

## Concepts of construction of autonomy under the psychosocial paradigm in the field of care for psychoactive substances users

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**Abstract** *The psychosocial paradigm in the field of drugs focuses on the suffering individual in relation to the social reality and values the uniqueness of users and professionals for the development of health care. A concept that bases these characteristics, and that comes from different theoretical frameworks, is the construction of autonomy. However, there is no study in the literature that summarizes it in its different meanings. This article aimed to systematize the concepts of autonomy construction under the psychosocial paradigm in the field of drugs. The methodology used was the integrative review. We searched, in the Psycinfo, PubMed, BVS and Web of Science databases, studies that analyzed the care process using the construction of autonomy. These concepts, their theoretical references and their foundations were identified and systematized. Among the 22 studies, there are concepts based on six theories, such as collective health and harm reduction. It could be considered that the construction of autonomy is a process that mobilizes different actions, such as co-responsibility and territorial sociopolitical action; which can be systematized in three inter-related dimensions; and which has different epistemological roots, such as the psychiatry of deinstitutionalization.*

**Key words** *Autonomy, Drugs, Mental health services*

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## Introduction

The services and actions aimed at health care for people who abuse psychoactive substances were consolidated in the early 2000s, overall with the Policy for Comprehensive Care for Users of Alcohol and Other Drugs<sup>1,2,3</sup> – even if they continued fighting for space with the prohibitionist and punitive policies in force<sup>2,3</sup>. For, until then, State policies related to drugs had for long been confined to the narrow and violent space of police, prison and/or asylum policies (public security and justice policies), and the approach to users, when it occurred, was performed through the logic of punishment and control<sup>2,3</sup>.

This new direction of drug-related policies based on the Policy for Comprehensive Care<sup>1</sup> gave way for a set of theories and care practices that were under development in different places, such as psychosocial care (CAPS/NAPS) and harm reduction strategies, aligned to the public system developed under the field of collective health. It was a set that came to be understood as a psychosocial paradigm, or collective health, in the field of drugs<sup>4,5</sup>.

As a common and important pillar, this set opposes the biomedical-psychiatric and moral model, which associated to economic-liberal policies shapes the War on Drugs<sup>2,6</sup>. This model was intensely criticized in the last decades of the 20th century due to its apparent ineffectiveness in face of the epidemiological profile, populational needs and effectiveness of health planning<sup>7,8</sup>.

Thus, the new paradigm based both on empirical processes and an expanded concept of health developed new concepts in the collective field of care. It placed conditions of production and reproduction of the lives of populations, the ties established under these conditions and the uniqueness of the subjects in the spotlight<sup>9</sup>. An appreciation of the potential of users and professionals began, which provided new perspectives for reflection and action<sup>10,11</sup>. It was understood that not only institutional actions affect the health of subjects and groups, but that community actions can and do affect health and the construction of care practices. A concept that unified the importance of subjectivity and protagonism of subjects is the construction of autonomy<sup>12,13</sup>.

In general terms, construction of autonomy seeks to rescue the social value and contractual power of users, making them co-responsible in the therapeutic process<sup>12-14</sup>. Amarante<sup>15</sup>, for example, emphasizes that the main way to evaluate services resulting from the psychiatric reform

should be the degree of autonomy built between users, professionals and society, and should always be an estrangement between the actions and places of care to avoid the care logic from changing and becoming a mere technocratic and institutional reorganization.

However, as fundamental as this concept is under the aegis of different theories and has similarities in its different meanings, they detain different historical conformations and genealogies and support different actions. Examples come largely from psychosocial care, health promotion and collective health precepts. Such as the humanization of services<sup>9,10,14</sup> through the co-construction of autonomy and co-management<sup>14</sup>, shared popular and technical knowledge<sup>13,14</sup>, enhancement of territorial ties<sup>12,15</sup>, ACS (community health agents) and NASF (Family Health Support Center)<sup>15</sup> and HR strategies, such as the distribution of safe application kits at drug use locations.

However, there are no studies that congregate the different notions related to the construction of autonomy in the field of care for users of psychoactive substances. The practical and political clash with the drug war paradigm has been intense, which may imply in the development of the construction of autonomy that took place in the years when the psychosocial paradigm that was implemented can be lost. An example of this debate is the abandonment of HR in the national policy on drugs, through presidential decree No. 9.761/2019. In addition to large public investments that have been taking place in therapeutic communities, surpassing the financing of the entire RAPS (Psychosocial Attention Network)<sup>16</sup>.

Thus, the objective of this study is to present the concepts on autonomy construction on which scientific production on the care for drug user in Brazil is based, enabling the production of a more important conceptual systematization; including to base assessments of ongoing changes in mental health and drugs.

## Method

This is qualitative bibliographic research. It followed the steps of performing integrative reviews<sup>17,18</sup>.

The integrative review aims to determine the scientific knowledge already developed on a subject through the analysis and synthesis of a range of studies on the same content. In the field of health, it provides the systematization

not only of practices and protocols, but of critical and conceptual understanding, given that it can integrate research from different areas and methodologies<sup>17,18</sup>. Ercole et al.<sup>18</sup> state that the variety in the sample together with the multiplicity of purposes provide “a framework of complex concepts, theories or problems related to health care” (p. 9). Thus, by adopting this method, a few understandings regarding the construction of autonomy in the field of care for people who are abusing the use of psychoactive substances can be aggregated and analyzed.

### Selection and organization

In the period between August and September of 2019, searches were performed in the Psycinfo, PubMed, BVS and Web of Science databases. The searches followed an appropriate protocol for each base, according to descriptors or keywords found in their thesaurus/Decs. Thus, each one was accessed with the following descriptors with terms in the singular and plural.

Protocol in Portuguese: (Serviço de saúde mental, Serviço de higiene mental, Centro de atenção psicossocial, Centro de Tratamento de Abuso de Drogas, Caps, caps-ad, Consultório na rua, Unidade Básica de Saúde, Atenção Primária, Saúde da Família) AND (Usuário de drogas, dependente químico, drogadito, farmacodependente, drogas de abuso, drogas recreativas, drogas, crack, cocaína, álcool) AND (Autonomia, autonomia pessoal, empoderamento, cidadania, direitos do paciente, direitos civis).

In English: (Mental Health Services, Mental Hygiene Services, Drug Rehabilitation Centers, Drug Treatment Centers, Psychosocial Care Centers, caps, Primary health care, Family health, Street clinic, Street outreach office) AND (Drug User, Drug Abuser, Addict, drug-dependent, stoner, junkie, drugs, crack, cocaine, alcohol, street drugs, drug abuse) AND (Personal autonomy, free will, self-determination, empowerment, freedom of choice, Civil rights, client Rights, Interpersonal control, autonomy, Patient's rights).

The exclusion and inclusion criteria were applied after searching the databases with the protocols and removing the duplicate studies in the End-note web program. Five exclusion criteria were used: 1) non-Brazilian population, 2) different theme from the objective, 3) place of study not being a RAPS service, 4) do not address or allow analysis of autonomy, 5) do not contain primary data.

The criteria for selected studies were: 1) studies that addressed the concept of autonomy in

Brazilian public services for drug users and 2) studies that included primary data. After checking the criteria, 19 studies were left. The references of this set were read and three other studies that satisfied the selection criteria were added. The selection is summarized in Figure 1.

For the results herein presented, we followed the qualitative data analysis steps developed by Minayo<sup>19</sup>, which include data ordering classification and final analysis. The ordering step corresponds to mapping of the data found. The classification step aims to gather relevant information about the data, based on questions that support the theoretical foundation, carrying out synthesis categories. An attempt is made to make connections between the data and theoretical reference in the final analysis step, which should be directed towards the research objectives.

### Analysis process

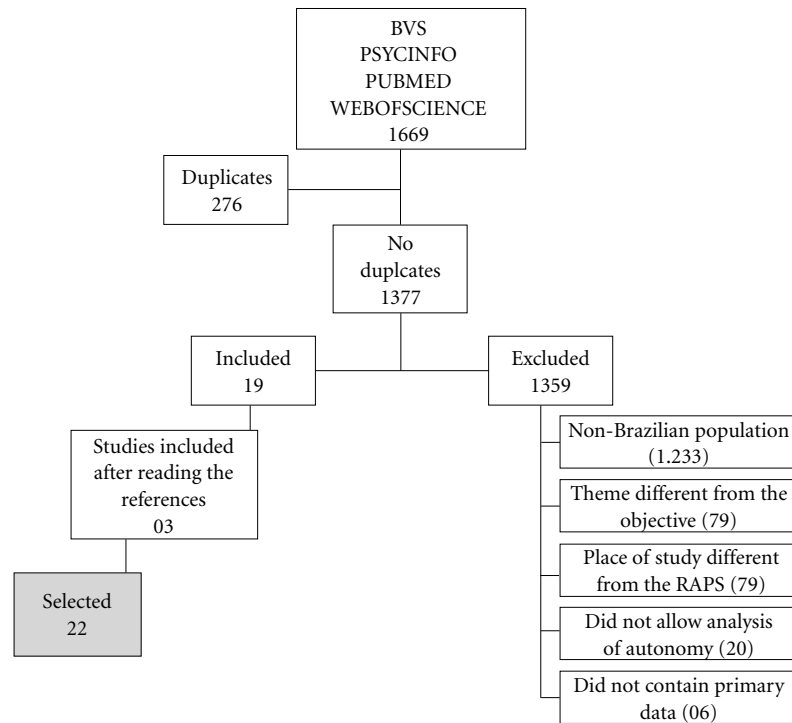
After an exhaustive reading, the concepts of autonomy and their references were placed in order. They are shown in Chart 1. The concepts are explained after presentation, seeking to show their foundations, followed by its basic theory: psychosocial care, health promotion and public health, practical-theoretical field of HR, support network theory, and the care theory.

Categories that emerged from the explanation of the concepts and synthesize the construction of autonomy were later highlighted. They are, for example: “rescue of contractual power,” “co-responsibility,” “development of employment or income generation relationships,” among others. These categories were organized through three dimensions, being presented in the “Summary of concepts” section and through Figure 2.

## Results and discussion

We initially present the 22 selected studies in Chart 1, together with the concepts of construction of autonomy, the theory on which they are based and the theoretical reference.

Psychosocial care was a theoretical field for nine concepts about the construction of autonomy. The HR strategy appeared in six. Health Promotion is the basis for one concept. Another two are influenced by health promotion and collective health. Collective health only supports two other concepts. Another two theories were the base for another two concepts, the support networks theory, and the nursing care theory.



**Figure 1.** Selection path.

Source: Authors.

The fundamentals of these concepts found are explained next, according to their references.

*Psychosocial care:* Among the references found under the psychosocial care are Kinoshita<sup>12</sup>, Costa-Rosa et al<sup>20</sup>, Luzio et L'abatte<sup>21</sup>, Yasui<sup>22</sup>, the National Comprehensive Care Policy<sup>3</sup>, Ordinance 3088/11<sup>23</sup> and the Mental Health report in SUS<sup>24</sup>.

Luzio e L'abbate<sup>21</sup>, when describing the experiences of the networks in Santos, São Paulo and Campinas highlight the process aimed at transforming the therapeutic in these municipalities, priorly centered in the concept of disease or disorder, and with a view to promoting autonomy. They define the need for therapy centered on users' everyday lives, on the relationship with health institutions and society. They express the proposal of new services to create a sociability network capable of making the therapeutic instance emerge. Therefore, a collectivity was needed, in which there was "the circulation of speech and listening, of experience, of actual doing and exchange, of the reveal of meanings, preparation and decision-making"<sup>21</sup> (p. 285).

The authors also express the importance of instances beyond services, such as the user associations. An example is the Associação Franco Basaglia, created by users and professionals of the CAPS (Psychosocial Attention Center) Luiz da Rocha. Its purpose was to "promote autonomy and a greater reach of the clientele, encourage the participation of the family and other social segments, enable extra-clinical management of users' lives (in a way to expand contractual power and the possibilities of affective and material exchange)"<sup>21</sup> (p. 285).

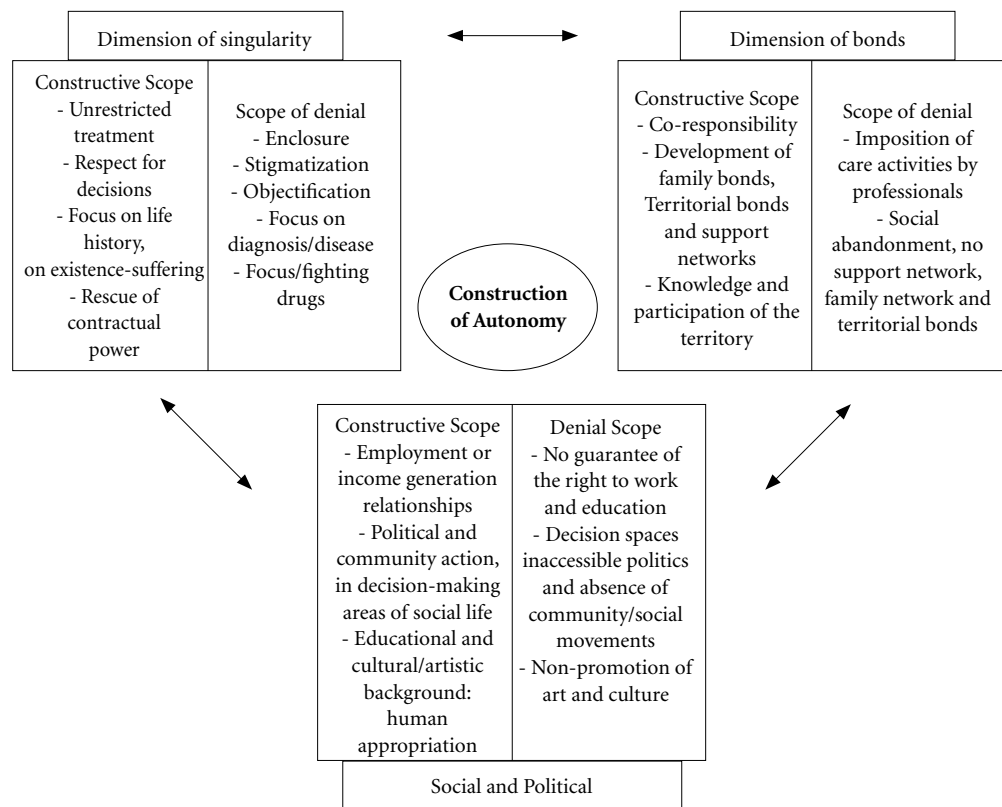
These notions were gradually consolidated by public agencies, such as the city of São Paulo, which held two premises in the mental health program at the time: "Psychiatric suffering was an integral and inseparable part of the global suffering of individuals subjected submitted to social inequalities" and the mental health policy should break "with the hegemonic model centered on psychiatric hospitalizations and asylum practices"<sup>21</sup> (p. 286).

In a similar way, Costa Rosa et al.<sup>20</sup> highlight terms such as valuing the subject, emancipation,

**Chart 1.** Concepts of the construction of autonomy, theoretical field, and base reference.

	<b>Title</b>	<b>Concepts of CA</b>	<b>Base theory</b>	<b>Concept reference</b>
1	Strategies of care for adolescent users of crack undergoing treatment	Promotion of autonomy	Psychosocial care	Ordinance 3.088/12 and National Policy (BR, 2003)
2	An exploration of relational autonomy of people with substance use disorders	Relational autonomy	Feminist Ethics and HR	McLeod, Sherwin (2000)
3	Care for drug users: between standardization and denial and denial of autonomy	Construction/expansion of autonomy	Harm Reduction	Sodeli (2010)
4	Homeless crack cocaine users: Territories/territorialities in constitution of social support networks for health	Support networks	Support Networks	Lacerda (2010)
5	Care for drug users: nurses' perception of Family Health	Promotion of citizenship and autonomy	Psychosocial care	Lacerda e Rojas (2017) base Luzio e L'abatte (2006)
6	The daily lives of adolescents in a CAPSAD: realities and challenges	Protagonism and co-responsibility	Harm reduction	Santos, Soares, Campos (2010)
7	Accountability and participation: how to overcome the guardian nature of CAPS-AD?	Construction of autonomy	Harm Reduction	Pinto et al (2015) based on IHR (2010)
8	Meanings and senses attributed to CAPS-AD by users: case study	Promotion of autonomy	Psychosocial care	Brasil, 2011. PT 3088 Luzio et l'abatte (2006)
9	Experiences of adolescents using crack and their families with psychosocial care and institutionalization	Promotion of autonomy and social inclusion	Psychosocial care	Yasui (2011)
10	Autonomy and social reintegration: perception of family members and professionals working with HR	Autonomy and social reintegration	Psychosocial care	Souza <i>et al.</i> (2016), Duailibi (2012), base Kinoshita (2001)
11	Harm reduction and tensions in trust and distrust in a mental health service	Relational autonomy and self-confidence	Feminist Ethics and HR	McLeod e Sherwin (2000)
12	Teamwork guided by the motivations of users in CAPSAD	Construction of autonomy	Health promotion/ Collective Health	Jorge <i>et al.</i> (2011), based on Campos (2007)
13	Biopolitics in the care for alcohol users and other drugs	Production/expansion of autonomy	Collective health	Merhy, 2002
14	The perception of users and the approach to alcohol and drugs in primary care	Increased freedom and co-responsibility	HR	Brasil, Política Nacional (PAIUAD) (2004)
15	Self-care demands in therapeutic groups: health education with users of psychoactive substance users	Self-care with co-participation	Care Theory	Orem (2001)
16	CAPS AD under the user's perception	Increased autonomy and citizenship	Psychosocial care	Brazil. Mental Health in SUS (2004)
17	Caring for CAPSAD users: a view of the collective subject	Construction/expansion of autonomy	Collective health	Merhy (1994)
18	Community therapy as a resource for addressing alcohol abuse in primary care	Empowerment	Health promotion/ Collective Health	Carvalho (2004)
19	Assistance practices at CAPSAD	Rescue of citizenship and autonomy	Psychosocial care	Kinoshita (2001)
20	Psychosocial rehabilitation of users of alcohol and other drugs: conception of health professionals	Rescue of autonomy	Psychosocial care	Kinoshita (2001)
21	Comprehensive health care model for the treatment of problems arising from the use of alcohol and other drugs	Redemption of contractual power	Psychosocial Care:	Costa-Rosa, Luzio e Yasui (2003)
22	Bonds and social networks of individuals dependent on psychoactive substances undergoing treatment in CAPS AD	Empowerment	Health Promotion	Andrade e Vaitsma (2002) base Labonte (1994), Israel (1994)

Source: Authors.



**Figure 2.** Synthesis of the dimensions of the construction of autonomy.

Source: Authors.

and power of social contractuality. This is also the direction of the approach by Yasui<sup>22</sup>, who expresses that the Psychiatric Reform was a political dispute that aimed at social transformation, contrasting ideas of autonomy and solidarity with control and segregation. The National Policy<sup>3</sup> also advocates territorial actions and the construction of support networks. It says that it is the duty of SUS to provide the construction of co-responsibility and a broader perspective of the clinic<sup>3</sup> (p. 11).

The construction of autonomy in psychosocial care, therefore, conceives that the subjects should be considered holders of social value and decision-making power; that these change with the quality of ties with alterity; thus, these ties develop under social conditions that guarantee more or less possibilities of life. This set of conceptions finds its main epistemological roots, according to Amarante<sup>15,25</sup> and Nicácio and Campos<sup>26</sup>, in the psychiatry of deinstitutionalization. This epistemological root is presented below<sup>27-30</sup>.

For the authors of this movement, that which marks what is designated as madness and lack of control is the conflicting relationship between society and individuals in the concrete development of their lives<sup>27,29</sup>. Giovanni Jervis, author of the critical textbook of psychiatry, expresses those disorders are a result of “a global existential condition. This condition of life is generally dominated by material contradictions, before being dominated by psychological contradictions. It can be recognized that there are a number of factors of great importance in determining mental disorders”<sup>27</sup> (p. 132). Among these factors, it expresses extreme poverty with its material and moral difficulties, domestic violence, oppressive education, alienating working conditions etc.

To these individuals, society, and its institutions, in the impossibility of readapting to the same standard that leads to illness, it protects the stigmatization and exclusion – instead of welcoming the existence in suffering and providing a collective transformation of this reality. Above

all, this happens for those that do not have power and socioeconomic value, with whom they could oppose the stigma of being considered out of control or sick<sup>27,30</sup>.

The psychiatry of deinstitutionalization, therefore, is based on the rescue of an autonomous life, restoring the individual's contractual power in the face of the inevitable social contract<sup>29,30</sup>. Since under the diagnosis of psychological loss of control, medical science removed the individual's power over himself, leaving them to the scrutiny of the professionals who carry out the treatment. For those in a process of deeper institutionalization resulting from a life of diagnoses and hospitalizations, Basaglia<sup>30</sup> expresses that rescuing non-conformity is needed above anything else: "It would be more important for us to strive to awaken in him a feeling of opposition to the power that has, until now, determined and institutionalized him, even before building a welcoming and humane space around him that he needs"<sup>29</sup> (p. 116).

Thus, rescuing power permeates an evident relational dimension. For, it is only with recognition as persons (and not objects) that individuals do not find the situation of freedom; they actually find an emptiness<sup>28,29</sup>. There must be a reconstruction of bonds, they must exercise their value in practice. Given the social institutions, the roles to be played, the decisions of one person can affect others, just as group decisions affect the individual. In the promotion of autonomy, a procedural tension of this relationship in face of the social reality is needed: "the institutional transformation should act in the context of the relationship that unites the opposite terms of that relationship, to deny the evident opposition. This means that contradictory terms such as slavery and freedom, dependence, and autonomy, cannot be understood as the opposite of one another"<sup>28</sup> (p. 149).

That is, developing autonomous relationships requires responsibility towards the other. In deinstitutionalization, for example, be it the user, professional or the family member, it is necessary to try and deal with the tensions of relationships, facing the return to authority/authoritarianism.

Thus, tension between roles in treatment pervades awareness<sup>27,31</sup>. Basaglia, based on Gramsci, develops this way when he expresses that health technicians must oppose their own power. The author connects the term "technical" to the "consensus official": the intellectuals who legitimate institutional; in contrast, it is necessary for professionals concerned for persons in suffering to

fight for the hegemony of power where it happens, in the person in distress to dispute the hegemony, in the territory with the subjects.

The construction of autonomy in the theory of psychosocial care, therefore, is rooted in conceptions that emphasize the fight against institutional violence, which conceive the intrinsic relationship between autonomy and collective responsibility and develop this construction inside services and treatments, but also within the scope of institutionalized society.

*Harm reduction:* among the authors who addressed the construction of autonomy in HR are McLeod and Sherwin<sup>32</sup>, Santos et al.<sup>33</sup> and Sodeli<sup>34</sup>.

In the concept presented by Santos et al.<sup>33</sup>, the users should not be seen as drug dependent or sick and destitute of rationality about their actions. And HR actions should focus on guiding users on the consequences of use in relation to their life context, integrating health conditions, housing, family, and social ties. Thus, developing user protagonism in relation to their therapeutic process. The notion of HR is also directed towards the transformation of the sociocultural context based on care services, considering that the abusive use is seen because of the impact generated by the conditions of existence<sup>33</sup>.

Sodeli<sup>34</sup>, based on existential phenomenology, directs these reasonings towards the construction of possibilities of choice. It expresses that the human being constitutes himself as the holder of a sphere of freedom, as he can always make decisions. Drug use is one of the possible ways to alleviate existential anguish. Therefore, the author rejects the prohibitionist understanding that drug use is always a deviant behavior or pathology. For, if it is a choice, individuals do not feel bad about it at first. The author expresses that it is a fact that use can become abusive, but not necessarily. Thus, it is necessary to build other possibilities of more authentic choices with the other, in the sense of reducing vulnerabilities. Education about drugs (primary prevention) is advocated, including before use<sup>34</sup>.

Two studies based on McLeod and Sherwin<sup>32</sup> relate the HR perspective of empowering users to the perspective of relational autonomy of feminist ethics. This considers the many determinations that act on each person's life, which implies the possibility or not of taking autonomous actions. That is, social characteristics, such as structural oppressions and identity oppressions that act in interpersonal relationships, such as racism and chauvinism stand out. Only with the possi-

bility of reflecting on these determinations and having the construction of actions that oppose them could one speak of autonomy.

Another approach in this sense is that of the International Harm Reduction Association (IHRA)<sup>35</sup> that expresses the protagonism of users in a community dimension. This means that it defends that the public of HR actions should be part of the preparation of these actions, discussing their objectives. And, not only drug users, but their family members, in addition to policy-makers. Therefore, it has a conception based on public health, with clear goals for not getting sick and maintaining life.

HR is frequently explained<sup>36,37</sup>, as an epistemological basis, by Canguilhem's understanding of health-disease, in Normal and Pathological<sup>38</sup>. According to Canguilhem, the human being can create new norms based on the changes they face throughout their life. This is because life has a procedural and variable nature. In this sense, the author opposes the biomedical premise that health is the contrary of disease and is equivalent to an objective norm. Each individual is always producing meanings of their body-existence in relation to the environment with which they live, precisely to carry out their way of going about life. The pathological would correspond to normative inertia; to the extent that, as this normativity takes place, there is a health process.

This conception reverberates in the notions developed, for example, by Marlatt<sup>39</sup> and Lancetti<sup>40</sup> about abstinence as mandatory treatment. Marlatt expresses that abstinence is not an imperative, and any HR action for health must be supported. There is flexibility, according to the relativization of the use that each person desires and endures at each moment. Lancetti<sup>40</sup> expresses that HR is antagonist in the fight against drugs, for it is not the drug that is in question, but the subject. And, as a public health action, HR is congruent with every act of care aimed at defending life<sup>39,40</sup>.

*Health promotion and collective health:* the authors based the construction of autonomy on the theoretical field of health promotion by Labonte<sup>41</sup> and Israel et al.<sup>42</sup>; the concepts of Carvalho<sup>43</sup> and Campos<sup>44</sup> influence collective health and health promotion. The production of Merhy<sup>13,45</sup> is included in the theoretical field of collective health. Both theoretical fields are addressed at this same point, considering they are fields that have come together in the shaping of the field of health in Brazil<sup>7</sup>.

Onocko-Campos and Campos, when addressing the need to reformulate the health field,

brought by the expanded understanding of the concept of health, consider that the construction of autonomy should be at the center of health policy, management, and work, being the fundamental objective of the entire system.

*The main change refers to the redefinition of the "object" of health work, it refers to thinking of this "object" as a synthesis between health problems (risks, vulnerability, and illness) always embodied in concrete subjects. This valorization of the "subject" and its singularity radically changes the field of knowledge and practices of collective and clinical health* (Onocko-Campos, Campos, 2006, p. 669).

It would be critical for all health system and service planning to seek shared autonomy, a co-construction of autonomy: "The co-construction of the ability to reflect and autonomous action for the subjects involved in these processes, workers and users"<sup>14</sup> (p. 669). This conception of autonomy does not correspond to absolute values, but relative ones, corresponding to each reality. It is conceived as the ability for subjects or the collective to deal with their network of dependencies. That is, the ability to understand and act on themselves and on the context<sup>44</sup>. Therefore, subjects need information and the power to use it to act on the world. Consequently, autonomy is intimately connected to a subject's ability to face conflicts, conduct, and organize personal and collective contracts and commitments<sup>14</sup>.

Merhy<sup>13</sup> says that the process of building autonomy corresponds to a living care/work technology in health and that it is also a relationship production technology. It is part of the light technology category, necessarily related to reception and bonding. The author says that the development of these technologies is directed toward the increase in the degree of autonomy in the way people live, which, at an individual and collective level, enables greater control of the risks of getting sick or aggravating health problems. This process, when performed by the health professional together with the user, entails therapeutic treatment on its own<sup>13</sup>.

The concept of Empowerment in health promotion, based on Labonte<sup>41</sup> and Israel et al.<sup>42</sup> has similarities with the concepts mentioned above. They express that empowerment comes from the process of individuals acting together to decide their own lives, thinking critically about reality. An example occurs when organized service users can influence the many dimensions of their health, from the change in individual and community habits, in addition to the conditions for organizing services<sup>41,42</sup>.



However, Carvalho<sup>43</sup> expresses that the term empowerment is used by several theoretical lines, not always homogeneous. When exposing the history of Health Promotion, the author says that a few of the concepts are based on an ideal notion of autonomy. This concept comprises subjects that can make autonomous decisions for themselves, without having knowledge about the determinations that affect them. Carvalho<sup>43</sup> says that terms such as risk and empowerment are linked to “health public policies” or “contemporary prevention policies:”

*The possible autonomy is, almost always, a regulated autonomy since individuals tend to follow rules and norm conceived by experts and parameters build by Health Public Policies. [...] many of the narratives of progress that support the New Public Health strategies leave discussion on unequal power relations between specialists and non-specialists, rich “developed” countries and populations of poor of poor “in development” countries, men and women, male and female heterosexuals, and homosexuals untouched (Carvalho, 2004, p. 674).*

The term empowerment therefore carries the ambiguous character of some health promotion premises. Thus, it can limit the construction of autonomy. This means that a liberal conception of empowerment can make the State abstain from its responsibilities towards the population<sup>43</sup>. The author concludes that the term “community empowerment” would be more suitable since it brings the notion of a dispute for the control of resources and redistribution of power.

This way, health promotion understands that the increase in the ability to analyze and act on one’s own problems should not be relegated only to individuals and their communities, but these individuals must effectively participated in the formulation of policies, resource distribution, socially exercising power.

*Support network theory:* Lacerda<sup>46</sup> says that support networks that are formed in everyday life in various social spheres “translate into health” (p. 76), once the subjects and collective members begin to have more autonomy in the way they live their lives. This happens due to participants sharing symbolic and material goods. Sharing these goods feeds bonds, causing the subjects to influence, and be influenced in a circulation and mutual concern dynamic.

Therefore, based on Mauss’ gift theory, it is shown that it is not simply about giving and receiving for one’s own benefit, based on a utilitarian view of subjects and networks. The gifts or endowment comprises a system of social ac-

tion that involves the triple movement of giving, receiving, and repaying symbolic and material goods. The dimension of autonomy in support networks is built dialectically between subjects and their different bonds. In sum, networks enable support and citizenship not only between the person or group that provides support and receives support, but also generates a sharing that circulates, influencing the micro and macro relationship of social life.

This way, it is important to mention, based on Amarante and Lancetti<sup>47</sup>, the potential for strengthening bonds with the support networks in the context of primary care and other levels of health care. Because social support as a health promoter allows the analysis of the health-disease-care model, instead of an analysis strictly based on health-disease. Social supports enables one to consider health-disease not as a biological state experienced by subjects, but a process that changes health-disease through the conscious action of all members of the social collective<sup>46</sup>.

*Care theory:* in the care theory, developed by nurse Dorothea Orem, a person becomes autonomous when they act consciously, meaning intentionally, in addition to effectively acting to preserve health and well-being<sup>49</sup>. It considers that adaptation and learning in new physiological situations, such as pregnancy and old age, and pathological situations, are part of building autonomy. Professional care permeates the construction of autonomy of subjects, considering the support bond for the development of care is common.

Regarding the relationship of individuals with the care professional, it can be of three types: fully compensatory (self-care cannot be performed by the person); partially performed with assistance; and care that is focused on support and education for adaptation. It is important to emphasize that therapeutic demands consider more than the individual dimension alone, also considering the environment, society. That is, care is organized according to the characteristics of people as a member of groups in a given time and space<sup>49</sup>. According to Remor et al.<sup>49</sup>: The functioning of man is linked to his environment and together they form a functional whole, a system.

Therefore, Orem’s theory expresses that establishing a bond between the professional and the person under care takes place to overcome the process of illness through adaptation and self-care actions; in addition to considering socio-environmental aspects to produce everyday autonomy, which demonstrates the relativization

of health ideas to be met - manifesting a certain overcoming in relation to the biomedical model.

### Conceptual synthesis and discussion

From the concepts of construction of autonomy explained, and their respective theoretical frameworks, the inter-relation between the theories on which the paradigm of collective health in the field of care for people abusing psychoactive substances is evident. Among the practices and foundations of this set, the importance of social participation and the collective promotion of care actions stand out, which is the foundation, for example, for actions such as workshops and health promotion groups and services such as street ambulatories. In addition to the notions of territoriality and comprehensive care. This set seeks to overcome the vulnerability and health inequities of this population, with the understanding of the social determination of health and illness processes as background.

Considering this confluence of theories, there was an attempt to synthesize its complexity and plurality. For this, we associated the categories that emerged from the theoretical explanation through three dimensions: (1) dimension of singularity: rescue of autonomy in the therapeutic processes; (2) dimension of bonds: co-responsible construction of autonomy; and (3) social and political dimension: construction of autonomy in collective amplitude.

It was also found that these categories come from a need to overcome something opposite or absent. HR, for example, is the opposite to the biomedical concept, which focuses on drugs instead of the subjects, reiterating the need for abstinence. Thus, what is propositional to develop autonomy in the constructive scope, and what must be overcome as a denial scope, was considered. These elements and their dimensions are presented in Figure 2.

It was also evident that the construction of autonomy depends on multiple actions in each dimension, with these three dimensions being correlated. In the dimension of singularity, the elements that comprise the process are related to bringing the human suffering to the surface, providing a rescue of the person's condition as the individual who detains value to himself and others. This enables the person to overcome practices based on health concepts that consider the disease, drugs, individual inadaptability as the object of the disease, and blame subjects for abusive use.

In the dimension of bonds, it is understood that the construction of autonomy is not only individual, but it also depends on the relationship with others in a co-responsible way to develop social value. This second dimension seeks to develop the increase in the universe of addictions, a notion brought by the psychiatry of deinstitutionalization<sup>28</sup> and found in Kinoshita<sup>12</sup> and Onocko-Campos and Campos<sup>14</sup>. This means that depending on several bonds creates the possibility of satisfying several needs, not just one. This set of dependencies expands when participating not only in the CAPS or Health unit, but in the family, the social center, and other territorial networks.

The third dimension addresses the execution of development of autonomy in a broad social way, not only performing exchanges that the social norm itself already allows but expanding rights to overcome social conditions through the guarantee of work, formal education, improving access to health, for example. It also seeks the power to oppose and transform this new norm politically, through the claims of user associations and participation in health councils.

What this review points out, therefore, is that the promotion of autonomy takes place both through the denial of exclusion processes and the construction of effective social participation policies. This takes place, to a certain extent, through the social security network, given that the literature points to the importance of the CAPS-AD, the health units and street ambulatories, for example, especially when using technologies that seek autonomy, such as unique therapeutic projects, harm reduction workshops, health education and promotion groups, and the access to services itself<sup>50-52</sup>.

However, what the review also points out is that autonomy is not only carried out within the services. They permeate the territory precisely to articulate it, discover and intensify bonds, and to create support network possibilities, devices to guarantee rights, leisure and culture<sup>46,47</sup>. Given that abusive use results in the loss of autonomy, either due to direct individual effects of abusive use, or for difficulties in social relationships, as well as family and work conflicts, in addition to invisibility on the part of the State that intensifies this situation of vulnerability<sup>36</sup>.

However, the set of actions discussed above has been mitigated against current policies. The last changes to the National Mental Health and Drug Policy, through presidential decree No. 9761/2019, for example, defines the abandonment of HR while simultaneously assuring total

abstinence. There are also large financing deficits in RAPS funding and large public investments in therapeutic communities<sup>16</sup>. Therefore, the co-responsibility and especially socio-political participation dimensions face many difficulties, both due to the lack of relationship between the network's devices and for the difficulty professionals face to be in the territory strengthening bonds.

These limitations, therefore, often prevent a practical transformation in the life of users, making them dependent on CAPS, health units and even on expanding therapeutic communities, reoxygenating the process known as revolving-door or inpatient career<sup>54</sup>. That is, the non-transformation of the conditions for reproducing the users' daily life in the process of building autonomy often makes them return to the same place of treatment, with the same demands.

### **Final considerations**

It was possible to show the plurality and complexity of the construction of autonomy, in the confluence of the theoretical-practical frameworks that comprise the psychosocial field. It comes from the foundation of these schools, going through the praxis of the care process and pointing to the objectives of this set: the autonomy of individuals and groups in the process of

health promotion during the reproduction of individual and collective life.

Furthermore, the systematization in three inseparable dimensions allowed us to emphasize that such concept is developed together with the paradigm of collective health, which is also in an ongoing process. There is therefore a need to move forward with the care network, valuing the services already developed. It is even possible that new theoretical and practical conceptions of care will be developed based on the own current development of RAPS and the health system, despite the barriers and setbacks to be overcome.

It was possible to present a comprehensive description of concepts regarding the construction of autonomy that have been supporting the analysis on Brazilian care services. It is considered that the concepts and their underlying theories represent a cohesive set that potentiates the development of actions and services in mental health and drug policies in the country.

Finally, it is evident that, for the autonomy construction strategy guideline to take place, there must be a larger investment in RAPS to combat the marginalization of users who abuse drugs. In addition to CAPS and health units, investment is needed in devices that favor the promotion of health with quality housing, employment, education, to oppose the impacts of a society that is getting sick.

### **Collaborations**

MER Martins worked on the design and final writing of the entire article; FB Assis and CC Bolsoni participated in the elaboration of the article design and the final review, with a fundamental theoretical-scientific contribution.

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