PSICOLOGIA EM ESTUDO

ARTICLE

10.4025/psicolestud.v29i0.55188

STIGMA AND DRUG USERS: THE BELIEFS OF HEALTH PROFESSIONALS

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ABSTRACT. The stigmatization of health professionals related to alcohol and other drugs users limit the access to treatment and allow practices that violate these population's rights. Therefore, this study aims to comprehend the stigmatizing beliefs of health professionals concerning these users, through a qualitative approach. This investigation was composed by eleven professionals of three areas: CAPSad-III, CAPS-II and Multiprofessional Residence. The strategy applied for data collection was the Focus Group, and they were examined accordingly to the thematic analysis of content. The results showed the presence of beliefs surrounded by stigmas; bigger social damage to women, which can justify bigger acceptance of men to treatment; the importance of a responsible attitude toward the own stigmas and the relevance of the intersectorial approach, which provides autonomy to the user. In view of the results of the investigation, it is concluded that although all the participants present beliefs permeated by stigmas, they are also critical of the discourses that lessen the rights of social participation of drug users and that legitimize their exclusion.

Keywords: Social stigma; substance-related disorders; health care provider.

ESTIGMA E USUÁRIOS DE DROGAS: AS CRENÇAS DE PROFISSIONAIS DE SAÚDE

RESUMO. A estigmatização dos profissionais de saúde sobre os usuários de álcool e outras drogas limitam o acesso ao tratamento e legitimam práticas que violam os direitos dessa população. Portanto, o objetivo do estudo é compreender as crenças estigmatizantes de profissionais de saúde relacionadas a estes usuários a partir de uma aproximação qualitativa. Compuseram esta investigação 11 profissionais de três serviços: CAPSad-III, CAPS-II e Residência Multiprofissional. A estratégia de coleta de dados foi o Grupo Focal, examinados conforme a análise de conteúdo temática. Os resultados demonstraram a presença de crenças permeadas por estigmas; o maior comprometimento social da mulher, podendo justificar a maior adesão dos homens ao tratamento; a importância de uma atuação consciente sobre os próprios estigmas e a relevância da intersetorialidade no cuidado, provendo autonomia ao usuário. Diante dos resultados da investigação, conclui-se que apesar de todos os participantes apresentarem crenças permeadas por estigmas,

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os mesmos também são críticos aos discursos que minoram os direitos de participação social de usuários de drogas e que legitimam sua exclusão.

Palavras-chave: Estigma social; transtornos relacionados ao uso de substâncias; profissional da saúde.

ESTIGMA Y USUARIOS DE DROGAS: LAS CREENCIAS DE PROFESIONALES DE LA SALUD

RESUMEN. La estigmatización de profesionales de salud a usuarios de alcohol y otras drogas, limitan el acceso al tratamiento legitimando prácticas que violan los derechos de dicha población. El objetivo del estudio es comprender las creencias estigmatizantes de profesionales de salud relacionados a tales usuarios desde una aproximación cualitativa. Esta investigación estuvo compuesta por 11 profesionales de tres servicios: CAPSad-III, CAPS-II y Residencia Multiprofesional. La recolección de datos fue mediante Grupo Focal, siendo analizados según el análisis de contenido temático. Los resultados demuestran la presencia de creencias impregnadas por estigmas; el mayor compromiso social de la mujer, justificando mayor adhesión de hombres al tratamiento; la importancia de una actuación consciente sobre los propios estigmas y la relevancia de la intersectorialidad en el cuidado, proporcionando autonomía al usuario. A la vista de los resultados de la investigación, se concluye que si bien todos los participantes presentan creencias permeadas por estigmas, también son críticos con los discursos que menoscaban los derechos de participación social de los usuarios de drogas y que legitiman su exclusión.

Palabras clave: Estigma social; trastornos relacionados con substancias; profesionales de la salud.

Introduction

Globally, drug use has been listed as one of the most serious public health problems (Silveira, Tostes, Wan, Ronzani, & Corrigan, 2018), and the complications arising from this increasingly growing use are associated with other relevant issues, such as poverty and violence (Cerqueira et al., 2019). Research into the origins of problematic drug use must consider the multideterminations that permeate the phenomenon, aiming to improve its understanding and base interventions on solid evidence for broader, contextualized, and comprehensive care for the user (Mota, Ronzani & Moura, 2014).

Even in the face of a scenario of political and social mobilization around the problems arising from drug use, many people who use drugs choose not to seek care or prematurely abandon treatment due to stigmatization (Silveira et al., 2018). Among the effects of stigma on the health and quality of life of subjects, we can highlight the decrease in self-esteem, self-efficacy, limitation of social interactions, unemployment, hopelessness, low levels of education (Silveira et al.,2015; Nieweglowski, Dubke, Mulfinger, Sheehan, & Corrigan, 2018) and discrimination (Lundquist & Gurung, 2019).

The moralistic attitudes and public policies of the first half of the 20th century reinforced the negative beliefs of the general population and current health professionals, as they disseminated that drug use is the result of a personal choice (Pickard, 2017). Especially concerning health professionals, the causes may include the lack of

understanding of different cultural expressions, lack of adequate education and training, the fragmentation of care models, and even the precariousness of technologies that favor the formulation of appropriate diagnosis and care (Tavares, Souza and Ponte, 2013).

In the current scenario, care for users of alcohol and other drugs is still permeated by stigma, resulting in insufficient investments to promote adequate treatment, in addition to violating rights and blaming drug users for various social problems (Silveira et al., 2018). As the moral ideal of the care model prevails, stigma, injustices, and violations of rights will continue to be legitimized (Pickard, 2017), and the users will continue to be victims of treatment devices that do not offer adequate care.

Stigma is initially formed and maintained by beliefs, firstly encompassing the processes of labeling and stereotyping and then affective and behavioral manifestations (Link & Phelan, 2001). Rosenberg and Hovland (1960) theorize that beliefs are one of the elements of attitudes, comprising three components: affective, cognitive, and behavioral. Beliefs constitute the cognitive component and are explained by individuals' information regarding the object towards which the attitude is directed.

Due to this intersection between stigmatizing beliefs and a mismatch of care models, understanding the beliefs of health professionals about drug use and drug users can subsequently support improvements in actions, strategies, and interventions aimed at improving care and reducing stigma. Therefore, the objective of the present study was to understand the stigmatizing beliefs related to users of alcohol and other drugs among health professionals using a qualitative approach. These professionals work in specialized and non-specialized services in the treatment of users of these substances.

Method

As the goal of this study concerns a deeper understanding of the subjective experience with the object, the qualitative approach was considered the most appropriate (Cavazza, 2008). The planning of this research was carried out in conjunction with a multicenter study. Data were collected approximately one month after the Workshop proposed by the aforementioned study and conducted to raise awareness among professionals about the issue of stigma related to alcohol and drug users. Thus, the workshop contributed to generating important discursive triggers upon data collection. The responsible researcher actively participated in the Workshop, taking notes and sharing professional and personal experiences to familiarize herself, interact, and enter the reality under investigation.

The scenario

Data collection comprised three types of service, namely: Group 1 (G1) was composed of specialized service professionals from the Psychosocial Care Center – Alcohol and Other Drugs III (CAPSad-III); Group 2 (G2) formed by professionals from a Psychosocial Care Center II (CAPS-II), both from the same municipality in the state of Rio de Janeiro; and Group 3 (G3) comprised professionals part of the Multiprofessional Residency Program at a public University Hospital (UH's) in the state of Minas Gerais. All residents have contact with users of Alcohol and Other Drugs (AOD) throughout their specialization through the UH's Alcohol and Drugs outpatient clinic or the municipality's CAPSad.

Participants

One month after the Workshop, the researcher made telephone contact with the professionals who fully participated in it to invite them to form the collection group, explaining the research objectives and the voluntary nature of participation. After that, the institution's coordination was informed about the professionals' acceptance, and a room was requested within the work environment.

This investigation was composed of 11 health professionals working in the aforementioned services. The professional categories were nursing technician, nurse, psychologist, social worker, occupational therapist, and administrator (CAPS-II coordinator). We also adopted the criterion of a minimum service period of six months.

Collecting information

A Focus Group (FG) session was held for each scenario in their respective service. The FG constitutes a privileged instrument for the in-depth study of a socially shared belief system (Cavazza, 2008). We assume by definition that FG is a technique that promotes group interaction through a focal, specific, and directive discussion. As a result, a space is obtained for exchanging experiences and perceptions, encouraging the protagonism of participants through collective discussions and constructions (Dall'agnol, Magalhães, Mano, Olschowsky, & Silva, 2012).

A script was used to conduct the discussions, and its topics were presented as "discursive triggers" to professionals, with the intention of starting the subject and eliciting comments from the participants. The expected duration of the FG session was 90 minutes, and this time was exceeded in two of the three groups conducted, not exceeding 120 minutes. The collection took place in August and September 2018.

In addition to the moderator, the groups had two observers. They were present to record the group dynamics, collaborate in time control, monitor the recording equipment, and take notes regarding the participants' speeches to facilitate data transcription. All researchers involved in the project were previously trained to ensure the quality and equality of the entire data collection procedure. Furthermore, the project was approved by the Ethics Committee (process 104554/2017). The general coordination of the health services involved provided their authorization, and all participants signed an Informed Consent (IC).

Data analysis

Data from the FG were analyzed by a group of three researchers according to the guidelines of Braun and Clarke (2006). Throughout the process, the first three phases were carried out individually, and the subsequent phases were carried out jointly in meetings. The analysis phases are explained in Table 1.

Table 1. Content analysis phases.

Phase	Method description
Phase 1 - Familiarization with data	Perform standardized transcription of the data, followed by repeated reading of the data corpus, taking note of the central ideas identified.
Phase 2 - Generation of initial codes	Systematically code the characteristics of the data corpus that were linked to the delimited object and research objectives, grouping relevant data for each code.
Phase 3 - Searching for central and specific themes	Group the codes into potential themes, bringing together the datasets (all data within the corpus used for analysis) relevant to each potential theme.
Phase 4 - Review of themes	The chosen themes were checked against the extracts (excerpts extracted from the dataset). At this phase, thematic tables were generated (containing the summary of the question or discussion axis, the central theme, and the specific theme), and then, thematic maps of the analysis were produced.
Phase 5 - Defining and naming themes	Throughout the process of analyzing and writing the results to refine the specificities of each theme, and generate clear definitions and names for each theme.
Phase 6 - Production of the report	Given the final analysis of the selected extracts, the results were related to the literature, and the academic report of the analysis was produced (the respective study focused on the central themes).

Results and discussion

Regarding the characterization of the 11 participants who made up three focus groups (FG), participation was mostly female (08 women and 03 men). As for the profession, the groups were made up of six psychologists, a social worker, a nurse, a nursing technician, an occupational therapist, and an administrative support agent, who was the institution's coordinator. The average age of the studied population was 39 years old, including participants from 23 to 62 years old. Working time ranged from six months of experience to 30 years, and the average time of CAPSad-III and CAPS-II professionals was 3.14 years. Taking into account that residency professionals worked rotating between health services during the group meeting period, the institutions where they worked were CAPSi, two university hospitals (UH) in the municipality, and a CAPS-III. The entire information collection process included the discussion of five thematic axes, which, after analysis, were categorized into central themes and are listed in Table 2.

Table 2. Central themes of content analysis.

Summary of discussion axes	Central themes of the groups		
	Focus group 1 (G1) CAPSad-III	***Focus group 2 (G2) CAPS-II***	***Focus group 3 (G3) Multi Residency***
Reasons for an individual to make problematic drug use:	Factors such as gender, race, social class, and the "war on drugs"	There are no specific factors that determine problematic use	Social influences based on the capitalist system.
What is it like to work with drug users:	Critical and conscious action is necessary in this area	Contact with drug users changes the prejudices they had about them	Action must be appropriate to the complexity of the service.
Have you ever witnessed and how you reacted when faced with a situation of stigmatization of a drug user:	They tried to talk to their teammates.	They tried to help when witnessed, the stigmatized user.	They tried to talk to reduce the stigma.
How to deal with your own prejudices to ensure quality of care:	Contact with the service user provides a critical reflection on one's own performance.	They denied the existence of their own prejudices	Critical reflection on their view of service users, which is permeated by prejudice.
Challenges and potential in working with drug users:	Challenges: Lack of effectiveness in public policies. Potentialities: - Team motivation. - Quality of welcoming	Challenges: - Lack of financial resources. - Lack of professionals. Potentialities: - Motivation of the service team.	Challenges: - Maintaining motivation in the face of obstacles encountered in the public policy service network. Potentialities: - The autonomy of the users themselves. - Public policy guidelines.

Determinations of Problematic Drug Use

In G1, social markers of race, social class, sex, and the current prohibitionist policy were highlighted as important to be considered to understand problematic drug use. The sex marker stands out, as they considered that women's social commitment is greater, culminating in family abandonment, which, according to them, may even justify men's greater adherence to treatment. Participants also agree that work in the specialized service must adapt to the specificities of the female sex, including the fact that, culturally and historically, the female figure has been linked to family care. The excerpt below exemplifies these conclusions:

> I realize that the impact on women is a little different, right? [...] There is shame on their part; I remember some patients who arrive and say: 'I don't want anyone to know, there are people I

> know waiting there. And I also realize that the impact on health is a little more disastrous (Professional 1, G2).

Participants said that race and social class of drug and service users influence both the form of treatment and exposure to the risks of drug use. The speech of one of the participants in the first group, in this sense, is illustrative:

> [...] Today, many more people die due to the drug war than due to the use of drugs itself [...]. If you are poor and live within a community, you are more exposed to the risk of local drug trafficking, armed domination, being reprimanded by the police, getting slapped in the ear, and being arrested (Professional 1, G1).

This statement summarizes the scenario of Brazilian states that had an average of 65,602 homicides due to violence in 2017, a number that grows annually, driven by the fight against drug trafficking based on drug repression (Cerqueira et al., 2019). Rêgo, Oliveira, Lima and Holanda (2017) argue that in Brazil, there is an intersection and association of the "profiles" of black, poor, low-education people and slum residents with drug users. They also add the labels of "trafficker," "dangerous," and "out of control," and public security policies must categorically target them. Thus, according to the authors, this policy has reflected that the phenomenon in question is an individual or group option or maladjustment, culminating in the criminalization of poverty as one of the ways to combat it.

Patriarchy still expresses the current social, political, cultural, and symbolic arrangement and was represented in the participants' speeches, especially from G1 and G2. This organization reproduces the inequalities and violence that victimize women, such as the obstacles they face concerning education, income, employment, workload, and violence (Cruz et al., 2014). This means that drug abuse in women generates social disapproval and stigma, which can prevent them from seeking help (Stringer & Baker, 2015), which makes it necessary to ensure greater visibility for female idiosyncrasies in the field of addictions, aiming to adapt public policies to this population.

G2 provided little content regarding this topic, pointing out that there are no specific factors that determine problematic substance use, contrary to the opinions of other groups. This content is summarized below:

> [...] I ask myself this question often, right [...] which for some people becomes a problem for the rest of their lives [...] I think about my friends [...] others still have problems arising from the use and [...] others still use it today, without any problems, they work, they have families [...] so I don't have an answer for that, right, I have questions (Professional 1, G2).

We also observed statements consistent with G1's verbal statements about the greater impact on women's health and social sphere, also highlighting the significant male predominance in the institution. This pattern of male prevalence in drug addiction treatment services is repeated in another Brazilian study (Barbosa et al., 2015).

Analysis of G3's statements indicates they believe that problematic use is a means of adapting to the form of social organization governed by capitalist logic. Participants in this group consider that the discussion must go beyond the "social determinants of health," understanding that drug use is a historical and cultural process of humanity, having been aggravated by the growing consumerism driven by the capitalist system. Consistently, Rêgo et al. (2017) mention that the social and historical conditions of capitalist society determine how individuals are seen in their decision-making power regarding drug consumption. Participants in G3, similarly to G1, point out that the economic condition can favor the use of drugs in a more comfortable and safe way. Thus,

users suffer less direct impact from violence related to trafficking, in addition to ensuring better quality of the substance.

Working with drug users

When asked about direct action with this population, G1 professionals pointed out that critical and conscious action is necessary to ensure that service users have their demands met. Frustration is a present feeling, but when the subjectivities of the public served are considered, combined with a conscious practice regarding one's own stigmas, it can lead to a reduction in expectations regarding the treatment, which, according to them, becomes positive.

According to G2's statements, contact with drug users changed the prejudice held against them. The conceptualization of stigma is known to be broad and exists at the intersection of varied concepts, such as labeling, stereotyping, separation, loss of status, discrimination (Link & Phelan, 2001), social distancing (Lundquist & Gurung, 2019) and prejudice (Martinez & Hinshaw, 2016). This multi-component definition of stigma makes it possible to identify the elements that must be present for its identification (Link & Hatzenbuehler, 2016). Contact is widely seen as a privileged strategy to reduce stigma, consisting of positive interpersonal experiences with stigmatized groups. This experience will make it possible to question negative attitudes through direct interactions, reducing the desire for social distance (Lundquist & Gurung, 2019). Nevertheless, evidence from a national study indicates that contact, unlike what was mentioned several times by professionals, was not significant in reducing the desire for social distance (Silveira et al., 2015).

The presence of fear and frustration was also reported, in line with Ferreira and Engstrom (2017), which refers to feelings of fear on the part of nurses and professionals from the Family Health Strategy when working with drug users. Another point to be highlighted is the greater empathy that professionals show towards alcohol users, as users of other drugs are seen as more threatening. Furthermore, the participants' statements indicate that an understanding attitude is crucial for establishing user trust. Below is an excerpt that precisely elucidates the above regarding the management of treatment with alcohol users:

> [...] I realized that I had better empathy with alcohol [...] so people with problems of chemical dependency on alcohol, I think I knew how to deal with it a little better [...], and with drugs, I already found people more challenging, threatening [...], so, I prefer alcoholics more, and I think they are more frank [...] so much so that I picked some up on the street and took them there [another specialized service the professional worked] [...] but the drug, the drug addict themselves, I have serious, nowadays not so much, but I already had that resistance, right? (Professional 1, G2).

Regarding G3, despite having had contact with AOD users at some point, none of them had been to CAPSad. Only one psychologist had previously worked at the UH AOD Outpatient Clinic. Therefore, the experience with this population on the part of these professionals is still very limited, and the discussions focused on their future beliefs regarding work with drug users. The central core of these participants' responses is that action must be taken that adapts to the complexity of the demand. Intersectoral action is identified as a goal of more comprehensive treatment for this population, which converges with Costa, Ronzani and Colugnati (2017).

The stigmatization of drug users

Notably, addressing the issue of stigma in research is a challenge, especially in studies that aim to measure it. This is a construct subject to a strong social desirability bias (Wood & Elliott, 2020). Therefore, in this investigation, the topic was approached by placing it in the past to minimize resistance related to questions and subtly bringing this phenomenon closer to the daily lives of professionals. Initially, participants were asked if they had ever witnessed a situation of stigmatization of a drug user and how they felt and reacted to it. It was unanimous across all groups that had already witnessed scenes of stigmatization, which mainly involved the processes of labeling, discrimination, and social exclusion.

In G1 and G2, participants recognized the presence of stigma in themselves and the service, stating that they opted for dialogue as a way of highlighting the stigma present. In G1, however, they discussed the lack of an external mediator to work on the issue due to the friction in the team when approaching the subject. As examples pointed out in G1, the negative beliefs they have, such as distrust of the user, reflect the stigmatization process.

Also, according to G1, internalized stigma is a barrier to adherence to treatment, and teamwork and coordination with the network minimize the consequences of stigma. In effect, the implications of internalized stigma culminate in the attempt to avoid the diagnosis and negative disclosure of the health condition, reducing the demand for services by users (Corrigan & Wassel, 2008), which was also mentioned by professionals, with true examples of the CAPS in question.

In G2, participants stated they try to help users when they witness situations in which they are being stigmatized. The examples of situations and reactions were permeated with a strong emotional charge, as they were experiences with family members or users who died as a result of drug use.

In the discussion axis "*How to deal with one's own prejudices to guarantee the quality of care*," the central theme of G1 is yet another note that contact with users provides a critical reflection on one's own performance, an issue previously addressed by G2. Professionals recognize they are afraid of some users, which is aggravated by psychiatric comorbidities, the belief of dangerousness, and distrust. They argue that this is a factor that compromises the bond between professionals and users and that this bond is the fundamental bridge to the quality of care. Similarly, Giandinoto, Stephenson and Edward (2018) point out that most health professionals also consider individuals who suffer from problems resulting from drug use and patients with schizophrenia as dangerous, even more so than patients who only had one alcohol-related disorder.

An attempt to explain the compromised bond between professional and user may be due to the desire for social distance, which is yet another effect of stigma. This process can be defined by an individual's lack of willingness to relate intimately or not to another person who has suffered a certain degree of deterioration in their identity (Lundquist & Gurung, 2019). Silveira et al. (2015) reported that the perception of dangerousness is explanatory of the desire for social distance related to cocaine and marijuana addicts.

In G2, the analysis revealed a movement away from prejudice on the part of the participants, i.e., the opinions expressed indicated that prejudice and stigma do not come from the professionals in the group but from others and people outside the service.

> [...] Well, I think there was no prejudice for being here because the team was very well chosen [...] they already knew how to deal with it [...] they know how to treat normally, like any other psychiatric patient

> [...] we know that they are flawed, that they are not equal to others, many come looking for benefits, we are aware of that (Professional 2, G2).

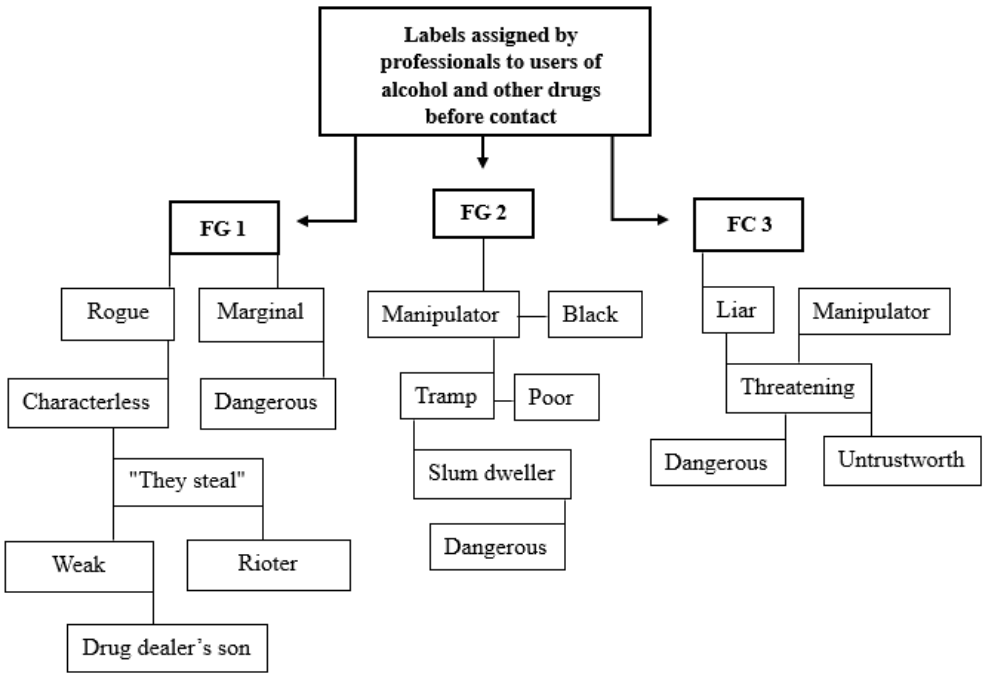
However, a member of the group disagreed, stating that he/she noticed prejudice in the service and him/herself, as shown in the following extract:

> [...] I think there is still prejudice, yes, sometimes I catch myself thinking things that suddenly I say 'what's that?, like robbery [...] day of a chemical dependency group I am much more careful with my bag [...] (Professional 1, G2).

Considering G3's little experience with the target audience of the discussions, the question was aimed more directly at identifying one's own prejudices and labels. Regarding the attempt to provide quality care, participants consider that it is essential that professionals reflect on their beliefs about users, permeated by prejudice. They presented examples of their immediate beliefs when they think of a drug user, and the physical image is almost always directed towards an older man, slimmed, dirty, poorly dressed, weakened in his health and appearance, and associated with a psychiatric comorbidity. They agreed that the physical stereotype is first formed in the mind, and then other labels are attached to the subject, such as "dangerous," for example. They add that this entire process can result in selectivity in reception, which had already been evidenced by Deslandes (2002), where the moral evaluation of emergency service users revealed discrimination and stigmatization on the part of professionals, given their socioeconomic characteristics, culture, race, way of speaking, clothing, among others.

To conclude the presentation of the analysis of this axis of discussion, we considered it appropriate to provide a mental map (Figure 1) that presented a synthesis of what had been declared by professionals as the "labels" attributed to drug users, especially before contact with this population. Namely, within Link and Phelan's (2001) psychosocial perspective on stigma, labeling is the first component that will trigger subsequent processes that can lead to stigmatization. For the authors, the label is something affixed and leaves an open evaluative category, which will make an automatic connection to a set of undesirable characteristics that constitute the stereotype.

Figure 1. Mental map. Labels given by professionals to users of alcohol and other drugs.



Challenges and potential in working with drug users

The FG's last triggering question was about the challenges and potential in working with this public, which could encompass both the practice and the care network, as well as public health policies. In G1, participants spoke about the lack of effectiveness of public policies, covering issues related to user access to the network, structure of public services, and training of team professionals.

Professionals argue about the challenge of dealing with the "Affective Network," i.e., that network articulated through the links existing within a public service, which is the fastest way to access the treatment device. Furthermore, they consider that if the care network were "effective" and not "affective," the user's care would be guaranteed based on their rights and through the coordination of the team, and not due to their kinship or relationships. The discontinuity of care in the network was also a challenge highlighted.

In this sense, Costa et al. (2017), when they mention the implementation of drug policies and their normative-legal apparatus, consider a fragmentation between the ideal and the real, what is expected and what actually is present in the ordinary context of drug care devices. Careful. This process contributes to the disconnection between policies and normative instruments of professional activity and the consequent naturalization of exclusionary practices, such as the "Affective Network."

What is at issue is not only the lack of effectiveness of public policies that seek to fully encompass the complexity of the demand of users of alcohol and other drugs but also how they have been analyzed and implemented. The potentialities and contradictions of this and other legislation, the social, economic, and political contexts in which they are inserted, in addition to the subjects and devices composing it (with their beliefs and values) (Costa,

Ronzani & Colugnati, 2017) must be taken into account. Therefore, there is a contradiction between the ideal and the real, or better said, the possible.

G1 also highlights the lack of training of some public servants who deal directly with users (e.g., secretary and receptionist), the lack of investment in the professionalization and training of users, and the precariousness of the service. In fact, deficient training and education based only on the clinical and biomedical model does not prepare professionals to work on the issue of alcohol and other drug use and may justify stigmatization on the part of health professionals (Costa, Mota, Cruvinel, Silveira, & Ronzani, 2016). We agree with Souza, Souza, Souza, Abrahão and Fernandes (2016) that it is necessary to consider the need for careful reflection on practices, as health devices can be seen as places of continued education, and these are important spaces that promote transformation in training.

As potentialities, the professionals present the motivation of the team, which, despite challenges, strives to become a place of reference for the user through the quality of welcoming (welcoming listening, appreciation, and understanding). Motivation is also a potential cited in G2. They mention that despite the lack of financial and professional resources, with a very small team, and the challenge of dealing with employees without an employment contract, service professionals work in cooperation with users, even in maintaining the structure of the location.

On the other hand, maintaining motivation represents a challenge in G3. Participants point out that society is not prepared to deal with users, faced with judgments, lack of trust, and policies that criminalize poverty. The stigma arising from the family and the service is an obstacle in dealing with this population, depending on the group, as it can increase internalized stigma and harm treatment. However, they agreed that harm reduction policies, intersectorality, and territorialized care are potential tools, in addition to the user's own autonomy in this process, thus encompassing their capacity for change.

In the context of the present study, the changes contained in resolution 1 of March 9, 2018, had not yet been implemented, where the current National Drug Policy is positioned against the legalization of drugs, starting to be guided by the logic of abstinence, abandoning harm reduction as the main treatment tool (Brasil, 2018).

The guidance of prohibitionist public policies is based on stigmatizing beliefs that moralize drug use, supported by the medicalization and criminalization of this condition (Silveira et al., 2018). The focus on promoting abstinence as the main treatment strategy goes against the various scientific evidence that points to the ineffectiveness of therapeutic protocols that use it (Medeiros & Tófoli, 2018). Given this, the effectiveness of the harm reduction strategy focused on the freedom of the service user through a comprehensive view of their health is still denied. This prohibitionist bias becomes one of the main fuels that drive the "war on drugs" mechanism, a phenomenon associated with violence against people, and not the substance, culminating in incarceration, avoidable deaths, and a strong racial bias (Medeiros & Tófoli, 2018).

Another factor observed concerns issues relating to sex, class, and race, which were one of the highlights of the discussions, mainly regarding comments regarding the vulnerability observed both in women who enter the services and in men. The other stigmas associated with the population served must be understood in order to articulate network care, minimizing the damage resulting from violence experienced by women (Cortes, Padoin, Vieira, Landerdahl, & Arboit, 2015). The violation of rights and legitimization of exclusion are linked to prohibitionist public policies that reiterate the criminalization of poverty, naturalizing and criminalizing young black, poor people living in Brazilian outskirts,

with the alleged justification of punishment and coercion in favor of the security of society. The guarantee of rights and equity, the encouragement of citizenship and autonomy, the leading role of the subject in their treatment, and the focus on promoting comprehensive health are principles that should guide professional practice in any public service focused on care, especially in the treatment of drug users.

Final considerations

The present investigation demonstrated that the beliefs of all participants are still permeated by stigmas, expressed, for example, by labels, stereotypes, and feelings still linked to drug users, such as fear. There was a certain homogeneity in the discourses between the CAPSad-III and CAPS-II groups regarding the determinations of drug use, differing slightly from the group of residents, who have more politicized and censorious manifestations of the form of social organization and its implications on people's lives. At this point, the context in which each service is inserted and its level of structuring must be considered. The exchange between the university and services/community, in which professionals from the multidisciplinary residency are still involved, can lead them to higher criticality regarding their practice.

Precisely, a highlight of the discussions was the high level of vulnerability observed in women who enter the services, with these commitments being the result of gender stereotypes and specific stigmas, with serious impacts on their adherence to treatment and, consequently, on their health. As already highlighted, in an attempt to guarantee continued care for these women, it is important to broaden the view of their unique needs, including the social determinants of health surrounding their lives, such as their relationships with their partner, children, family members, neighbors and, especially, when there is a disruption in these relationships. Furthermore, actions aimed at this population must be guided by the perspective of intersectorality and interdisciplinarity, sharing responsibility for the care of drug users with different segments of society and prioritizing investment in professional training (Souza et al., 2016).

As for the strengths of the study, the choice of the focus group as a method of collecting information enabled a wealth of meanings in the data and helped the process of giving new meanings to beliefs and reviewing professional practice. The peer analysis process carried out can guarantee higher internal consistency of the data presented, which was facilitated by the presence of an already consolidated research group on the topic of stigma. The limitations of this study include the well-defined power relationship in G2, which may have compromised the discussion and the achievement of more reliable meanings, and the lack of balance in the composition of the groups, restricting the comparison of beliefs based on the model of professional qualification. Finally, further studies in other territories and with a wider range of informants are suggested, considering the relevance of investigating professionals' beliefs, to improve training processes and, consequently, health services and care for this historically stigmatized population.

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Received: October 13, 2020
Approved: March 03, 2022