, realizamos entrevistas semiestructuradas, compuesta de cinco secciones: 1) perfil profesional de los entrevistados, 2) concepciones morales, 3) conocimiento sobre drogas, 4) Reducción de Daños (RD), 5) percepciones del entrevistador. Realizamos los análisis descriptivos mediante el Paquete Estadístico para las Ciencias Sociales (SPSS), v. 20. Los resultados muestran la coexistencia de concepciones tradicionales que sostienen y orientan los modelos médicos y morales que dificultan la adopción de una actuación orientada hacia la reducción de daños (RD) y hace que estos profesionales asuman posicionamientos que de caracterizan e impiden el desarrollo de acciones de mercado RD en los servicios.

Palabras clave: Núcleos de atención en salud de la familia; reducción de daños; psicología social.

Introduction

The World Health Organization (WHO) estimates that there are approximately 205 million people who use illicit drugs worldwide, including 25 million who are addicted to them (World Health Organization [WHO], 2008). In research jointly with the United Nations Office on Drugs and Crime (UNODC), it has been recognized that "[…] drug addiction is often aggravated by poor social and economic development, and drug trafficking, along with many other forms of transnational organized crime, compromising human development"(United Nations Office on Drugs and Crime [UNODC], 2013, p. IV). On the other hand, traditional forms of intervention, especially those directed at isolation and treatment from the perspective of abstinence, rather than discouraging drug use by these subjects, reinforce it by continually lowering self-esteem and (re)production of stigmas and marginalization.

Not surprisingly, WHO (2008) and UNODC (2013) have pointed out that interventions in the field of alcohol and other drug use must be developed in the sense of the right to autonomy and self-determination, in the fight against stigma, prejudice and discrimination and respect for human rights, especially because they imprison the subjects who use drugs to the marginal, irrecoverable, dependent characters, or even to the figure of the subject reduced to the condition of inhumanity and, therefore, being alienated from any right.

Among the proposals that focus on WHO and UNODC guidelines, the Harm Reduction (HR) strategy stands out as a care practice against problems related to drug use and appears as a possible alternative for clinical and political intervention. This is because HR follows a more general theoretical model characterized as sociocultural, opposing the conception of drug addiction as a chronic disease (nosological model) and the moralistic-religious and moralistic-scientific conceptions sustained, above all, in Farms, Therapeutic Communities and Self-Help Groups (Lima, 2005). Opposing also to the repressive policy, centered on the motto of 'war on drugs', typical of the state, as well as the so-called 'pedagogy of terror', this model does not advocate total abstinence as a goal, but the minimization of organic and social damage arising from the situation of drug use, even

because it understands that there has always been interest and use of substances by subjects since the earliest records of civilizations and human cultures (Carneiro, 2002; Venâncio & Carneiro, 2005).

Thus, the network formed by professionals, families, governmental and non-governmental organizations, each with its own form of organization, organizing each other, has come to be understood as essential for the creation of varied access, by embracing, guiding, referring, preventing and treating from psychosocial rehabilitation. Propositions that were reinforced from the approval of Law 11.343 of 2006, which explicitly brings in its text the need to articulate the discussion of drug policy with the discussions in the field of human rights, highlighting the need for recognition of cultural diversity existing in the country and user autonomy, especially respect for the fundamental rights of the human person, especially regarding the autonomy, freedom and respect for population diversity and specificities ((Lei n˚ 11.343, 2006, Art. 4). It is widely discussed and incorporated in the *Relatório final da IV Conferência Nacional de Saúde Mental – Intersetorial* (CNSM-I), in 2010, in which the investment in the different actions of mental health in the Family Health Strategy (FHS) through the Family Health Attention Centers (NASF) appeared as one of the indispensable actions to broaden the scope of the problem solving capacity resulting from mental suffering in PHC (Brasil, 2010a). Later, in 2011, such a conception of the network also began to inhabit the ordering of the assistance policy in Mental Health (MH), upon the approval and establishment of the Psychosocial Care Network (RAPS) in which the HR strategy is incorporated as an operational-therapeutic guideline of this articulated web of services and actions.

In the case of the State of Ceará, this proposal did not appear exactly as new, after all, according to authors of the reformist field (Sampaio, Guimarães, Carneiro, & Garcia Filho, 2011), there would be a great concern to provide mental health care in articulation with Primary Health Care (APS). The 2009 Management Report corroborates this statement, pointing out that the NASFs were part of the bet on the implementation of comprehensive care in the city of Fortaleza, as they were implemented with the mission of ensuring full integrity in the physical and mental care of users of SUS, through the qualification and complementarity of the actions of the FHS Health Teams (Fortaleza, 2011).

The municipality of Fortaleza, located on the northern coast of the State of Ceará, with approximately 313.8 km² and estimated population of 2,451,813 inhabitants (Instituto Brasileiro de Geografia e Estatística [IBGE], 2010), distributed in 116 neighborhoods, being considered in this last census, the second largest city in the northeastern region and the fifth most populous in the country, was divided into six territories or political-administrative regions, called Regional Executive Secretariats (RES). These operate as managers and executors of municipal public policies, with each RES being thematic districts (namely: Health, Education, Infrastructure, Social Assistance, Environment and Finance Districts), which act as 'mirrors' of the thematic secretariats (Frota, 2009). Recently, the Regional Executive Secretariat of the Center of Fortaleza (RESCEFOR) was created, increasing to seven the RESs (Fortaleza, 2012), but still in the political-administrative process of implementation.

Regarding the NASF, until the beginning of 2013, Fortaleza had 25 teams, made up of 183 professionals, distributed to work with the municipal Family Health Centers (FHC), as found in this period a research by one of the authors of this research (Oliveira, 2013). The teams were composed, following the ordinance 154 (Portaria GM nº 154, 2008; Brasil, 2010b), of the following professional categories: pharmacist, physical therapist, speech

therapist, nutritionist, social worker, physical educator, psychologist and occupational therapist. In addition, the multiprofessional teams were distributed into six Regional Executive Secretariats (RES), as well as an afternoon/evening team that conducted outreach activities to homeless people in the city downtown.

The Management Report of this period evidences, in fact, some concern about the actions on Mental Health by NASF teams (which would be in line with the CNSM-I report). However, it is explicitly stated in the same report that these actions were not the focus of NASF, the priorities were: 1) attention to bedridden patients and 2) activities related to the demand of school-age children and adolescents through the School Health Program (PSE).

In fact, as Oliveira (2013, p. 68) points out "[…] mainly between 2006 and 2007, during the same period of the FHS increase described above, the Mental Health Care Network was also implemented based on psychiatric reform guidelines". However, the expansion of the Mental Health Network, although it has triggered some processes, among which only the transformation of RES II type II CAPS into CAPS III - 24 hs and the implementation of the Crack Intersectoral Reference Center were effective, it did not advance much after the implementation of the Substitute Network in 2006, which is not surprising when we know that the growth of the substitute network in Fortaleza (the last municipality to fully adhere to the psychiatric reform in Ceará) was not a process resulting from the strong claim of the closure of psychiatric hospitals and the opening of substitute services, but the result of political and economic interests that kept the care models (asylum and psychosocial) in coexistence and sometimes in conflicts, as some researchers point out (Quinderé, Sales, Albuquerque, & Jorge, 2010). Not surprisingly, the justification given for the pause in the progress of implementation of the substitute network in the management report was the scarcity of funding from the federal government.

In fact, the relationship of the advances with the political-economic interests, despite any claim of social movements (as has been done by the Antimanicomial Struggle Forum in Ceará), is even more explicit with the change in municipal management, as occurred in 2013. This year, the divestment in mental health actions deepened, as services were increasingly privatized through the hiring of outsourced teams for existing substitute services. Mental health actions focused on the issue of alcohol and other drugs, for example, began to be considered with reference to therapeutic communities (campaign proposal of the mayor-elect), especially when formalized, in a public policy enabling agency in interface with MH, the Special Coordination of Drug Policies (CEPOD) in the capital of the State of Ceará.

The above elements point out that the reduction of complex and intersectoral interventions that should be funded in this field, especially through the strengthening of PSCN, has been placed in conflict of horizons (as PSCN and CEPOD have different strategies such as HR and coping with chronic disease, respectively, occupying the therapeutic models) and also pointed the municipal drug policy towards the return of hegemony of an assistance model that seeks abstinence from the substance consumed, reversing the potential of the Substitute Network as a territory promoting the increase of the 'self-management degree' in search of greater autonomy, as pointed out by Lima, Gonçalves Neto and Lima (2011) in research on the theme of assistance to psychoactive substance users. More than that, municipal policy represents yet another national dispute over the models of care in which current research points to the growing public funding of institutions such as therapeutic communities at the expense of PSCN (Trapé & Onocko-Campos, 2017).

Regarding Primary Care (PC), since the NASF multiprofessional teams of Fortaleza, which were distributed in the six regional executive secretariats, practically ceased to exist in 2015, being represented by a staff of only 48 workers, divided into 16 teams, only five had the minimum number of members to be considered complete. Not to mention that the other teams were incomplete, and in some cases became nonexistent, since they now have only one or two professionals as representatives of this strategy in health units and, in some health centers (or health units, as they are called at the municipal level), the NASF strategy is no longer used, meaning that eight NASF teams have gone extinct. Thus, it is pointed out that there is a mental health management in Fortaleza that has been developed from a merely instrumental logic, which values the saving of resources employed in health from the minimum implementation of professionals and resources, even if they are insufficient in relation to those indicated by the laws and ordinances that serve as guidelines for the services (Portaria nº 3.088, 2011; Portaria nº 2.488, 2011b; Brasil, 2014).

Faced with this scenario, we proposed a research to analyze the conceptions and actions of NASF workers in the field of mental health, more specifically regarding the interventions of problem cases of use of crack, alcohol and other drugs. Since this would enable the discussion of the difficulties and possibilities encountered by NASF professionals for the implementation of HR actions in PC, understanding the weaknesses of the NASFs of Fortaleza with regard to actions in MH in PHC, especially regarding refers to problem drug use, would offer elements for the improvement and promotion of NASF strategies in actions against the problem use of crack, alcohol and other drugs.

General Considerations on Research

This research, which was supported by the Research and Development Program (PPSUS) of the Research Support Foundation of Ceará State (FUNCAP) - Notice 07/2013 - SPU process: 13192398-6, was submitted to the Ethics Committee in Research from the Federal University of Ceará, registered with CAAE: 17475813.4.0000.5054 and approved with the number: 492.539 on 12/19/2013. This was a quantitative, descriptive and exploratory study, based on non-probabilistic sampling, with data obtained through volunteers who answered a semi-structured interview. Interview was prepared and adapted by researchers from the self-applied questionnaire, developed by Queiróz (2005), in which the questions of the instrument were relevant for the assessment of the conceptions and values of professionals of the Family Health Strategy of Belo Horizonte, State of Minas Gerais. and revealed the permanence of traditional values and practices, based on the ideal of abstinence, causing the characterization of the harm reduction proposal in its original grounds. The interview consisted of five parts: 1) introduction, which addressed the professional profile of respondents; 2) moral conceptions, investigated the way the interviewee is organized facing moral and sociopolitical issues; 3) knowledge about drugs, which recorded knowledge of the field of drugs and the possible harmful consequences for users; 4) harm reduction, which questioned the appropriation and possibility of adopting the harm reduction in NASF and; 5) interviewer's perceptions about the content of the interview, which recorded problems that may have occurred.

The choice for the semi-structured interview occurred for the reasons that were widely discussed in Laville and Dionne (1999), such as: a) the possibility of obtaining a larger number of interviews completely filled, since there is a decrease in the effort required from the interviewee (including completing and returning questionnaires, etc.) and b) ensuring that the answers followed the sequence in which they were presented, since it was known

that the inversion of the sequence could interfere with the production (elaboration) of the answers.

The pre-test, which took place between April and May 2015, months before the interviews, as advised by Oksenberg, Cannell and Kalton (1991), was attended by a psychologist and a social worker. It is important to note that even after the adjustments made to the interview structure, the interviewers were asked to resolve any questions that were observed or presented by the interviewees. Nevertheless, since the educational and socioeconomic levels were similar among the interviewees, no problems regarding the understanding and sharing of information were identified.

The interviews, thus, took place from June to December 2015, in the PHC units of Fortaleza, where were inserted the NASF teams, which accounted, during the research period, with a total of 48 professionals. From this total of 48 professionals, those who were on vacation, leave or on external work/course during the period of application were excluded from the interviews, which reduced the number to a total of 38 active professionals. Interviewers contacted each of the teams by telephone or in person and invited the professionals present to participate, of which 19 agreed to be interviewed for the research[5]. To minimize the refusals, we tried to schedule and, when necessary, reschedule with professionals the best time to apply the interview. However, the precariousness of employment contracts and the short time in services due to the high turnover of professionals was often used as an argument to justify the refusal to accept invitations. The chosen methodology was adequate to address the object in view of the objectives expected in the research, since the 19 participants represented 50% of the active professionals present in the units and 40% of the total NASF strategy professionals at the time of the study.

Due to the reduced number of active professionals and their restricted distribution in local or regional services, it was necessary to hide the work areas of professionals of each NASF, to ensure their anonymity. However, it can be noted that the distribution of respondents was defined as follows: a physical education professional, a pharmacist, a nutritionist, three social workers, three psychologists and ten physical therapists (profession most present in the NASF in the municipality and here also the most frequent). Most respondents were aged between 30 and 39 years (42.1%). Regarding graduate studies, the most cited were those specific to each profession (78.9%) to the detriment of only (21.1%) graduate studies in the area of collective health and/or family health. As for religion, of the 19 participants, 100% declared to be catholic.

Concerning the application of the interviews, in order to make the interviews faster and in order to ensure the uniformity of the process, face-to-face interviews, with an average duration of 40 minutes for each application, were performed in pairs by 12 undergraduate and graduate students, previously trained. The interviews were conducted according to the sequence in which the questions were presented, whose five parts were mentioned above. The rigor of the application following the modules was essential for the research, since we

[5] Acknowledgements to Antonio da Costa Ciampa, Walberto Silva dos Santos, Luís Fernando Farah de Tofoli, Paulo César de Almeida e Fabiane do Amaral Gubertfor their contributions as researchers, to Beatriz Oliveira Santos, Brígia da Silva Amaro Lelis Moraes, Cristofthe Jonath Fernandes, Emanuel Messias Aguiar de Castro, Gabriela Gomes Freitas Benigno, Kilson Pinheiro de Sena, Lucas Bayde Ribeiro, Marcelo Góis Cordeiro Barroso, Renata Bessa Holanda, Thiago Sousa Felix, Vinicius Furlan, Yuri Marcondes Lisbãofor their support in the application of survey, data typing in spread sheetand for their participation in theresults discussions and Dr.Yarimar Rosa-Rodriguez, from the Institute for Psychological Research at the College of Social Sciences of the University of Puerto Rico, Rio Piedras (UPR-PR) for her contribution to the translation to English and Spanishfrom the title and abstract of this article.

were interested initially to know the moral values of the interviewees and their conceptions about drug use and later to investigate their opinions and harm reduction actions. The sequence also sought to prevent respondents from having a general reading of the interview and from experiencing some kind of politically correct pressure, contaminating the relationship between the questions.

After the interviews, a database was built that became the starting point for the analyses performed. The data obtained were processed using the Statistical Package for the Social Sciences (SPSS), version 20.0, license number 10101131007. The descriptive statistics technique was chosen, crossing the variables alluding to the moral conceptions and actions of the professional about drug use against the harm reduction strategy.

Presentation, discussion and critical analysis of constructed data

The data were organized into tables with a simple distribution of percentage and frequency, as well as tables distributed through a bivariate analysis, depending on the purpose. We will begin our presentation and analysis of the data by presenting the knowledge of the proposed harm reduction proposal by NASF professionals.

First, 36.4% respondents said they knew about the harm reduction proposal, while 26.32% said they had never heard of it. It is curious this lack of knowledge about the proposal by health professionals, mainly because several documents and training (including classes on HR in health training courses in Brazil) have been conducted over the last few years, posing harm reduction as a central issue, either for or against its use. It is also possible to observe that another significant part of the interviewees (which correspond to the same amount who say they know the proposal) seem to know somehow what harm reduction is, but they could not get enough information to respond safely about their knowledge. The lack of accurate and reliable information interferes with the way NASF professionals understand drug use and its consequences, for 68.42% of any drug use, whether legal or illegal, brings problems to the user.

These moral conceptions can interfere and cause ideological obstacles to the acceptance of the HR proposal in the NASF, as we will see below. When asked about the possibility of NASF professionals to live with different groups of drug users, it was also observed that there is great difficulty for this coexistence for more than half of professionals, which inevitably interferes with the possibilities they had to adopt the HR proposal in services.

With regard to living with alcohol users, of the 17 professionals who answered the question, five (29.4%) considered living with alcohol users easy, and of these, three would adopt the HR proposal and two would not. The difficult coexistence was the majority opinion, totaling 11 (64.7%) professionals. Of these, six stated that they would adopt the proposal and five would not. Finally, one (5.8%) professional stated that he could not live with alcohol users. Two (11.7% of the 19 professionals) interviewees chose not to answer if they would live with alcohol users. Regarding living with cannabis users, it was observed that of the 18 participants who answered, eight (44.4%) considered it easy to live with these users, obtaining the same proportion (4) for those who would adopt the proposed HR in their daily lives, and those who would not adopt the proposal. Seven professionals (38.8% of the respondents of this item) considered this coexistence difficult and of these, four would adopt the HR proposal and three would not. Three (16.6% of 18) participants stated that they would not live with cannabis users and, consequently, would not adopt the proposal either. One respondent did not answer if he would live with marijuana users.

With regard to living with cocaine and crack users, the values obtained were similar for the 15 respondents: ten (55.5%) considered cohabitation difficult, and of these, six participants would adopt the proposal in their daily work and four would not adopt; regarding non-coexistence, four (22.2%) of these participants would not live with such users, being equally divided, i.e., two would adopt the proposal and two would not. Only one (5.5%) participant considered the coexistence easy and with possibility of adoption. Four respondents out of the 19 participants did not answer whether they would live with cocaine or crack users. As can be observed, the difficulty of coexistence and the limitations of professionals regarding the adoption of the HR proposal is considerable. If this coexistence with users of alcohol and other drugs is perceived as problematic, the development of less authoritarian and repressive actions will also be.

Still on the NASF professionals' conception of drugs, when asked about ways to reduce drug use by the population, 26.3% agreed that there would be a need to increase the fight against drug trafficking and its distribution so that there is a decrease in consumption, while 68.4% stated that there should be an increase in prevention and treatment of users in order to reduce consumption. This is important because it indicates some clarity of most interviewees regarding the need for more preventive interventions related to social and cultural contexts, reducing the emphasis on solving the 'drug problem' through police repression.

Regarding the decisions to be made regarding the problem of drug use, 31.6% respondents considered that decisions about the best way to work with the drug user should be made by the people who work in the area, whereas 68.4% agreed that drug users have a practical knowledge of the problems they face and should collaborate in the construction of health projects and programs.

In relation to the professional's conceptions regarding drug dependence, 31.6% considered that it is possible to use drugs without becoming dependent on them and 68.4% agreed that any drug use can lead to addiction; 47.4% stated that the dependence is more related to the substance consumed and 52.6% related the dependence to the person who uses the drug. These data, in addition to reinforcing the problem of professionals regarding the lack of knowledge of the substances, confirm the persistence of the moral model, which suggests that the problems arising from drug use are consequences of people's misbehavior, that is, that dependence is a result of substance use leading to dependence regardless of use and context and predisposition of the subject that makes use of the substance.

Considering prevention and education campaigns that approach drug use from an perspective without imposition, the predominant responses were that professionals considered it as a very effective (42.1%) or effective (36.8%) alternative to reduce drug use in our society, to the detriment of poor effectiveness compared to campaigns that reinforce the anti-drug model (47.4%). These are in line with the philosophy of harm reduction and may indicate maturity of professionals regarding the ineffectiveness of the repressive and punitive logic, however, the same positions appeared in contradiction when we observed that support for police action/repression to the user were also considered very effective (42.1%) and/or effective (36.8%) alternatives by professionals.

Legalization/decriminalization of drug use (73.6%) and compulsory hospitalization (68.4%) were perceived by professionals as having little or no efficacy, the former appearing to be incompatible with contemporary discussions about the positive impacts of decriminalization for public health, the second following the line proposed by the HR

regarding the defense of care in freedom. Again, positions that appear antagonistic, since the great majority criticize compulsory internment and, at the same time, is against legalization/decriminalization, which has contributed as an argument for the justification of compulsory internment.

In the conceptions on the effectiveness of treatment forms for drug dependence and hospitalization in Therapeutic Communities (TC), opinions were similar for those who agree that these methods are very effective or effective (31.6%), while 31.6% considered it little effective and 5.3% considered this treatment alternative to be ineffective. The same was said about specialized clinics: most professionals considered this form of treatment effective (63.2%). Regarding the responses alluding to religious treatments outside the TC, we did not perceive a level distribution among those who position themselves as effective and ineffective. However, treating users in CAPSad appears to be a very effective or effective device for professionals (78.9%), as 26.3% considered it as a very effective of treatment, 52.6% as effective, but only 21.1% found it little effective. Psychological treatments and self-help groups were also noted by NASF professionals as very effective alternatives in the treatment of users of alcohol, crack and other drugs (52.6%). Only 15.9% of the professionals interviewed said that self-help groups are not very effective.

The questions that involved actions in MH that could be developed for users of alcohol, crack and other drugs by NASF professionals were the ones that generated the most discomfort for participants. In any case, when asked about the identification of cases and referrals to specialized treatment (CAPS), more than half of professionals indicated that they perform the procedure, i.e. 57.9% of respondents said they identified and developed such activity; 36.8% said they did not develop and 5.3% of respondents did not answer the question. Given the lack of knowledge about drug use and recurrent damage, efficient and appropriate treatment, it is possible to imagine that many of these referrals to CAPS are unnecessary. Interestingly, with regard to case identification and referral for treatment in therapeutic communities, the majority (78.9%) said they did not develop such activity, compared to 15.8% of respondents said to develop, even though the vast majority has identified this type of treatment as very effective and effective previously.

Most of the professionals indicated that they provide assistance for problems resulting from drug use (52.9%), which, based on the data presented above, highlights the need for specific training on the theme for NASF team professionals, especially regarding the development of sensitization and socializing activities with this public, so that the moral and ideological imperatives do not prevent differentiated listening and clinic, singularizing the demand of the subjects. Considering these same issues, it is necessary to evaluate the quality of content related to education and prevention campaigns for the use and abuse of alcohol and other drugs, since the vast majority of respondents (73.7%) stated that they develop such activity and pointed out previously they personal and technical limitations on the subject.

A positive factor is observed regarding the interest and effort of professionals to build a relationship between the user and the service. This is because, despite having great difficulties in living with drug users, more than half of NASF professionals (52.6%) said to develop the approach of the user and build a relationship of trust with the health service, even though still 36.8% said they did not develop and 10.6% did not respond.

The analysis of the conceptions and actions of the Family Health Attention Centers (NASF) workers in the mental health field, more specifically with regard to interventions in problem cases of users of crack, alcohol and other drugs, allow to say that the current

configuration of the units of the city of Fortaleza has a fragile structure that mismatches the service of the NASF strategy itself. In this reality, most of the professionals who make up the services have been in the service for less than a year, in unstable contracts that made it difficult to accept the participation of some professionals working in the research, who justified "[…] feeling that they knew nothing about mental health and somehow get fired" [sic].

Of the professionals who participated in the interviews (19 professionals), it was observed that a significant part does not have training that supports a safe positioning regarding the knowledge about the harm reduction policy, besides presenting answers that evidenced the unpreparedness regarding the demands related to the field of mental health, especially those related to problem drug use. Results that, unfortunately, are close to those presented by Sampaio et al. (2011), in a research that analyzed the working conditions to which the workers of the CAPS of Fortaleza were subjected and showed the dissonances between the guidelines of the mental health policy and the operationality of the services.

Regarding the opinions and attitudes regarding substance use and abuse, we observed that professionals, since they are not theoretically qualified on the subject, end up taking in their activities the point of view of the moralistic and pathologizing models. This became even clearer when we observed that 68% NASF members believe that the use of any drug leads to addiction. The fact that 85% of respondents think in this way could then, from this perspective, build ideological barriers to the acceptance of the harm reduction proposal. It was also observed that, in line with the above, the predominance of moral and disease models is rooted in professional practice.

Thus, the lack of knowledge about the theme and the fact that most professionals claim to have difficulties living with drug users did not significantly interfere with the positive response about its adoption. We may think this means that practition ers may have claimed to adhere to a new action proposal without actually considering its elementary foundations. Data showing the urgency of investments in awareness and training in this field, as well as greater attention to the profile of professionals who willin evitably be related to people who may be making problem drug use, since for an effective approach in this field there is a need to direct approach (with out myths), creating a bond of trust between the health professional and the user.

This is confirmed when we realize that the care proposal is still thought by NASF professionals from the ideal of abstinence, guiding traditional approaches, and belief in the resolution of treatment in Therapeutic Communities (TC). Likewise, the fact that professionals consider compulsory hospitalization to be of little or no efficacy was not a criticism of hospitalization, since the vast majority believe that hospitalizations in TC, specialized clinics and religious 'treatments' are effective in many cases in opposition to the guidelines of WHO already presented in the introduction and opposed to the guidelines described in the participatory and deliberative space of policies in MH in Brazil, in its latest edition, the IV National Conference on Mental Health - CNSM-I (Brasil, 2010a).

Although they work in public services and have undergone training at a historic moment of much criticism to asylum forms of mental health treatment, most professionals reported believing in the effectiveness of treatment for drug dependence, TC admission and related services. Psychological treatment is understood by professionals as a technology that is at the same level as self-help groups, in which the theoretical-methodological framework is anchored in religious and moral models, whose use consists of sharing

reports/experiences of participants and abstinence as an end in itself without any scientific-psychological basis.

Final considerations for other horizons

In conclusion, it is important to reinforce that the research made it possible to identify numerous difficulties that prevent the development of MH actions by professionals of the NASF of Fortaleza, but perhaps similar to other realities of Brazilian capitals. The weaknesses in the formation and understanding of the phenomenon of drug use, the coexistence of moral and traditional conceptions, guiding and maintaining the moral and medical models, which hinder the adoption of action aimed at reducing harm by these professionals in the field of alcohol, crack and other drugs. For these limitations, associated with practical questions, it is possible to indicate the implementation of planning, training, expansion of the service network and management support in public policies for its resolution, since we find interest and willingness of these professionals to develop prevention and care actions in services.

Obviously, for this to happen, a change in the municipality's management model is essential, which has followed the logic of economic and political divestment in the psychosocial strategy of the PSCN, associated with coexistence with the abstinence model, as in drug policies made in parallel with the network's mental health services. Moreover, it is inevitable to note that the disarticulation of the NASF strategy, from the decrease in the number of professionals and the team distribution logic in the Matrix Support format (Campos & Domiti, 2007), as it was once present in the network, points out that the path of local health care goes against psychiatric reform.

However, we must not lose sight of the investment reserve in a type of long-term education, which has the potential for transformative awareness of these professionals, regarding mental health proposals, such as the harm reduction, where their moral limitations may impede the development of more effective actions that overcome the immediate association between drug use and marginality, crime or disease. One of the possible strategies is the implementation of the logic of Permanent Health Education (EPS) in the field of MH. In this sense, the qualification of health actions is based on the work itself, seeking alternatives and solutions for the transformation of practices through collective problematization among peers (workers), users and managers of mental health. After all, one of the possibilities of training in mental health is, as in EPS, through ways of transforming the health work itself that now has social needs in health as its center (Ceccim, 2005).

In other words, conceptions and actions in MH have to concomitantly occur from the formative and work processes implied with the possible transformations of the field. These transformations would appear to be underway, aiming to overcome the still hegemonic moralist biomedical model if professionals are not only able to operate with instrumental rationalities (which in practice eventually translate into the use of new names for supposed new actions, even when one continues thinking and acting in a conventional way, without any change in their worldviews and moral conceptions), but also as the sensitivity necessary to embrace and act, considering the user as a person of right, without reduction or arrangements regarding their moral conceptions. A practice available to a subject that surpasses the concept of 'dependent' (chemical dependent and many other metaphors) or a practice that administers suffering, but which enables service users to have small glimpses of life creation in the therapeutic encounter.

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Received: Sep. 23, 2018
Approved: Apr. 22, 2019

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