

# The use of psychotropic drugs in psychosocial care: an analysis in the light of care management

*Uso de psicofármacos na atenção psicossocial: uma análise à luz da gestão do cuidado*

Indara Cavalcante Bezerra<sup>1</sup>, Jamine Borges de Morais<sup>2</sup>, Milena Lima de Paula<sup>3</sup>, Tatiana Maria Ribeiro Silva<sup>4</sup>, Maria Salete Bessa Jorge<sup>5</sup>

**ABSTRACT** This study discusses health care in psychosocial care focusing on medication management. The theoretical axis articulates the psychiatric reform with daily lives of individuals in mental health service. The research was carried out at a Psychosocial Care Center (Caps) in Fortaleza, State of Ceará (CE), Brazil. The participants of the research were five professionals, ten users and nine family members. The research techniques used were: semi-structured interview, systematic observation, and focus group. The dialectical hermeneutic analysis followed the premises of Minayo. In the field, there was a lost subject-user in confrontation with an institutionalizing reality, highlighting the hegemony of the biomedical clinic, represented by the prescriptive practice of medicaments and the fragmented care management.

**KEYWORDS** Health management. Medicalization. Personal autonomy. Institutionalization. Mental health.

**RESUMO** *O estudo discute o cuidado em saúde na atenção psicossocial, com foco na gestão do medicamento. O eixo teórico articula a reforma psiquiátrica com o cotidiano dos sujeitos, no serviço de saúde mental. Realizado em um Centro de Atenção Psicossocial (Caps) de Fortaleza (CE). Participaram da pesquisa cinco profissionais, dez usuários e nove familiares. As técnicas utilizadas foram: entrevista semiestruturada, observação sistemática e grupo focal. A análise hermenêutica dialética seguiu os pressupostos de Minayo. No campo, observou-se um sujeito-usuário perdido, em confronto com uma realidade institucionalizante, evidenciando a hegemonia da clínica biomédica, representada pela prática prescritiva de medicamentos e pela gestão desarticulada de cuidados.*

**PALAVRAS-CHAVE** *Gestão em saúde. Medicalização. Autonomia pessoal. Institucionalização. Saúde mental.*

<sup>1</sup> Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.  
indaracavalcante@yahoo.com.br

<sup>2</sup> Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.  
jamineborges@hotmail.com

<sup>3</sup> Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.  
psicoim@hotmail.com

<sup>4</sup> Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.  
ribeirotatiana@hotmail.com

<sup>5</sup> Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.  
maria.salete.jorge@gmail.com

## Introduction

The process of the Brazilian mental health reform orients the construction of a unified mental health care network, regionalized, integrated, and hierarchized according to the technological density, and comprising different health care mechanisms (COSTA *ET AL.*, 2012).

The implementation of a new logic of care to subjects in situation of psychic suffering has its underlying basis on the development of a Psychosocial Care Strategy model, in which the services seek to substitute the psychiatric institution logic by redirecting mental health care toward treatment in community-based services. In fact, this model is based on a kind of care provided as from community-based care mechanisms with a broader view on health, in the perspective of territorial practice, intersectorality of policies, and network. (SEVERO; DIMENSTEIN, 2011).

The transition process from psychiatric asylums to community care reveals a dichotomous reality, in which the doctor-centered, medicament-centered care model prevails (BEZERRA *ET AL.*, 2014). Thus, the exacerbated consumption of medicaments is related to the hegemonic and market-driven social production of health, involving different stakeholders, such as: physicians, patients, pharmaceutical industry, and health regulatory agencies. In this logic, due to the 'magic formula' played by psychoactive drugs, individualities bear less and less suffering and resort to medicamentation in an unprecedented scale (ROSA; WINOGRAD, 2011; SANTOS, 2009; AMARANTE, 2007).

Medicamentation refers to the medical control over people's lives, the prescription and the use of medication being the sole therapeutics capable of responding to daily life situations; it differs from medicalization, which refers to the incorporation of social, economic, and existential aspects of human condition, such as sleep, sex, food, and emotions, under the dominion

of the medicalizable, like the diagnosis, therapeutics, cure, etc. Therefore, anguish, uneasiness, or difficulties once understood as part of the human being's complexity and singularity have become considered as diseases or disorders that may be diagnosed (ROSA; WINOGRAD, 2011; SANTOS, 2009; AMARANTE, 2007).

The literature (MAITI; ALLOZA, 2014; BEZERRA *ET AL.*, 2014; ROSA; WINOGRAD, 2011; SANTOS, 2009; AMARANTE, 2007) points out that the phenomenon of medicamentation becomes more evident in the field of mental health. In the health services, one observes the abusive prescription of medication for psychic suffering often related to social and economic problems, reflecting a therapeutics that is reduced to psychoactive drugs, with a fragile communication between professionals and users, and little use of light technologies.

It is important to highlight that the new model of mental health care seeks to build a new knowledge-practice, based on the broadening of the clinic and the approach subject-user. It seeks to promote the enhancement of light and relational technologies as components of the practice in the mental health services, allied to an emancipatory perspective of care operating, according to the premises of the psychiatric reform and the psychosocial care.

The National Policy for Pharmaceutical Assistance (PNAF) comprises a set of actions directed at the promotion, protection and recovery of health, both individual and collective, having the medicament as an essential input, aiming at the access and the rational use. In accordance with the principles of the Unified Health System (SUS), the PNAF seeks to ensure universality, integrality and equity (CNS, 2004).

Among the actions of pharmaceutical assistance there are those concerning pharmaceutical care, in which there is a direct interaction between pharmacist and user, aiming at an efficient medication management, i.e., a rational pharmacotherapy and the achievement of defined and

measurable outcomes that improve a patient's quality of life. This interaction should also involve the conceptions of its subjects, respecting the biopsychosocial specificities, from the perspective of the integrality of health actions (CNS, 2004), constituting light health technology.

Light care technologies are understood as generators of autonomy for the social subject, inasmuch as it provides user/family-centered care. In this sense, care management may be understood as a means to better ensure this autonomy and provide answers according to each demand, in the search of the resolubility and quality of the assistance. Thus, care management corresponds to the way in which the production of health care occurs regarding how it is established and organized in the interaction between the subjects.

In this perspective, Pires and Göttems (2009, p. 297) define management care as

the way in which intersubjective helping-power relationships are organized and manifest in the work process constituting scenarios nearer to the domain or to the emancipation of the other.

Thus, when handled with light technologies, care management potentiates this care, favoring the subject's emancipation.

Cecílio (2009, 2011) built the idea that care management may be represented by different dimensions: individual, family, professional, organizational, systemic, and societal, represented by six concentric circles to express the idea of immanence, in other words, of indissoluble character, inextricably linked to each other. The author defines the term as

the provision or making available health technologies according to the particular needs of each person in different moments of his/her life, aiming at his/her well-being, safety and autonomy to carry on with a productive and happy life. (CECÍLIO, 2011, p. 589).

In both definitions of management care, the objective is the autonomy/emancipation of the subject. Therefore, it is crucial to trigger strategies that aim at the commitment of health professionals and managers of SUS.

When analyzing the phenomenon of medicamentation as an instrument of care, one observes that this process permeates the various settings of care management and is counterposed to the achievements in the spheres of mental health and collective health. Therefore, the term medicamentation, as here presented, constitutes non-medical use of medicinal products to treat problems or situations of life that would not require 'pharmacological treatment'; as well as issues related to overdosage or chronicity of pharmacotherapeutic treatments that would not be necessary. It is also worth mentioning that the importance of the medicament is recognized in this sphere, but when it is based on its rational use.

Therefore, we believe that this study may provide substratum for the production of a mental health care that is coherent and resolute, inasmuch as it brings to light experiences of users, relatives, and health professionals, in search of a dialectic relationship between these subjects and the care management in the Psychosocial Care Network (Raps). In this perspective, we understand its potency to transform practices, build subjects, and produce knowledge.

To carry out this reflection, the guiding question adopted has been: How is care management configured in relation to the use of psychoactive drugs in the Raps?

## Methods

This is a qualitative study that seeks the understanding of users', relatives', and mental health professionals' experiences, senses, and significances in relation to

the use of psychoactive drugs as a way of management care of subjects in situation of psychic suffering, directed toward autonomy and co-responsibilization in the act of caring. The setting where the study was performed was the General Center for Psychosocial Care (Caps) of the Executive Secretariat - Regional IV of the municipality of Fortaleza, State of Ceará, in the Northeastern region of Brazil. This sectional was chosen for being within the covenant with the Municipal Health School System and for being linked to the State University of Ceará (Uece). The field period, from the approach, entering the field, and collecting information, occurred from January to October 2013.

Among the 24 subjects participating in the study, there were 5 mental health professionals from the Caps, 10 users and 9 family members, selected according to the following criteria: professionals with at least one year of practice in the health team of that institution; users of the General Caps connected to the service for at least 6 months and making use of psychoactive drugs; caregivers and family members who were regularly accompanying to the services of the Caps a user under use of psychoactive drugs for at least 6 months.

The study complies with Resolution nr 466/2012 of the National Counsel of Health and conforms to the ethical and legal principles and to the research norm that involves human beings (CNS, 1999). It has been submitted to and approved by the Research Ethics Committee of Uece under Report nr 387111.

The techniques used to apprehend the information and to understand the phenomenon were: systematic observation throughout the study registered on the field journal, making it possible to describe the routine and the care guided by the relationship professional-user-family member/caregiver, with the purpose of enabling the comparison between the actual practice of the mental health service and the

information apprehended in the narratives; focus group, carried out with caregivers and family members, where the themes covered various issues, among which were management and use of psychoactive drugs; and semi-structured interviews, enabling to complement and deepen the information obtained through the other techniques, besides enabling a greater contribution space for the subject.

The analysis of the study was delineated drawing on the combination hermeneutics and dialectics, based on the premises of Minayo (2010), which enabled the reflection on the subjects' experiences in mental health care: the organization of the information followed three stages: ordering (organization of the empirical material); classification (horizontal and comprehensive reading of the texts; transversal reading); and final analysis (horizontal synthesis, vertical synthesis, and comparison between information, gathering convergent, divergent and complementary ideas). In this path, the process consisted of discovering nucleus of meaning apprehended from the empirical material and categorized based on the dimensions that constitute care management, according to Cecílio (2011, 2009), and that gave signification to the experiences lived in the day to day of the service under study

## Results and discussion

The clinical practices of care related to psychic illness are still expressed in a technology of biopolitics of management, understood as social medicalization that is disseminated and accepted at the present time. The actions prioritize the organic diagnosis, the medicalizing and, especially, medicamentizing therapies, which follow unidirectional paths where the 'diagnostically ill' subject has not much choice left rather than adapting to the provided care process.

Mental disorders treatment with psychoactive drugs is symptomatic and its use must be limited to the imperative, and it should always be pondered whether the relation risk-potential benefit of the drug justifies its use, and whether other resources have been duly explored. Those drugs are no panacea, but rather a first order resource, sometimes complementary and other times ineffective. However, the use of medicaments, especially psychoactive drugs, which are of controlled use by Ordinance nr 344/98 of the Ministry of Health, is observed in the users' daily lives. The medicament becomes an efficient instrument for the sensation of relief and the sentiment of cure. The signification of the use of the medicaments is referred to the balance in the process mental health-disease (TESSER, 2006; AMARANTE, 2007).

Making use, or not, of medication is considered to be a decision that should be discussed at the meeting professional-user; it should neither be imposed nor treated as the main resource for the improvement of the ill subject's quality of life. It is believed that the holder of the decision should be, in fact, the user, and for this he/she should be informed about the risks and benefits of the use of the medicament.

According to Cecílio (2011), each subject has the potential to make choices concerning self-care. Thus, it is the subject who makes decisions according to his/her subjectivity. And in this regard the autonomy and co-responsibilization processes gain prominence, involving the dynamics of the relationships between the social stakeholders in the production of care and correspond to the individual dimension of the management care.

Here we highlight the importance of autonomy for the medicament management, considering the risks to which the user is exposed by making inadequate use of those substances. Moreover, the empowerment of the subject for his/her care greatly contributes to ensuring his/her quality of life.

Co-responsibilization refers to the

partnership between the subjects involved in the health care process for the improvement of the quality of life of the person with mental disorder. This partnership occurs in a multilateral way, taking into consideration the opinions and the possibilities of workers-users-family members in the composition of the therapeutic project, since the effort of the health team in promoting and stimulating the co-responsibilization of the subject potentiates the health care management. The importance of the context in which these stakeholders are inserted is to be highlighted, because to care is not only to project, it is to project being responsible; to project due to being responsible (AYRES, 2004). There is co-responsibility of individual and collective subjects in the health-disease process.

However, daily care in the services associates the medicalized dimension of mental health care in the users' lives, and also the fragmentation of the assistance in a partiality of tasks by professional nucleus, i.e., the fragmentation through specialization. The regency of biomedical knowledge operates casuistry to psychic illness that interposes different therapeutic compositions between the medical act and the multidisciplinary actions in a team (BEZERRA ET AL., 2014).

In practice, what is observed is reflected into actions that are not co-responsibilized. Or when they get closer, they are punctual, by specialization, and not belonging to a collective project, as revealed in the speech of a professional:

*So the issue of care with the use of psychoactive drugs is an one that has to be worked upon daily, since the moment I go to the primary care [...]. There is the issue of the group, the issue of family guidance, the issue of matrix support [...]. (Social worker Caps).*

Co-responsibilization for care emerges as a crucial element for autonomy. Thus, autonomy and co-responsibilization are relevant elements in the relationship between

people when care is established, either with medication or in the interpersonal relationship between the caregiver and the subject under care. In the conception of care in which there is predominance of the doctor-centered clinical model the subjects do not possess the power to decide on their treatment, and this implies absence of autonomy.

In fact, offering a propitious space for the subject's co-responsibilization, respecting his/her autonomy and right to participate and decide about the therapeutic project, means recognizing that the individual should possess certain points of view, and that it is for him/her to deliberate, elaborate his/her own plan for life and action, based on beliefs, aspirations, and own values, even if they diverge from society.

Even though the individual dimension is mediated by a set of forces, vectors and concrete conditions of life, it is possible to recognize the singularity of the subject in the construction of autonomy, which is translated into the achievement of the process of self-care, without the interference of broader social determinations (CECÍLIO, 2011). In this sense, the family context exerts influence on care management. In the family dimension, the stakeholders are constituted by family members, friends, and neighbors of the subject who demands care, in other words, people of his/her familiarity, and this becomes important for the strengthening of care and the re-insertion of the subject in the community's activities. On the other hand, they may act negatively, annihilating any possible way of social re-insertion.

In the interviews and in the focus group, the participation of the family as a crucial component for the process of care was evident. The professionals also highlighted the importance of the family in the care, as can be observed in the report of a psychiatrist of Caps:

*[...] for sure, the family must be totally engaged in the treatment, I always say this [...]. If there*

*would be the family's support, the patient would be much better; a significant improvement.*

It is noticeable that the majority of family members are co-responsible as to accompany the user to the health services, for the supervision and/or administration of the psychoactive drugs, and for the therapeutic management. On the other hand, it is noticeable that the co-responsibilization of the family member may, at times, reflect a situation of overprotection that hinders the user's emancipation.

Therefore, it is observed that the co-responsibilization between families, professionals, and users in relation to the psychopharmacologic treatment is retrieved and seems to indicate resolubility in the care, satisfaction with the treatment, and a path to 'being well', as reported by the sister of a user of Caps:

*Now, after this hospitalization, I am responsible for the administration of his medication. So, at the scheduled time the medication is kept with me, right? And I give him the medication at the right time.*

In practice, the narratives highlight the effectiveness of the treatment when the family is involved and co-responsibilized. The family, in this context, is perceived as a strong allied in the direction of resolubility, because it seeks to organize and adapt the care to the routine, observing the division of tasks and the adaptation of the family dynamics to handle the care, even counting on relatives who do not belong to the family nucleus in the organization around the subject. On the other hand, a burden of responsibilities was also noticed, due to it usually being held by only one relative:

*I'm the one who gives the medication; I give it to those who don't know how to take it. Maria knows, Joana knows, the ones who don't know are Rosa and João, and I come to fetch the*

*medicaments for all of them. [...] I think that I'm the one who can take care, because there is nobody to take care, there isn't anybody else. I'm a widower and live alone with them. (Mother of users of Caps).*

Therefore, the difficulties faced in daily life by the family with the individual in psychic suffering must be recognized. Understanding such difficulties is crucial for the establishment of a collaborative work between the team and the caregivers. The family dimension gains importance with the principles of de-institutionalization and de-hospitalization preconized by the psychiatric reform, which may enable family participation in an articulation of co-responsibility, but in practice they are still fragile.

In this sense, the professional dimension of care present in the relationships established between professionals and users is to be highlighted. This dimension is led by three main principles that grant it a greater or lesser capability to produce good care: the professional's technical competence; the professional's ethical conduct, especially in mobilizing all he/she knows and all he/she can do, within the actual working conditions, to assist in the best possible way such necessities; and the capability to build bonds with the person who needs his/her care (CECÍLIO, 2011).

The bond is understood as an expression of affection between persons, being an important element for autonomy. In health work, bonding is an efficient instrument for the horizontalization and democratization of mental health practices, because it favors negotiation between the subjects involved in this process, i.e., users and professional or team. This instrument, though, is also considered as capable of favoring the power over the other, depending on how it is utilized.

In the empirical field, it was possible to make evident that the mental health care at the Caps is very much centered on the process of medication prescription, corresponding to the maintenance of the therapeutic

conduct for the diagnosed mental disorder. Family members, users and professionals identify this situation, and question the psychiatrist's role and the incoherence of the care dynamics. Taking into account that the appointments are usually held with a long interval between one another, besides the great amount of medication prescribed and the increased influx of people, one observes the impossibility to build bonds, jeopardizing the systematic follow-up, besides the hindrance of the disposition to broaden the dialog relationship in the clinical practice. The appointments occur in face of a reality that is unfavorable to the maintenance of the integral therapeutic relationship, often limited by the demand for assistance, time, and shortage of professionals.

The medicamentizing practice aims at the reduction or elimination of signs and symptoms as demanded by users, emphasizing the disease, rather than the person's experience, in all its singularities, justified as a more complex dimension of action. Thus, the reduction of Caps therapeutic offers derives not only from the service structure, but from the interest of the user him/herself in broadening the therapeutic possibilities, i.e., it permeates the individual understanding of the need to broaden the relationships, the dynamics of life, and the meaning of the disease and the medicament. This re-structuring on the dynamics of the user's life would indicate the possibility to develop degrees of autonomy.

However, what occurs in the day-to-day raises ethical questioning on medicamentizing conducts, or the construction of dependence bonds, instead of the reference on care, as seen in the report of a Caps psychologist when referring to a user:

*[...] and she said: 'Doctor, this is my home!'. Last week, she came every day, though the Caps was closed for renovation works, and she said: 'I don't want to go in. I just want to stay here in front; because where I live I can't be myself.'*

The analysis and apprehension of the speeches raise again the critics to institutionalization and the reflection on the new chronicity, as well as the understanding that such services may create new manners of institutionalization, chronification, or even asylum (PANDE; AMARANTE, 2011).

*At first, he began with little: one pill, then two; then, it was alright; then, it went to three. But when it went on to four, I was very much sedated, even prostrate, sleeping a lot during the day. I didn't do anything. I say: 'Oh God, I'm am no longer in condition, no.'* (User 5 Caps).

With the institutionalization of health practices along the years, management care in its professional dimension develops, unappealably, in organizational contexts.

In the organizational dimension, work processes assume centrality, especially regarding the adoption of flows, assistance rules, and adoption of mechanisms shared by all professionals: agendas, protocols, team meetings, planning, assessment etc. In this dimension new elements are made evident, such as: team working, coordination and communication activities, besides the actual management function (CECÍLIO, 2011).

Convergences in the offer of services to users include assistance that is organized by referred flows, assistance relationships focused on the multi-professional approach in health, and emphasis on the use of psychoactive drugs. In this context, the subject-user gets lost in the space offered by the traditional and hegemonic clinic, limiting the (de)construction of autonomy of the therapeutic approaches operated in the Caps. Simultaneously, the user supports a prescriptive and medicamentizing practice by the intentionality of the care received. The permanence of the treatment reflects on the guaranty of the delivery of medicaments and its continuous use. Such consumption is required as the sole resolvent horizon for his/her health problems (TESSER, 2006).

Among the experiences of users regarding the service, the discussion is brought again on the access, not only to the institution Caps, but also to the doctor and the medication. In this process, the users attribute the care to having an appointment and receiving the medicament, as in the following reports:

*[...] the specialist is not there and there are no medicaments for three months already.* (User 10 Caps).

*[...] I am [satisfied], yes... I wish there was a neurologist, there is none here.* (User 9 Caps).

*[...] I think it should improve a bit more [...] the appointments shorter and not so long.* (User 7 Caps).

In practice, the assistential flow in mental health is restricted to the service structure of Caps, minimally exploring the resources of the community, family members, and the other institutions, such as schools and the Urban Centers of Culture, Art, Science and Sports (Cuca). Communication in this process is deficient, jeopardizing the co-responsibilization of those involved – professional/user/family – in the psychosocial care process.

The care delivered at Caps should permeate the understanding of those services as a strategy, i.e., as a mechanism that articulates and consolidates the care network, looking at the territory, its complexity and the relationships established between the social stakeholders in the care process. As Silva *et al.* (2012) highlight, the challenge lies in discovering and activating the hidden resources and establishing alliances.

The experiences of users, family members, and mental health professionals describe that sometimes the Caps institutionalizes the user in the service, when it should act as a de-institutionalizing mechanism in the interlocution with the mental health



assistential network. This means that to be in compliance with what is preconized by the psychosocial care, the Caps should act in the territory and in partnership with all the resources available in the community (PANDE; AMARANTE, 2011).

Therefore, it is necessary that the teams seek to deepen and improve the mechanisms that enable the organization of the demand, the qualification of the work process, and despite the structural limitations, excel at the service resoluteness.

By perceiving the phenomenon in a systemic way, the purpose is to understand the interrelations that involve the health services, with the different functions and various degrees of technologic incorporation. In the systemic dimension of care management, the analysis looks into how the construction occurs regarding the flows of the users, who utilize different equipments in the search of the resoluteness of their health problems. Moreover, an analysis is made of the way in which the subject moves through the care practice – by means of formal referral and counter-referral processes – revealing the path of those persons through the mechanisms that make up the network.

In health care, the offer of services and the set of social mechanisms for the formulation of an integral network of care would enable the production of autonomy in assistance to the user. However, the fragmentation of care, the partialization of knowledge and practices, and the tensions between offer and demand in SUS hamper the integration and the strengthening of a network to supply demands, problems and necessities.

In the territory under study, the itinerary of the user's care is unknown by the team and by the family, non-empowered, describing a situation marked by the insufficient autonomy in the management of the user's own life, in face of what is delineated by his/her psychosocial proposition. The study pointed out that users and family members ignore the formal assistance network and

the informal network in the community, and do not visualize interlocutions of the Caps with those mechanisms:

*[...] Dentist? He only went when there was no other way, the teeth were already very bad. Then he had to go. (Family member 9 Caps).*

*[...] she has an obesity problem, right? She, by herself [...] can't handle it and needed something to control it. She has diabetics and there is none, only the Caps. (Family member 7 Caps).*

The speeches reveal, thus, the disconnection between the Caps and the Primary Health Care. None of the participants mentioned the Basic Health Unity as another service used by them in the community, besides the Caps, thus making evident the disconnection in the organization of the assistential flows between basic and specialized care, and the failure in the responsabilization of professionals involved in the integral care process:

*[...] And so we have a fragile network, a network that is, in itself, already fragile. The articulation is fragile and the mechanisms we could use, they do actually exist, but we make little use of them. The network is fragmented. (Psychologist Caps).*

The societal dimension of care management corresponds to a broader aspect and refers to the encounter of civil society with the state. In this dimension, one observes how each society produces citizenship and public policies in general. The role of the state is analyzed, especially in the way it formulates and implements social policies (CECÍLIO, 2011).

In addressing the management of care production in a macro-social perspective, Merhy (2007) explains how the hegemonic doctor-medicament-centered model was established in society and reveals:

*[...] Even when one speaks of the place of public health, which seeks to understand the establishment of illness processes on the populations to produce interventions on a collective reach, aiming to control them, one sees that it is based on the understanding of the health and disease phenomenon as the installation on biological bodies, as pathological, of those dysfunctional moments [...]* (MERHY, 2007).

In this sense, in the field of practices where care technologies are articulated, they operate under the casuistry of the biomedical model, resorting to medicalizing practices directed to a sick biological body. Merhy (2007) adds that this social, practical and discursive process, when it is instituted in a hegemonic way concerning the manner of providing care in health, promotes an intense subjectivation in the various social groups. And in this path, imaginarily and institutionally, society is being medicalized, i.e., it seeks the normalization of life phenomena, like food deprivation, poverty etc. Medicalization is not the same as medicamentation, which corresponds to the exclusive use, often abusive or irrational, of medicaments in the therapeutic conduct.

In its articulation with medicamentation, the societal dimension of management care interferes in the practices and in the other dimensions. The use of medicaments in modernity corresponds to the main therapeutic resource in the western world. After World War II, adding to the industrialization process and science development, the medicament was established as a hybrid instrument, either as a drug or as a consumer good. When analyzing it as a cultural phenomenon articulated to the fields of economics and politics, medicaments are subordinated to the needs of the workforce production, being characterized as goods, thus succumbing to the logic of the market. Reality reflects the concentration in large markets with the participation of a reduced number of firms (SILVA; OLIVEIRA, 2014).

In the Brazilian scene, historically market relations linked to medicaments occurred through void policies, permeated by controversies, corruption, misconception, and assistencialism. In this context, foreign pharmaceutical industry found fertile soil in no one's land; it took over the space that was left empty by the state's negligence and by the lack of public policies to regulate the realm of pharmaceutical assistance. It was only in the 1990s, after the 1988 Constitution and the creation of SUS, that new policies were adopted in order to (re)conduct the pharmaceutical assistance, among which: the creation of the National Sanitary Surveillance Agency; the promulgation of the policy for generic medicaments, which among other attributions instituted the "breaking" of patents of reference medicaments produced by multinationals; and the approval of the National Drug Policy.

Currently, Brazil is situated among the ten largest markets for the consumption of pharmaceutical feedstock worldwide; it presents oligopoly characteristics, concentration by pharmaceutical classes, and strong participation in the market of transnational companies. As a consequence of the Generics Law (1999), the ascension of national capital firms occurred, presenting a growth above the market average in the last decade. The governmental policies directed to the industry, such as the adoption of the Industrial, Technological and Foreign Commerce Policy, using as dynamic vectors of the industrial activity the incentive to production efficiency, foreign commerce, innovation, and technological development. A consequence of this policy was the creation of the Program of Support to the Development of the Pharmaceutical Productive Chain, from the National Bank for Economic and Social Development (BNDES), among other initiatives for research and development in the area (SILVA; OLIVEIRA, 2014).

Although the access of the population to medicaments continues to be one of the

health problems in Brazil, some governmental initiatives have been adopted to improve this situation, such as the Popular Pharmacy Program, created to broaden the access to medicaments for the most common diseases affecting the population. There is also a particularity in the pharmaceutical industry in Brazil that refers to the existence of a public network of pharmaceutical laboratories, of variable sizes and distinct technical, operational and financial characteristics, linked to the national and state governments and also to universities. The objective of this network is to give support to the pharmaceutical assistance policy, focusing on the promotion of the access to medicaments by the population, contributing to the feasibility of public programs (SILVA; OLIVEIRA, 2014).

However, despite the presence of the pharmaceutical sector in the governmental agenda during recent year, and the broadening of the access to medicaments as a relevant fact resulting from social policies, there is still a long way to go, considering that the use of medicaments involves cultural and social practices inserted in historicity, which is in continuous transformation.

Indeed, the country still has a deficit with society when the subject is medicaments, because while developed countries focus their policies on a rational use of this resource, policies in Brazil continue to be centered on the expansion of the access. It is a fact that expanding the access to medicaments is crucial for the start of therapeutic care, but if there is no rationality in the use this access may cause harm to health.

The World Health Organization and the National Drug Policy propose that for the rational use of medicaments it is necessary to establish the need of the use of the medicament; the second step is that the appropriate medicament, the best choice, is prescribed, in accordance with the precepts of proven and acceptable efficacy and safety. It is also necessary that the medicament is adequately prescribed – pharmaceutical form, dosage

and duration period of the treatment; that it is available in opportune way, for an accessible price, and always responds to the required quality criteria; that they are delivered in adequate conditions, with the necessary guidance and responsibility; and finally, that the therapeutic regime already prescribed is followed.

However, in Brazil the reality is far from the rational use, considering that access can occur differently from what is preconized by the policies, which do not seem to be articulated with the real demands for the service, as reported by a professional, a psychiatrist of Caps:

*[...] Unfortunately, here one has to release a prescription for every two and a half months, which is absurd! It can't be less than this because the patient returns in five months. The ideal would be every month, every 15 days, but it is absurd, because one has to liberate a huge amount of medication. But there is no other way, because the patient can't come back here earlier. So, the patient takes home a huge amount of medication, which is a risk: the risk that the patient loses it, uses it inadequately, other people taking the medication away [...].*

The psychosocial approaches emphasize a historical-social dimension in the determination of the health-disease process, and become concrete and seek effectiveness as from the organization of the health services network. It is possible, though, to recognize the tensions at the entrance doors of the services and emergencies in the large and medium urban centers, due not only to the lack of involvement of the professionals, but also to the shortage of public resources, inadequate use of available resources, and verticalized funding policies that do not contemplate the needs of the population.

According to Barbosa *et al.* (2016), it is necessary to invest and broaden the spaces of reflection and invention of practices that integrate

the care into daily life of the services that constitute mental health, potentiating the constitution of the Raps. In order to surpass this challenge, it is necessary to de-naturalize the practices inversely developed that foment the medicalization of suffering – once understood as part of human experience, but nowadays not beared by modernity –, so that actually transforming practices may be consolidated.

## Final considerations

The information shared in this article propitiates a critical reflection on the use of medicaments, contributing to the diffusion and exchange of knowledge, drawing from the experiences revealed in this study, which demonstrated aspects that can most likely be observed in other settings in Brazil.

The analysis carried out in the light of care management highlighted subjects in psychic suffering who make use of medicaments that are, in some cases, unnecessary; and they do it as the only therapeutic resource. The subject – in this case, “made subject” – has no autonomy over the self-care, and the relationship professional-user often does not allow shared decisions on his/her therapeutic project.

In the search for the improvement of the quality of life of subjects in psychic suffering, the service, professionals, and family members agree that the presence of the family in the therapeutics is an important factor in health care. It is considered, though, that the care is concentrated on the family and that there is burden, causing anguish, which may cause illness in the family. Having said this, it is necessary that the Caps offers support to the users’ family members, seeking integral care.

It was also observed that the management of medication is the main attribution of the family. The relationship of the family with his/her ill member is a tenuous line of the care, because when this relationship happens with no guidance, it may promote a situation

of overprotection, favoring the impossibility of the user’s autonomy. In other words, the co-responsibilization of the family member may disfavor the co-responsibility of the subject with self-care.

The medicament was revealed as a therapeutic basis and also as a principle of medical conduct, considering that all care offered to the user is guided by its prescription, and therapeutic groups, workshops, and appointments with non-medical professionals are presented as adjunct in the treatment. Adding to these evidences, the great demand, the distance in time between each appointment, and the precariousness of working relationships make it impossible to construct bonds between the professional and the user, which is so much necessary for integral care.

Regarding the organization of the service, we observed a care restricted to the Caps, with the other mechanisms that make up the Raps being underused. There is also an important disarticulation from the Primary Health Care, considering the failures in the referral, besides no sharing in the projects. These facts contribute to the institutionalization of the user of Caps, by understanding this service as the only available equipment.

Thinking about the protagonism of the person in psychic suffering means reflecting on the (de)institutionalization of this subject, and in this process, even if still to be, autonomy deserves to be retrieved as a condition of health and citizenship, of life itself, as a fundamental value. The path to be followed in search of the integrality of care should be directed towards actions that seek to break through the limitation of actions taken by professionals, users and their family members, in face of the remission of signals and symptoms of the disease, to embrace a wider comprehension of factors that influence the capability of social participation, i. e., the understanding of a subject integrated in his/her collectivity, but recognizing the limits and potentialities of his/her singularity. ■

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Received for publication in: February, 2015

Final version: June, 2016

Conflict of interests: non-existent

Financial support: non-existent