REFACS

Original Article
Rev. Fam., Ciclos Vida Saúde Contexto Soc.
http://seer.uftm.edu.br/revistaeletronica/index.php/refacs/index
ISSN: 2318-8413 DOI*:* 10.18554/refacs.v11i3.7255

Risk and protective factors arising from the use of crack cocaine in the capital city of Brazil

Fatores de risco e proteção decorrentes do uso de crack na capital do Brasil

Factores de riesgo y protección derivados del consumo de crack en la capital de Brasil

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Received: 17/11/2023 **Accepted:** 21/12/2023 **Published:** 16/02/2024

Objective: to identify risk and protective factors in crack cocaine users at a Psychosocial Care Center for Alcohol and Other Drugs III. **Methods:** qualitative, descriptive and exploratory research using semi-structured interviews with crack users of both sexes and over 18 years of age in the Brazilian Federal District. Discourse analysis and categorization were used. **Results:** five categories emerged: *Physical and psychological effects*; *The context of crack cocaine use: form of use and places of purchase*; *The use of condoms*; *Violence situations associated with the context of crack cocaine use*; *Social network: family and friends*; *CAPS as a care device*. The data highlighted the risk factors in situations of social vulnerability, compromised physical, mental and sexual health, the quality of the substance and the lifestyle, in which individual behavior suffers insurgencies from the social group and the violence that permeates the use of crack. Family and friends were considered protective factors in paradoxical and fragile relationships due to trust. The Psychosocial Care Center stood out in terms of differentiated treatment as a protective factor from the perspective of the expanded clinic. **Conclusion:** knowledge of risk and protective factors allows the proposition of preventive strategies, guided by life trajectories and psychosocial context aligned with the proposal of harm reduction and comprehensive health care, in an intersectoral and multidisciplinary way.
Descriptors: Crack cocaine; Protective factors; Risk factors; Public health; Mental health.

Objetivo: identificar os fatores de risco e proteção em usuários de crack de um Centro de Atenção Psicossocial de Álcool e Outras Drogas III. **Método**: pesquisa qualitativa, descritiva e exploratória com aplicação de entrevista semiestruturada com usuários de crack, de ambos os gêneros e idade superior a 18 anos no Distrito Federal. Utilizou-se análise discurso e categorização. **Resultados**: emergiram cinco categorias: *Efeitos físicos e psicológicos; O contexto do uso de crack: forma de uso e locais de compra; O uso de preservativo; As situações de violência associadas ao contexto de uso de crack; Rede social: família e amigos; O CAPS como dispositivo de cuidado.* Os dados evidenciaram os fatores de risco nas situações de vulnerabilidade social, comprometimento da saúde física, mental e sexual, na qualidade da substância e no estilo de vida, no qual o comportamento individual sofre insurgências do grupo social e da violência que permeia o uso de crack. A família e amigos foram considerados fatores de proteção nas relações paradoxais e frágeis em função da confiança. O Centro de Atenção Psicossocial foi destaque no tratamento diferenciado como fator de proteção na perspectiva da clínica ampliada. **Conclusão**: o conhecimento dos fatores de risco e proteção permite a proposição de estratégias preventivas, orientadas pelas trajetórias de vidas e contexto psicossocial alinhadas com a proposta de redução de danos e da atenção integral em saúde, de forma intersetorial e multidisciplinar.
Descritores: Cocaína crack; Fatores de proteção; Fatores de risco; Saúde pública; Saúde mental.

Objetivo: identificar factores de riesgo y protección en usuarios de crack en un Centro de Atención Psicosocial de Alcohol y Otras Drogas III. **Método:** investigación cualitativa, descriptiva y exploratoria con entrevistas semiestructuradas a usuarios de crack de ambos sexos, mayores de 18 años, en el Distrito Federal. Se utilizó análisis del discurso y categorización. **Resultados:** surgieron cinco categorías: *Efectos físicos y psicológicos; El contexto de consumo de crack: forma de consumo y lugares de compra; Uso del preservativo; Situaciones de violencia asociadas al contexto de consumo de crack; Red social: familia y amigos; CAPS como dispositivo de cuidado.* Los datos mostraron factores de riesgo en situaciones de vulnerabilidad social, salud física, mental y sexual comprometidas, la calidad de la sustancia y el estilo de vida, en los que el comportamiento individual está influido por el grupo social y la violencia que impregna el consumo de crack. La familia y los amigos fueron considerados factores de protección en relaciones paradójicas y frágiles debido a la confianza. El Centro de Atención Psicosocial fue destacado por su tratamiento diferenciado como factor protector desde la perspectiva de la clínica ampliada. **Conclusión:** El conocimiento de los factores de riesgo y protección permite proponer estrategias preventivas, orientadas por las trayectorias de vida y el contexto psicosocial, en consonancia con la propuesta de reducción de daños y atención integral en salud, de forma intersectorial y multidisciplinaria.
Descriptores: Cocaína crack; Factores protectores; Factores de riesgo; Salud pública; Salud mental.

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INTRODUCTION

The abusive use of crack cocaine is both a social and public health issue, and it presents a complexity of several risk and protective factors that occur in different social components: family, peers, school, community and media, in varied situations, and with the capacity of influencing the lifestyle of multiple drug users[1].

A systematic review study on the action of public authorities in the Cracolândia area, in the city of São Paulo, Brazil, highlighted the co-existence of repressive and supressive practices aimed at eliminating the consumption and production of drugs, accompanied by care practices in addressing harm reduction, which is an ethical guiding paradigm for care with an emphasis on reducing harmful use and the importance of integrated social policies to tackle the problem. These approaches are generally reproduced throughout Brazil and also in other countries[2]. The possibility of controlling and reducing damage through the articulation of programmed and guided strategies aimed at improving physical, psychological and social conditions of drug users strengthens decision-making by health professionals in mental health services[3,4].

From a biopsychosocial perspective, the improvement of the study on these factors in the context of the use of psychotropic substances, and crack cocaine specifically, makes it possible to support decision-making in therapeutic planning, in the management of work organization in multidisciplinary health teams and in the improvement the formulation of public policies in the field of mental health[5].

In this scenario, the Brazilian Ministry of Health, with Ordinance No. 3,088 of 2011, strengthened psychiatric reform with the structuring of the Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS), with an emphasis on Psychosocial Care Centers (*Centros de Atenção Psicossocial* - CAPS), which now have more than 2,462 units throughout Brazil[6]. In the Brazilian Federal District, 18 CAPS operate with different modalities that serve children and adults with specific needs, such as mental disorders and/or dependence on alcohol and other drugs[7].

Harm reduction as a preventive intervention requires a comprehensive view of the complexity of risk and protective factors, seeking to minimize social and health impacts as a counterbalance to the consumption of psychoactive substances, mainly crack. However, prejudice and stigma related to drug users make it difficult to institutionalize harm reduction strategies in health services and in the implementation of public policies[8].

The adoption of new care policies for drug users by the Brazilian Ministry of Health, starting in 2017, with financial emphasis directed to hospital beds and therapeutic communities, puts advances in psychiatric reform at risk. Therefore, it is necessary to go

forward with the formulation of policies and strategies to reduce harm related to behaviors and practices considered as potentially harmful factors to the individual that allow expanding possibilities with small and significant healthy changes, without determining sudden changes in the personal choices of crack users[9].

The first seizure of crack in the Brazilian Federal District happened in 2006, making it a challenge for local public health to reproduce the notoriety of good therapeutic practices carried out in Brazil and around the world[10]. Considering that crack addiction is chronic and serious, treatment approaches must seek support from trained community-based teams with open doors to achieve the individual's recovery potential[11].

There is little research that highlights the use of crack cocaine in the Brazilian Federal District, the need to understand the risk factors and protective factors resulting from crack consumption allows us to strengthen care practices aimed at comprehensive health care. Therefore, this study aims to identify risk and protective factors in crack cocaine users at a Psychosocial Care Center for Alcohol and Other Drugs III.

METHODS

Qualitative descriptive exploratory study that involved a dynamic and complex social context, in order to broaden the understanding of diversity in everyday life, cultural multiplicity, dynamism and contradictions that crack users are part of. The theoretical method provides the perception of the qualitative approach that is elucidated through the challenges experienced every day by crack users, and it is understood that they do not fit only in numbers of the positivist approach, since social reality goes beyond the Cartesian planes, since their interfaces require the use of methods that reach subjectivity[3].

In this research, a crack user in treatment was defined as someone who is in a therapeutic environment, that is, in treatment in individual or group sessions, as well as those who live together in the service for therapeutic purposes[12,13]. Data collection was carried out with crack users, from 9/26/2019 to 10/6/2019, at the Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD III) Candango in the Brazilian Federal District, which operates 24 hours a day. The sample selection was intentional, supported by key informants and health professionals who facilitated contact with crack users. The collection instrument applied was a semi-structured interview, individually in consultation rooms, recorded and transcribed with the Listen N Write software version 1.17.02, which allowed the recording speed to be reduced. The duration of each interview varied from 15 minutes to 1 hour and 20 minutes.

The inclusion criteria for participants were being over 18 years old, without distinction of sex or gender, history of a pattern of continuous crack use for at least one year before the interview, whether or not in association with multiple drugs. As an exclusion criterion, users with altered states of consciousness, without the objective ability to understand and articulate responses at the time of the approach. Sampling was done until data saturation was reached.

To characterize the profile, sociodemographic data (sex, gender identity, age, marital status and educational level) and socioeconomic data (purchasing power of the studied population) were collected. Risk and protection factors were identified based on physical, psychological and social parameters, considered from the user's perspective.

Data analysis was carried out by tabulating the data in the Microsoft Excel 2016 spreadsheet editor, in which the set of each question and their respective answers developed reports evaluated and interpreted collectively. Each interview was identified with an alphanumeric code, in sequential order of interview and gender. For qualitative data, structured content analysis was used according to Bardin[14] parameters. Also, qualitative data about risk and protection factors were structured by thematic categories that emerged from the complexity of risk and protection factors structured in the care of users who use crack.

The participants' gave their consent by signing the Free and Informed Consent Form (FICF) and the Authorization For for Use of Image and Sound, following the guidelines of the Brazilian Ministry of Health with Resolution 466/2012. This study deals with an excerpt from the project: "*Reorganization of and in work processes in the Psychosocial Care Network mediated by participatory evaluation*", with the approval of the Ethics and Research Committees (CEP) of the Faculty of Health Sciences, Universidade de Brasília (UnB); Opinion No. 2,200,022, and that of the Health Sciences Teaching and Research Foundation (FEPECS); Opinion No. 2,270,086. This project was developed by the Observatory of Mental Health Care Policies of the Federal District (OBSAM), with financial support from the Brazilian Ministry of Health.

RESULTS

Characterization of participants' profiles

According to the profile of the 24 participants, the majority declared their gender identity as male (No=21). Ages ranged from 25 to 63 years (with a mean age of approximately 39 years). The educational level of most participants was low, with incomplete and complete primary education (No=13). Most of the interviewees were unemployed or had some type of informal employment (No=19). And the majority described a situation of socioeconomic

vulnerability, with no income or an income equivalent to minimum wage (No=15), according to data in Table 1.

Table 1. Crack cocaine users from a CAPS AD III in relation to sociodemographic and socioeconomic variables, Brazilian Federal District, 2019*.

Variables		No	%
		24	100.0
Sex	Male	21	87.5
	Female	3	12.5
Gender identity	Man	20	83.3
	Woman	3	12.5
	Travesti	1	4.2
Age group	18 to 29 years	2	8.3
	30 to 44 years	17	70.8
	45 to 59 years	4	16.7
	60 years or more	1	4.2
Marital status	Single	20	83.3
	Married/Civil union	3	12.5
	Divorced/Separated	1	4.2
Educational level	Incomplete Primary Education	8	33.3
	Complete Primary Education	5	20.8
	Incomplete Secondary Education	2	8.3
	Complete Secondary Education	7	29.2
	Incomplete Higher Education	1	4.2
	Complete Higher Education	1	4.2
Occupation	Unemployed	10	41.6
	Formal employment	4	16.7
	Informal employment	9	37.5
	Retired	1	4.2
Individual income	No income	8	33.3
	Up to ¼ minimum wage	3	12.5
	More than ¼ up to ½ minimum wage	1	4.2
	More than ½ up to 1 minimum wage	3	12.5
	More than 1 up to 2 minimum wage	6	25.0
	More than 2 minimum wage	3	12.5

* Authors' elaboration

Characterization of risk and user protection factors associated with crack use

The results were grouped under the simple category of analysis: risk and protective factors resulting from the use of crack, with six subcategories emerging: *Physical and psychological effects*; *The context of crack cocaine use: form of use and places of purchase*; *The use of condoms*; *Violence situations associated with the context of crack cocaine use*; *Social network: family and friends*; *CAPS as a care device.*

Physical and psychological effects

Users significantly and easily mentioned the physical and psychological changes they developed as a result of crack use, mainly in the respiratory, gastrointestinal and sexual/reproductive systems, as well as cognitive and sensory changes. They recognize these changes as being risk factors, with negative consequences for their own health.

The physical changes users reported the most in their sleep patterns. Most of them reported that they had gone without sleep for more than a week; in addition to shortness of breath, wheezing and lung injuries such as Chronic Obstructive Pulmonary Disease (COPD) and asthma. The gastrointestinal changes mentioned by all interviewees were vomiting, changes in the hunger pattern, and lack of appetite. Furthermore, some users reported that after using crack, they experienced sexual impotence:

[...] *Breathing while using it is fine, as they say... You can breathi normally. It's cool! But when you stop, you see that you are very tired. Breathing is very weak, very weak, very weak. I felt chest pain and coughing. It was even difficult for me to climb a ladder, it felt like I was clearing my throat. Then I discovered I had pulmonary emphysema* [...]. (E22M)

[...] *A lot of nausea. When I used too much crack, I felt like vomiting. I wasn't sleepy. It was like this, while I had crack I didn't sleep* [...] *I felt little hunger, I hardly slept. I ate garbage, I ate leftover food, anything satisfied me at that moment, I smoked while I ate.* (E11M).

The main psychological changes mentioned as effects caused after immediate use were auditory and visual hallucinations; change in behavior to an aggressive pattern, occurring in a reactive and hostile manner towards family, friends and other drug users, predisposing to situations of violence; loss of consciousness; depression; and suicidal ideation:

[...] *I was very hostile, very aggressive, agitated, I fought in the street* [...] *I heard people saying things like that, I really wanted to commit suicide* [...] *I didn't sleep at night, in the dark I saw like diabolical things, faces of entities that were not normal, that spoke to me, that were horrible, I lost consciousness. I had depression and was almost suicidal. I just didn't commit suicide then, because someone came at the time and took away the substance I was using.* (E4M)

The context of crack cocaine use: form of use and places of purchase

The individual use of crack was considered safer by the majority, due to the psychological instability at the time of consumption, the non-solidarity distribution of the drug and the enmities between consumption partners, resulting in some risks (fights, attacks and death). Collective use was considered a protective factor by few users in the case of overdose and in reducing phobia by reassuring the partner affected by visual and auditory changes:

[...] *I prefer to do it alone, because in a group there is always malice, you never know who you are using with. You just want to know how to use it. You don't know if the person is good, if the person is bad, what their past is. You don't know if they have enemies. An enemy can arrive and harm you and it ends up being your responsibility. Then alone, I think it's safer. And it's also not safe, because you could overdose and have no one to help you* [...]. (E14M)

Mostly, the collective use of crack is the most prone to risk factors due to difficulties in inter-user relationships in obtaining and sharing drugs, psychoanaleptic changes leading to

confusion, arguments and situations of violence related to exacerbated consumption and resulting from hallucinations or paranoia:

[...] *In groups, they already tried to kill me while I was using, in a circle of crazy people. They set up a little house for me, I had to run out and the guy had a knife to kill me... The guy had used crack... When he was hallucinating, he got distraught and mistook me for someone else, I don't know what got into his head, if he thought I picked up more crack. I had to break into a bakery and he still had the knife* [...]. (E4M)

Open spaces were reported by most interviewees to convey a feeling of risk, as exposure in a public area allows for better visibility of the police, users and the community who can act as possible whistleblowers. This exhibition highlights the relationship between illegality and stigma and prejudice. Abandoned and uninhabited open spaces where drugs are sold for money or sex were also highlighted, increasing possible vulnerabilities to Sexually Transmitted Infections (STIs), sexual and urban violence:

[...] *If I were to smoke on the street or in an abandoned open place I would be very scared, but I've already exchanged crack for sex in that place and I've seen people being forced to do it too... I was scared, I kept looking everywhere, paid atthention to who I was arriving, if the police were arriving, afraid of someone reporting it and ashamed of someone I knew seeing me, I was very scared of the police* [...]. (E10M)

Closed places were mostly perceived as a protective factor against risks related to violence such as aggression and injuries and even the illegality that permeates the drug. However, some crack users said they felt a sense of imprisonment and persecution that someone might find them:

[...] *In hotels, in closed places I feel safer to use and protect myself from the police and other enemies, but when I'm in the room it gives me a headache, it's the effect of the drug, sometimes I feel watched by someone, in the keyhole, in any crack there is, or someone is going to break in, or that I'm trapped* [...]. (E20M)

The use of condoms

The use of condoms was mentioned as an important protective factor for the prevention of STIs and highlighted as an effective method to avoid unplanned pregnancies. The majority of participants reported using condoms during sexual intercourse and that condoms were easily accessible. However, condom use occurs discontinuously, with the justification of not using it due to forgetfulness and/or having a steady partner. Other participants reported having already contracted or had an STI such as the Human Immunodeficiency Virus (HIV), syphilis and gonorrhea:

[...] *I think it's important to use a condom, at the time and depending on the company! The way things are. You can't expose yourself when being with a woman you don't know and having sex with her without a condom. Firstly, you are avoiding a disease, secondly, you are avoiding bringing a child into the world that you cannot take care of* [...]. (E6M)

Violence situations associated with the context of crack cocaine use

Violence was considered a risk factor in four dimensions: the first was sexual violence with abuse and rape against female crack users, in which the perpetrator of the violent act is usually someone close to the victim; the second was the violence caused when distribution of the drug, as the competition between users leads to dissimulation during the partition of the crack rock, culminating in fights, attacks, and even death; the third, violence due to debt to illegal drug trade, commonly mentioned in the drug dealer x user relationship; and fourth, violence motivated by increased consumption of crack, in which users use violence as a form of coercion to obtain money or drugs:

[...] *There was me and another guy wanting to use it and we bought half of it exactly, each one gave half the money to buy an exact piece. When he went to get it when it was time to divide it, he had already divided it, taking out a piece for himself. But along the way, he had hidden a piece and when we were using it, he waited for me to leave so he could use that piece and I saw it, and I called him a crook and everything. He also confronted me head on and said I wasn't a man and started a fight and everything. Then, he grabbed me and stabbed me in the head* [...] *I almost died because of a rock.* (E11M)

Social network: family and friends

The family is seen by most individuals as having an important role in the protection and recovery of crack users, as it communicates and provides guidance with the aim of preventing new episodes of use. The search for care is constant in family emotional ties, but the distrust and insecurity experienced by users' families are weakened by crime, often resulting in social exclusion. It takes time for users to understand that their family is by their side to help with their treatment. At the same time, it also takes time for the family to realize the extent of drug addiction as a disease:

[...] *Now with my family it's great because everyone is helping me so I don't go down. In the past I didn't have a family, for me family was nothing, for me family was drugs, even if they were with me. Now I have a family because I see that they are making an effort to see me free from this. And I didn't see that before* [...]. (E3M)

Friends are also social actors who strengthen the crack user's recovery and assist in initiatives related to work, study, culture and social insertion. However, friends involved with drugs are risk factors for crack use relapse:

[...] *The friends I'm avoiding... Now, the friends, as you say, who want what is best for me and help me to free myself from this, I'm going to separate them. Also build new friends, new walks. I want to study, I want to live, I want to go forward, I want to learn how to study, I want to get a formal job. A job that I haven't had in the 40 years of my life. I want a decent work. May someone accept me in society as a person* [...]. (E3M)

CAPS as a care device

CAPS was seen as a protective factor in most reports, as the search for help with a view to changing and recovering health is strengthened by this reference center, in addition to social well-being with improvements in family and employment relationships. Some motivating factors for treatment were addressed by crack users, such as not living in situations of violence related to drug use and the engagement of friends and family who attend CAPS strengthens treatment:

[...] *I tried to stop... That's when I lost part of my finger. When I decided to stop, seek help even because I was shot, I was stabbed, I went through several deadly situations and I never appreciated it. It was when I looked for a nursing home that I met a nurse there. She picked me up and took me to a place that was CAPS. There she talked to a girl and she invited me to talk... When I sat in the circle, the first thing the guy said was how he managed to quit dring alcohol and how he used to harm his wife. I remember that, when I was with my daughter's mother, I beat her a lot because of the drugs. So, he started saying that, I remembered that. So, I tasked the nurse to ask if she wouldn't let me get treated there. She said I could. That's when I discovered CAPS. And soon I started to improve. I wanted to work.* (E11M)

DISCUSSION

The crack user profile in this study presents high social vulnerability and corroborates other findings from the states of São Paulo and Rio Grande do Sul, Brazil, which warn that crack may have a greater insertion in populations with greater social vulnerability[15,16]. Another factor associated with the greater use of crack in cocaine this context can be explained by the discrepancy in costs, since crack cocaine form is cheaper than powdered cocaine, as although both have the same active ingredient from the Erythroxylum coca plant, crack cocaine is generally mixed with numerous substances enhancing the effect of the drug[17,18].

This factor adds greater risk to maintaining the integrity of physical and mental health. It is understood that the physical changes resulting from the use of crack demonstrate the degree of aggression to the individual's health, as well as its direct relationship with other pre-existing diseases[19,20]. In this context, preventive measures must be taken, focused mainly on greater availability of information about the drug as well as the losses associated with its use, since even in the short term, it can compromise the user's life[15]. It is recommended, based on this work, that such measures are primarily based on the subjects' protective factors, with an emphasis on their life experiences.

Respiratory impairment related to crack use, identified in an investigation in the state of Goiás, pointed to lung involvement causing serious consequences with Chronic Obstructive Pulmonary Disease (COPD)[8]. The precarious hygiene conditions, as well as the chemical effects of crack, allow gastrointestinal fluctuations with diarrhea, vomiting and flatulence, also seen with the occurrence of a series of lesions in the intestinal wall, even causing intestinal ulcers[20]. Furthermore, inappetence was perceived as an occasional factor in low immunity, leading to susceptibility to opportunistic pathologies due to not having a minimally adequate diet[21].

The psychic effects caused on cognitive and sensory abilities were also characterized by delusions, hallucinations, feelings of persecution associated with depression and regret after crack consumption, in addition to neurological changes that impair attention, concentration and memory[22]. In some situations, depending on genetic predisposition, crack users can develop mental disorders such as schizophrenia and bipolar disorder[23].

Crack is a drug that triggers unrestrained consumption, intense cravings and other damages to the social aspects of users[8]. With this in mind, it is necessary to expand and implement existing public policies, with the aim of strengthening integrated and intersectoral intervention processes that address actions related to health promotion, disease prevention and information about the risks caused by the use of crack[19].

In collective drug use, it is common to establish psychological and social relationships with the exchange of feelings, experiences and the perception of affinities represented in crack culture, which is a space to minimize concerns and disappointments[24]. Individual use achieves a standard of self-control and reduces compulsiveness, as the individual is not encouraged to consume by other users[25].

It is also observed that, in the media, crack consumption is generally concentrated in the streets or central squares of large cities. However this is demystified when realizing that there is a major preference for closed spaces is identified in this research, determining the presence of crack users in other scenarios[26]. It is understood that the social location is diverse and influenced by self-control mechanisms, moving away from the place of consumption is a protective strategy to reduce new episodes of crack use, which also contributes to strengthening the therapeutic activities applied by specialized centers[27,28].

The exchange of sex for crack is worrying because it increases the risk of contracting an STI in unprotected relationships. Crack users generally delay seeking care at Basic Health Units (*Unidade Básica de Saúde* - UBS) and do not continue taking medication to prevent and control STIs, which considerably increases the transmission of these diseases among crack users[29].

Furthermore, cocaine circulating in the bloodstream allows for an increase in the viral replication phase of HIV[30].

The use of condoms is inconsistent, being a protective method with low effectiveness in the social context of crack users. It is noteworthy that there is still little knowledge available to users, little directive guidance from health professionals and the difficulty in improving public health policies in the search for contraception strategies and STI prevention[31]. Non-use of condoms among crack users showed high proportions in a multidisciplinary study in Brazil with approximately 65% for vaginal sex and 79% and 62%, respectively, for oral and anal sex[32].

The systemic violence involved in the crack trade is motivated by conflicts related to the illicit drug market and contributes to police repressions marked by prejudice. The unequal treatment given to homeless people and drug users is often seen as having a hygienic nature, increasing social stigmas[33]. In this context, female crack users are more vulnerable as they suffer frequent rapes in interactions involving drug use in which the male user is the main aggressor. This also reflects that historically male domination has been present in different scenarios, including trafficking and the organization of group use[34].

It is worth mentioning that disputes in the division of drugs and the violence associated with increasing consumption performance are generally determined by multivariate causes such as the intensity of crack consumption, the effects of abstinence, financial difficulties, in addition to little consensual psychological stability in the division of crack rocks[35]. It is also clarified that harm reduction actions are more effective when absorbed by therapeutic activities experienced in the daily lives of users and with the coordination of different social actors[36].

In relation to trafficking, crack users identify the illegality of the drug and the fact that they are afraid of the drug dealer as a risk factor. This follows the imposing rules, creating supposedly easy protection strategies for attitude and behavior. In view of this, the police approach is coercive, seeking to reveal information to reach drug traffickers. This dichotomy is presented in the speeches and, although it reveals a close interface, it does not demonstrate resoluteness, since the legislation is incipient from the perspective of harm reduction and does not occur in an intersectoral manner[37].

In this research, users can have their family and friends as a point of support and guidance to discuss their joys, anxieties and desires, which strengthens their recovery, but at the same time these social actors can weaken users due to distrust, causing insecurity in academic, professional and romantic relationships. Thus, it is considered that family problems or emotional losses are one of the main causes for the first contact with crack reported by

approximately 30% of individuals[32]. Also in this study, it was reported that around 27% of individuals tried it with friends out of curiosity, dissatisfaction at work or school, and difficulty in emotional relationships[32].

The aspects of vulnerability to drug consumption are also determined by the need to be included in groups, in which, often in order to validate and make the individual's inclusion legitimate, their freedom and control over their financial resources are compromised, encouraging new models of conduct[38]. Therefore, reproducing attitudes and actions of a group is understood as a system of social acceptance generally imposed as a prerequisite to achieving its integrality.

In the CAPS AD III researched, both individual and group care demonstrate the importance of strengthening the recovery and follow-up of treatment for crack users. Furthermore, detoxification care presents itself as a positive strategy for social reintegration, as it allows the reduction of the number of hospital admissions and helps to prevent new episodes of use, by providing full-time service[39].

CAPS represents one of the main territorial-based devices and replaces traditional psychiatric hospitals as it assumes the role of promoting the development of life projects, social production and promoting the quality of life of users and families, through the clinic that promotes autonomy of patients[40]. Based on the results of this study, it is observed that it is essential to develop a comprehensive approach to the complexity of risk and protective factors in order to support harm reduction strategies, from the perspective of users of crack cocaine and other drugs.

Comprehensive care supported by the understanding of risk and protection factors guided by the mental health deinstitutionalization model, CAPS AD III, allows advances at different levels of treatment complexity and mainly promotes participatory inclusion in therapeutic interventions aimed at crack cocaine users and other drugs[41]. Thus, the outcomes highlighted here bring to light implications for professional practice in mental health that can guide better arrangements and rearrangements in the care of users of crack cocaine and other drugs, in addition to supporting decision-making by social actors in the psychosocial care network.

CONCLUSION

In the context of crack cocaine use, it was found that physical and psychological changes can be minimized by applying the harm reduction policy. Individual and collective use, as well

as open and closed places, are decisive in interpersonal relationships in the search for a safer form of consumption.

It is considered that being careful when purchasing the drug, reestablishing ties with the family and maintaining treatment at CAPS are necessary conditions for the survival and protection of users. Preventive aspects associated with the use of condoms and the types of violence caused by the use of crack need to be the subject of government mobilization strategies in the reformulation of multidisciplinary and intersectoral guidelines, in order to delve deeper into future epidemiological and gender studies.

This study has the limitations of its qualitative nature, considering only users undergoing CAPS AD III treatment, which can sensitize professionals to this approach in defining preventive strategies, and also encourage the promotion of future work aimed at those users who do not seek the health service.

The need for transformations in mental health protection strategies highlights harm reduction as a fundamental strategy for health promotion, with the participation of different social actors, the necessary reframing of stigma and empathy in actions to combat drug use. Furthermore, it is important to use CAPS as a space for discussing changes and articulating with other RAPS devices for better treatment and social rehabilitation of users of crack cocaine and other drugs.

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Associated Publisher: Rafael Gomes Ditterich.

Conflict of Interests: the authors declared there is no conflict of interests.

Financing: none.

CONTRIBUTIONS
Aurélio Matos Andrade and **Maria da Glória Lima** contributed to the conception, collection and analysis of data, writing and revision. **Marina Lessa Gomes da Matta** and **Maria Aparecida Gussi** participated in the writing and revision.

How to cite this article (Vancouver)
Andrade AM, Matta MLG, Gussi MA, Lima MG. Risk and protective factors arising from the use of crack cocaine in the capital city of Brazil. Rev Fam, Ciclos Vida Saúde Contexto Soc. [Internet]. 2023 [cited in *insert day, month and year of access*]; 11(3):e7255. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
ANDRADE, A. M.; MATTA, M. L. G.; GUSSI, M. A.; LIMA, M. G. (2023). Risk and protective factors arising from the use of crack cocaine in the capital city of Brazil. **Rev. Fam., Ciclos Vida Saúde Contexto Soc.**, Uberaba, MG, v. 11, n. 3, e7255, 2023. DOI: *insert DOI link.* Available from: *insert access link*. Access in: *insert day, month and year of access*.

How to cite this article (APA)
Andrade, A.M., Matta, M.L.G., Gussi, M.A. & Lima, M.G. (2023). Risk and protective factors arising from the use of crack cocaine in the capital city of Brazil. Rev Fam, Ciclos Vida Saúde Contexto Soc., 11(3). Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.