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HEALTH EDUCATION FOR THE QUALITY OF LIFE OF USERS OF PSYCHOACTIVE SUBSTANCES

EDUCAÇÃO EM SAÚDE PARA A QUALIDADE DE VIDA DE USUÁRIOS DE SUBSTÂNCIAS PSICOATIVAS

EDUCACIÓN EN SALUD PARA LA CALIDAD DE VIDA DE LOS USUARIOS DE SUSTANCIAS PSICOACTIVAS

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Objective: to compare the impacts of two health educational strategies on the quality of life of people with psychoactive substance use disorders. Method: descriptive, analytical and experimental study conducted with 40 users of a Psychosocial Care Center for Alcohol and Other Drugs. A questionnaire was applied to compare treatment adherence and the problems reported by users undergoing treatment, before and after the application of two educational strategies. The variables studied were treatment adherence and frequency of problems in the financial, social and health spheres. Results: in the group with dialogical interventions, there was a higher score on the participation and better gain in the economic, family and social aspects compared to the group with traditional strategy. There were no differences in health. Conclusion: the dialogical educational strategy proved to be more effective in solving some problems reported by users of psychoactive substances.

Descriptors: Health Education. Quality of Life. Mental Health. Psychoactive Substance Use Disorders. Nursing.

Objetivo: comparar os impactos de duas estratégias educativas em saúde na qualidade de vida de pessoas com transtornos por uso de substâncias psicoativas. Método: estudo descritivo, analítico e experimental realizado com 40 usuários de um Centro de Atenção Psicossocial Álcool e Outras Drogas. Foi aplicado um questionário para comparação da adesão ao tratamento e os problemas relatados pelos usuários em tratamento, antes e após a aplicação de duas estratégias educativas. As variáveis estudadas foram a adesão em relação ao tratamento e a frequência dos problemas nos âmbitos financeiro, social e de saúde. Resultados: no grupo com intervenções dialógicas, houve maior pontuação na adesão e melhor ganho no aspecto econômico, familiar e social em comparação ao grupo com estratégia tradicional. Não houve diferenças no âmbito da saúde. Conclusão: a estratégia educativa dialógica demonstrou ser mais efetiva na resolução de alguns problemas relatados por usuários de substâncias psicoativas.

Descritores: Educação em Saúde. Qualidade de Vida. Saúde Mental. Transtornos por Uso de Substâncias Psicoativas. Enfermagem.

Objetivo: comparar los impactos de dos estrategias educativas en la salud en la calidad de vida de las personas con trastornos del consumo de sustancias psicoactivas. Método: estudio descriptivo, analítico y experimental realizado con 40 usuarios de un Centro de Atención Psicosocial en Alcohol y Otras Drogas. Se aplicó un cuestionario para comparar el cumplimiento del tratamiento y los problemas reportados por los usuarios sometidos a tratamiento,

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antes y después de la aplicación de dos estrategias educativas. Las variables estudiadas fueron la adhesión al tratamiento y la frecuencia de los problemas en los ámbitos financiero, social y de salud. Resultados: en el grupo con intervenciones con diálogos, hubo una puntuación más alta en la participación y una mejor ganancia en los aspectos económicos, familiares y sociales en comparación con el grupo con la estrategia tradicional. No hubo diferencias en la salud. Conclusión: la estrategia educativa con diálogos demostró ser más eficaz en la resolución de algunos problemas reportados por los usuarios de sustancias psicoactivas.

Descriptores: Educación para la Salud. Calidad de Vida. Salud Mental. Trastornos Psicoactivos por Consumo de Sustancias. Enfermería.

Introduction

The measurement of quality of life (QoL) can only occur if people's reality can be perceived subjectively and multidimensionally, that is, biopsychosocially[1]. In relation to health, this measurement is characterized by the impression of each person, through self-reports, regarding the ability to perform functions and the development of skills before the pathological consequences installed[2].

The use of psychoactive substances causes disorders that affect negatively and directly and progress throughout life in a disorderly manner. Priority for consumption generates manipulative and illicit behaviors, despite the presence of financial, social and family problems[3-4]. In the destructive process settled, at some point, suffering for feeling alone with all the sequelae awakens the individual to change his/her life and, consequently, to search for solutions. Thus, the search for help from professionals[5] specialized in the treatment of chemical dependence becomes the only alternative for overcoming it.

Health education is one of the main therapeutic tools used in Psychosocial Care Centers. Moreover, for the user, it can generate opportunities, promote citizenship, democratization of the right of knowledge and empowerment of people and collectives, because it allows not only knowledge of the health and disease process[6], but can also favor the change of attitude and improvement of QoL. Educational actions are among the attributions and responsibilities of nurses, who must perform them in such a way that they consider the real social and collective needs. Thus, they can promote healthy lifestyles and become an agent of social transformation[7].

There are different ways of achieving health education. Among these, two models stood out for the purposes of this study: traditional, whose transmission of knowledge, because it is vertical-oriented, with little or almost no dialogue, and does not promote the participants' reflection; and the dialogical educational model, which proposes dialogue and reflection of the participants based on their reality, promoting the construction of knowledge horizontally. It is important to clarify that the educational model used interferes not only in the planning but also in the action to be performed and also in the strategy chosen for the application of the educational proposal[8-9].

In the case of users of psychoactive substances, it is important to verify whether the type of educational strategy used, through the application of low-cost actions and performed daily by health professionals, can improve treatment adherence and produce improvements in the QoL of those individuals. Thus, based on the models highlighted for this study, traditional and dialogic health educational strategies were established.

To clarify the research path and understand the problem under study, the following research question was formulated: What is the impact of two educational strategies on health on the quality of life of people with psychoactive substance use disorders?

The answer to this question may contribute to reflections and decision-making of mental health professionals, as well as in other spaces

where educational actions are applied in health, improving the QoL of people and their collectives.

The aim of this study is to compare the impacts of two health educational strategies on QoL of people with psychoactive substance use disorders.

Method

This is a descriptive, analytical and experimental study with a non-equivalent control group. To identify the results of each intervention in both groups, in the aspects related to health, financial and social, a pre-test was applied and individual and group interventions were performed, following the traditional model, in the control group – which was called Traditional Group (TG) – and guided by the dialogical model, in the experimental group – which received the name of Dialogical Group (DG).

This study is a cutoff of the dissertation entitled "Comparison of two Health Educational Strategies and their Relationships in the Actions of Self-Care of Users of Alcohol and Other Drugs". It was performed with users of a Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD), in a municipality in the state of Alagoas. Recruitment was performed by convenience, with people who were undergoing treatment, with the Nurse as responsible.

Inclusion criteria were: male person dependent on psychoactive substances with indication of daily treatment, three times a week, twice or punctually in the self-care group; registered with the institution. At the time of the interview, in the pre- and post-tests, they should be lucid, oriented in time and space, older, and agree to participate in the follow-up. This would occur through individual interventions and interviews over a period of three months. People who did not participate in any educational group, with impaired cognition at the time of the evaluation interview, female or expressed a desire not to be part of the study were excluded.

Thus, the sample consisted of 40 male participants, divided into control and experimental groups. There were no female participants, because they were not within the inclusion criteria in the period surveyed.

The allocation in each of the two groups was achieved after the application of the pre-test, based on an instrument to evaluate self-care Agency-ASA-SCALE (ASA-A).

In order to seek similarities between the groups – Control Group and Experimental Group –, the participants were allocated 1:1, based on the classification of self-care obtained in another study[10].

To assess the type of drug and the perception of the problems experienced by the participants in relation to health and social and financial aspects, a questionnaire constructed based on three instruments validated in Brazil was used[11]. The questionnaire was applied in the pre-test and at the end of the first, second and third month, by telephone or in person, at the participant's desire.

The participants were individually invited by the head researcher and, after signing the Informed Consent Form (ICF), the pre-test was applied. Subsequently, they were included in the two groups, for the beginning of group and individual interventions. The theoretical framework used for the execution of the groups – traditional and dialogical – was determined according to the differences between the traditional educational model, with a banking, vertical-oriented strategy, and the dialogical model, based on the collective construction of knowledge based on the participants' reality[9].

From October 2018 to March 2019, 14 interventions were applied to each group (TG and DG).

The variables studied were: participants' adherence and solving the problems experienced. In the latter, the frequency of self-reported problems in relation to financial, social and health aspects was observed. The records were tabled and stored in the Excel program, so that the qualitative data were presented as chart and frequency.

The participants' adherence was verified based on two angles: the first, according to the calculation elaborated by the formula "no. of exposures x no. of participants", in which those

exposed to the methodology of each intervention were identified, generating the total value analyzed; the second was recorded by the amount of exposure frequency. The criteria of this study were: frequency (F) below 4 exposures = low or insufficient adherence; frequency between 5 and 6 exposures = moderate adherence; and frequency greater than or equal to 7 exposures = good or excellent adherence.

This research was carried out after approval by the Research Ethics Committee (REC) at the State University of Health Sciences of Alagoas, under Opinion no. 2.768.354 and Certificate of Presentation of Ethical Appreciation (CAAE): 89195918.6.0000.5011, as recommended by Resolution no. 466 of December 12, 2012, of the National Health Council (NHC), which regulates the guidelines and standards of research involving human beings.

Results

The results of the research are presented in two sections that address the participants' adherence to the two groups – Traditional Group (TG) and Dialogical Group (DG) – and the resolution of the problems (financial, health and family reported) experienced.

Participants' adherence

The data indicated that there was greater adherence in the group with dialogical interventions (97 points) in relation to the group with traditional exposure (84 points), a difference of 13 points. Table 1 shows the frequency in these groups.

Table 1 – Participants' frequency in the traditional and dialogical groups. Arapiraca, Alagoas, Brazil – 2019. (N=40)

Frequency of exposure	Traditional Group (no. of participants)	Score Traditional Group (TG)	Dialogical Group (no. of participants)	Score Dialogical Group (DG)
1	3	3	2	2
2	3	6	3	6
3	5	15	2	6
4	2	8	4	16
5	1	5	2	10
6	1	6	-	-
7	2	14	1	7
8	-	-	5	40
9	3	27	-	-
10	-	-	1	10
Total	20/100	84/100	20/100	97/100

Source: Created by the authors.

Notes: 1 Frequency of exposure:
Low or insufficient adherence: frequency (F) below 4 exposures.
Moderate adherence: frequency (F) between 5 and 6 exposures;
Good or excellent adherence: frequency (F) greater than or equal to 7 exposures.
2 Conventional sign used:
- Numeric data equal to zero not resulting from rounding.

Regarding the frequency of participation, according to the methodological parameters of this research, in both groups (TG and DG), there was low participation. This can be observed in Table 1, in which 75% of the users in the TG and 55% in the DG had a low frequency of up to four exposures. Both groups obtained 10% of moderate adherence.

However, there was a better frequency, even if discrete, of the participants exposed to the dialogic strategy, classified as "good" in the DG (35%), compared to the TG (25%). The

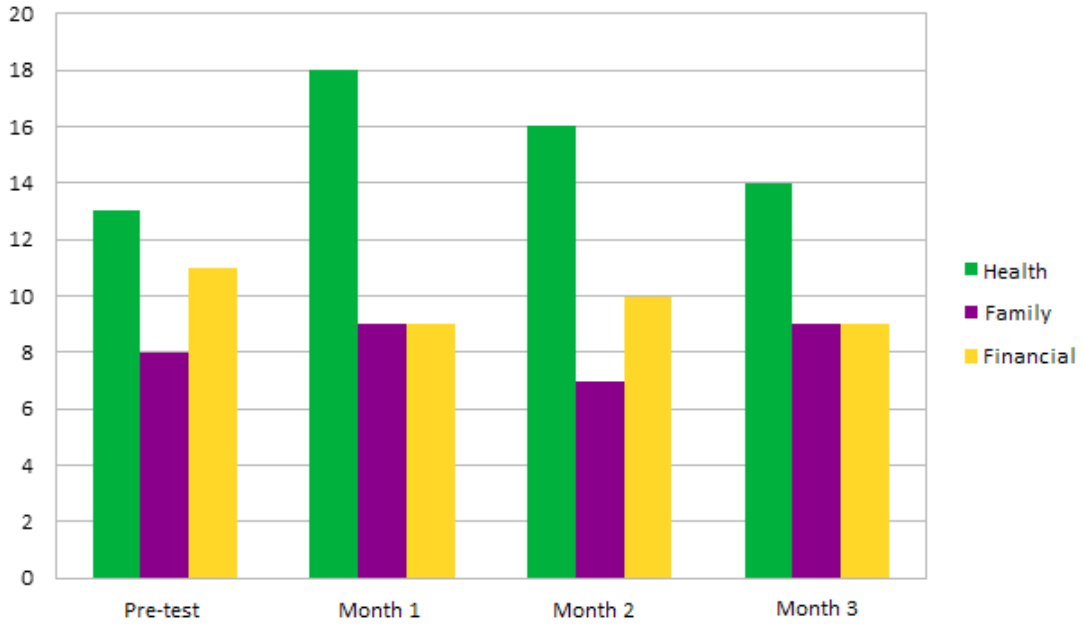
dialogical strategy favored greater involvement of users and greater frequency in relation to the group in which the traditional strategy was applied.

Despite the lower support, the TG participants showed interest in the themes brought by the facilitators, especially when they had a relationship with diseases that were associated with their history, that is, when those activities were able to approach their reality. Although this behavior occurred in a singular and sporadic way, the fact that they were in a group favored their greater opening before the orientations provided at the time of the intervention.

Resolution of the problems experienced

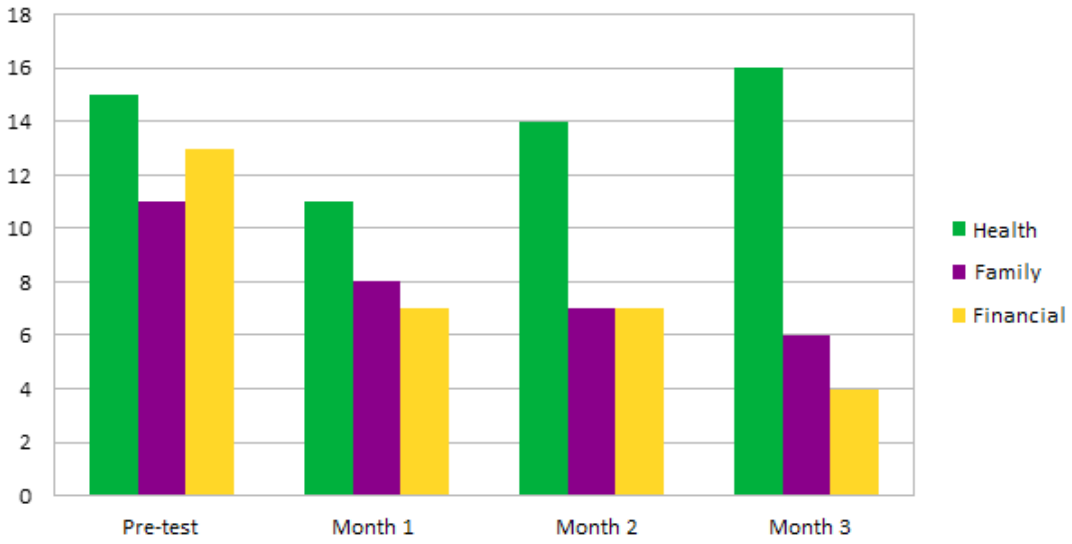
Despite the education activities, in both groups, there was no decrease in the frequency of problems and situations experienced in relation to health, while there were differences in relation to family problems and economic aspects between the TG and the DG, as expressed in Graphs 1 and 2, respectively.

Graph 1 – Types of financial, health and family problems reported and experienced by participants in the Traditional Group. Arapiraca, Alagoas, Brazil – 2019. (N=20)



Source: Created by the authors.

Graph 2 – Types of financial, health and family problems reported and experienced by participants in the Dialogical Group. Arapiraca, Alagoas, Brazil – 2019. (N=20)



Source: Created by the authors.

Concerning the aspects that involve the health context, there was an increase of 1 point in relation to the pre-test in both groups. That is, there was no improvement in the aspects that involved the participants' health, regardless of educational interventions.

Also in relation to health, during the follow-up, the types of complications identified and reported by the participants are described in Chart 1.

Chart 1 – Health complications reported by participants in the Traditional Group and the Dialogical Group. Arapiraca, Alagoas, Brazil – 2019. (N=40)

Types of Complications	Traditional Group (TG)	Dialogical Group (DG)
Psychiatric	Nervousness, anxiety, sadness, depression, insomnia	Aggressiveness, nervousness, anxiety, depression, suicide attempt
Neurological	Hallucinations, seizure disorders	Hallucinations, seizure disorders
Cardiovascular	Diabetes, hypertension, edema, chest pain, hypotension	Edema
Gastrointestinal	Gastritis	Diarrhea, vomiting, heartburn, anemia
Trauma	Fracture, surgery	Fracture, sharp wound
Parasitic infections	Leprosy, schistosomiasis	-
Skeletal	Backache	Backache
Other complications	Tremors, lack of appetite, physical weakness, weakness, headache	Tremors, pain, dysuria, fever, weakness, weakness, rash, asthma

Source: Created by the authors.

During the application of the dialogical strategy, participants showed greater interest in discussing psychiatric diseases, with emphasis on depression and suicide, which allowed identifying people with depressive state and high risk.

In the TG, there was greater involvement in relation to chronic diseases to the detriment of psychic issues. Thus, the dialogical strategy favored the subjective communication of feelings and thoughts in relation to the traditional strategy.

The family relationship and economic aspects were also mentioned as permanent problems and difficulties by some participants of the DG. As for family life, there was no significant difference over time (increase of 1 point). Regarding the financial, there was a reduction of 3 points in relation to the pre-test. Among the participants of the DG, there was an improvement in family ties (reduction of 5 points) and in the financial scope (reduction of 9 points) during the period surveyed.

Regarding the family relationship, the data obtained showed that the relationships remained impaired, although the treatment began with reduced consumption, the presence of feelings of repentance, besides presenting results in relation to the beginning of the change process.

Discussion

The best, although discrete, adherence of the participants exposed to the dialogical strategy, applied in the DG, is accepted, because it allows greater approximation of the professional with the reports of life histories. This possibly results from the process of identifying the own participant with the discussions constructed, planned and elaborated based on individual contexts, for the development of his/her autonomy.

Studies have pointed out the bond as a tool that contributes to the establishment of trust between professionals and assisted users due to problems from the use of psychoactive substances. This is a noninvasive resource that enables the provision of care and commitment of professionals, resulting in healthy social relationships free of prejudice[12].

However, the possibility of other factors also interfering needs to be investigated and studied in order to improve the degree of user involvement with their treatment. Thus, assisting this population becomes a daily challenge, because the relationships established by the person who makes harmful use of the substance present specific and complex singularities; are bonds constructed between the individual and the drug, for the relief of uncomfortable symptoms of physical and psychic human suffering[13].

On the other hand, the educational strategy focused on the traditional biomedical model, in which the prescription of drugs guides the treatment, results in a teamwork that is not motivated, despite the actions and behaviors of the multidisciplinary team. Therefore, frustrations arise in professionals, because they cannot visualize the concrete effects of their efforts and actions, whether individual, group or team[14].

Positioning those who are sick as the only ones responsible for the success of treatment is an attitude that negatively affects the case of patients with chronic diseases, becoming a challenge for professionals[15]. The applied educational strategy may reflect on the difficulty of adherence to therapeutic proposals and new lifestyles, as evidenced in the best result of the DG in relation to the TG, in the financial, social and family spheres.

One of the causes pointed to the lower adherence of the participants in the TG was the fact that the traditional strategy may have a lower effectiveness, when it comes to facilitating the formation of bonds between users and between users and professionals in health spaces. This is a very peculiar factor in treatment adherence, since individuals have histories of conflicting and fragile family ties. Researchers argue that the construction of bonds and the understanding of the relationship between users and drugs are fundamental aspects for treatment adherence[16]. The situations faced and self-reported in this study were also found in other studies, which identified, in the participants' reports, some problems in the financial, social and health spheres, with greater reflection on nutritional issues[17].

The consequences of drug use, regardless of whether being acute or chronic, affect the lives of individuals and their families, in addition to the whole society. This occurs in the short, medium and long term, since they cause damage in various life spheres, such as automobile accidents, expenses with hospitalizations, chronic diseases, sexual infections, social and family life, as well

as work activities. These aspects directly affect the QoL of those people.

The fact that these individuals and their families seek the reduction/interruption of drug use does not exclude the expectation and the opportunity to recover physical, mental and social health, through individual or collective educational actions. People seek assistance due to the serious sequelae caused to the body by intoxication, abstinence or consumption, as well as by the social and family situations constructed, marked by stories of abandonment, conflicts and stigmatization in a singular way[18].

In this study, it was assumed that the non-reduction of health problems was motivated by the fact that the diseases indicated in Chart 1 were associated with prolonged drug use and thus chronic, such as gastritis and hypertension. In addition, another observed fact were psychiatric, neurological and acute diseases – such as hallucinations, convulsive disorders, depression (Chart 1). These require a longer time of treatment and better social, family, psychological and financial support. This support, however, is a difficult aspect to be conquered by the participants of this study in such a short time (3 months), despite attempts to change habits and postures.

This explanation was also reported by people undergoing treatment in a municipality of Ceará, who recognized the association of some of these biopsychosocial problems resulting from drug use, considered by them as something very uncomfortable[19]. The search for treatment and educational actions favored the discovery and diagnosis of some diseases, such as leprosy, gastritis, hypertension, diabetes, which, due to characteristics, cannot be stabilized or cured in the short term.

Direct irritating changes and during the metabolism of alcohol in the body have already been proven. When there is an association with other types of drugs, the probability of the onset and worsening of installed diseases of various types increases, such as cardiopulmonary, gastrointestinal, hepatic, neurological, psychiatric, hypotension and even death[20]. Moreover, there is also the deterioration of the bonds caused by situations resulting from chemical dependence[21].

In relation to the psychic problems most mentioned in the DG (Chart 1), other studies have also verified that users undergoing treatment have problems such as moderate to severe depression, anxiety and stress[22-23].

In the health field, concerning the non-improvement in the complaints reported by these individuals, it is understood, since they experience difficulties in various aspects of their lives. These can have psychosocial, family, economic and cultural nature, and influence their perceptions and contexts in relation to their quality of life.

In this sense, in this study, the participants recognized that the problems resulted from uncontrolled drug use, and negatively affected their quality of life and that of their families. A study evaluates that the situations experienced by family members, especially in the emotional sphere, cause irreparable damage[24]. Therefore, it is difficult to overcome the traumas caused. On the other hand, the family is a fundamental part, so that the balance and the resumption of these people occur to cope with the disease.

Contrary results were found in another study[25], when a questionnaire was applied about the participants' perceived QoL. These presented positive perceptions: 57% of the interviewees rated it as good and 39% believed that their QoL was similar to that of other people, not being associated with the disease. However, these participants reported good social, economic and family conditions, which did not occur with the participants of this research. The identification of this disagreement is accepted because, at the time of the interview, the participants reported good health conditions and satisfactory family relationships, in addition to 72% of the sample being employed, which may have definitely affected the research results[25].

In view of the above, it is evident that professionals who work in care should promote reflections to rescue the self-esteem, autonomy and social reintegration of these people. They are conflicting life stories and losses in the

various areas, whose treatment can become the only resource[14] to promote better QoL and encourage the search for a new trajectory, to start a new story.

Although there is agreement regarding the importance of professional actions for the success of treatment, one of the limitations of this study was the lack of previous research, which related the impact of health education in the various areas of the lives of these people undergoing treatment for harmful use of psychoactive substances, with a quantitative approach. Another limitation was the performance of this research in only one health unit and the use of a convenience sampling.

Conclusion

The dialogical educational strategy, developed in groups and individually, when compared to the traditional educational strategy, proved to be more effective to improve the participant's treatment adherence, family relationships, as well as to identify emotional and psychic states. This was due to the fact that this strategy allows greater approximation between the professional and the individuals under treatment and allows dialogue with the context of life, which interfere in decision making, the desire for change and the change of habits, directly influencing QoL.

However, more studies should be conducted involving the impacts of professional actions in the contexts of the individuals assisted, and that can be applied in different realities for a longer time, so that the problems experienced by users seeking treatment are reduced through professional care based on scientific evidence.

Collaborations:

1 – conception, design, analysis and interpretation of data: Cláudia Cristina Rolim da Silva and Célio Fernando de Sousa Rodrigues;

2 – writing of the article and relevant critical review of the intellectual content: Cláudia Cristina Rolim da Silva and Célio Fernando de Sousa Rodrigues;

3 – final approval of the version to be published: Cláudia Cristina Rolim da Silva and Célio Fernando de Sousa Rodrigues.

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