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Embracing and caring for problematic drug users

Acolhimento e cuidado à pessoa em uso problemático de drogas

Acogimiento y cuidado a la persona en uso problemático de drogas

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ABSTRACT

Objective: with a comprehensive care focus, to examine practices in care for problematic drug users. **Method:** this qualitative study of 14 users and nine health professionals at a Psychosocial Care Center in Pernambuco, Brazil, in 2015, was approved by the research ethics committee. The empirical material was produced at four reflection workshops, and analyzed by discourse analysis. **Results:** the service users' and health personnel's discourses converged towards welcoming care practices able to build relationships of trust and lasting bonds, thus facilitating therapeutic processes that both groups characterized as producing solutions. **Conclusion:** the care provided to problematical drug users is progressing towards comprehensiveness, by way of user embracement practices that users and professionals describe as dialog-based, affective and potentially leading to solutions in a context favorable to autonomy and stronger citizenship.

Descriptors: Integrality in health; mental health services; drug users; substance-related disorders.

RESUMO

Objetivo: analisar práticas de acolhimento na atenção à pessoa em uso problemático de drogas sob o enfoque da integralidade. **Método:** estudo qualitativo, tendo integralidade como categoria analítica, realizado com 14 usuários e nove profissionais de um Centro de Atenção Psicossocial em 2015, Pernambuco/Brasil. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa. O material empírico foi produzido por meio de quatro oficinas de reflexão e analisado pela técnica de análise de discurso. **Resultados:** os discursos de usuários do serviço e de profissionais convergem para práticas de cuidado acolhedoras, capazes de construir relações de confiança e vínculos consistentes, facilitando processos terapêuticos caracterizados pelos dois grupos como resolutivos. **Conclusão:** O cuidado prestado a pessoas em uso problemático de drogas caminha ao encontro da integralidade, com práticas de acolhimento qualificadas como dialógicas, afetivas e potencial para resolutividade em um contexto favorável à autonomia e ao fortalecimento da cidadania.

Descritores: Integralidade em saúde; serviços de saúde mental; usuários de drogas; transtornos relacionados ao uso de substâncias.

RESUMEN

Objetivo: analizar prácticas de acogida en la atención a la persona en uso problemático de drogas bajo el enfoque de la integralidad. **Metodología:** estudio cualitativo, siendo que la categoría analítica es la integralidad, realizado junto a 14 usuarios y nueve profesionales de un Centro de Atención Psicosocial en 2015, Pernambuco/Brasil. La investigación fue aprobada por el Comité de Ética de Investigación. El material empírico fue producido por medio de cuatro talleres de reflexión y analizado mediante la técnica de análisis de discurso. **Resultados:** los discursos de los usuarios del servicio y de profesionales convergen hacia prácticas de cuidado acogedoras, capaces de construir relaciones de confianza y vínculos consistentes, lo que facilita procesos terapéuticos caracterizados por los dos grupos como siendo resolutivos. **Conclusión:** El cuidado ofrecido a personas con uso problemático de drogas va hacia la integridad, con prácticas de acogida calificadas como siendo dialógicas, afectivas y con potencial para resolución en un contexto favorable a la autonomía y al fortalecimiento de la ciudadanía.

Descriptores: Integralidad em salud; servicios de salud mental; consumidores de drogas; trastornos relacionados con sustancias.

INTRODUCTION

Since the late 1970s, the implementation of the Psychiatric Reform has changed the meaning of mental health care and its practices, which has also affected drugs users. Such change has raised new care-provision paradigms and, consequently, new ways of providing care. Although with many obstacles, Brazil has been a reference by the United Nations Organization (UN) even for first-world countries[1].

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However, a new scenario is announced without the necessary debate with society, representing setbacks and compromising the organizational logic of network-shared care. The Ministry of Health (MH) has issued regulations that contradict the provisions of Law no. 10.216/2001, whose most powerful care-delivery tool is based on user embracement.

User embracement is noteworthy in the reorganization of Mental Health Policies, since it has supported changes in relational practices focused on the person and on overcoming the model centered on disease and on the vertical relations that insist on subsisting in health-care services[2]. Therefore, it requires the integration of promotion, prevention, treatment and rehabilitation actions, thus promoting care provision at the different levels of the network from the perspective of integrality.

In care provision for drug users, integrality comprises a plurality of actions that compose singular therapeutic projects, designed by collaborative teams. This bet includes the regulation of public policies, reorientation of relations between the State and society and viewing users under a care-provision logic that is free from prejudice and considers care provision in its multiplicity[2].

In this conception, the Center for Psychosocial Care - Alcohol and Other Drugs (CAPSad) requires that therapeutic plans be shared among professionals, users and family members, based on the valorization of a less bureaucratic work process which respects diversity and singularity, in an encounter that makes it possible to understand individuals and their demands, consider their experiences and pay attention to their needs[3].

In this (re)design of care provision, user embracement is the intercessor that sustains a relationship of trust among all those involved, providing collaborative and accountable care[4]. In short, it acquires important space in the national scenario of public policies, promoting practices that enable access and accessibility, encourage self-care and promote greater visibility for nursing and other non-medical professionals[4].

In a study on the care provided by CAPSad, integrality constituted a perspective that guided interprofessional practices, and user embracement constituted a device that imprinted change in practices, produced and consolidated bonds among professionals, users and family members in the encounter of those who provided care with those who were cared for. In this article, we disclose the empirical category of the abovementioned study, in which user embracement is expressed as a dimension of integrality, aiming to analyze user-embracement practices in the care provided to individuals making problematic use of drugs under the integrality approach.

LITERATURE REVIEW

User embracement implies an ethical posture and interprofessional complicity in agreement with the needs of individuals, collectives and populations. Thus, it is not stationed in a single service or worker, but it should be present in all avenues of the care network[5]. Therefore, it is considered a dynamizing and transforming device that intermediates actions, qualifies professionals and enables the user to play a leading role[6].

User embracement is consolidated in a quadrilateral that potentializes encounters: listening, bonding, accountability and resoluteness, emanating the quality of care. It is the mediating device that aims at producing intersubjective relationships of trust in the constitution of commitments, embodied in the collaborative care between professionals, health-care services and other devices[7], making integrality effective.

Integrality, in principle, concerns comprehensive care and the way health services are organized. These notions eventually gained other dimensions that involve professional knowledge and practices, political strategies in defense of the Unified Health System (SUS), quality of care, social legitimacy and sustainability[8], in the construction of effective health care.

In this circumstance, the Psychosocial Care Center (CAPS) incorporates actions aimed at social inclusion, protagonism and social bonds and stimulates potentialities. Its proposal is to provide care for people with mental disorders and disorders resulting from the use of alcohol and other drugs, based on psychosocial care guided by the Damage Reduction (DR) strategy[9]. This service has become a reference for mental health care by establishing the reorganization of the health-care network, based on a territorial logic[10], which requires devices in the community to compose and articulate the multiple nuances of care from the perspective of integrality.

In psychosocial care, the devices that make up the Psychosocial Care Network (RAPS) are articulated and professionals are responsible for resolving the demands, whether in primary care, at CAPS, the referral hospital or other services, deconstructing the referral and counter-referral logic, which favors unaccountability and hinders the population's access[11].

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METHODOLOGY

This is a descriptive study with a qualitative approach and integrality as its analytical category. It was conducted at a CAPSad in Pernambuco/Brazil from March to August, 2015.

Fourteen users and nine professionals collaborated with the study. For the group of users, the inclusion criteria were: having a relationship with CAPSad for at least three months and showing conditions to discern the topic according to the objectives proposed in the study.

Fourteen professionals composed the team, and nine met the inclusion criteria, which were: having been working at the unit for more than five months and not being on sick or a paid leave. The time period of five months was established because it was considered to be appropriate for proper inclusion in the routine of the service, as well as to ensure the participation of all categories.

The empirical material was produced in four reflection workshops, two with each group of participants. They were entitled: Meanings of Care at CAPSad and Rescuing Care at CAPSad.

The workshops allow for the emergence of emotions that are, at times, dormant or unknown, provided that they take place in an embracing and respectful atmosphere, thus articulating what participants think, feel and do around a central issue in a social context[12,13].

The first workshop with users was developed based on reflective questions: How did I feel when I first came to CAPSad? What care experiences have I gone through since my arrival? How have these experiences affected my life?

In the first workshop with professionals, we started with the reflective questions: Who is the person who attends CAPSad? What experiences have I had here? Have I met this person's needs?

In the second workshop, in both groups, the aspects valued by the participants in the first meeting, which had been evaluated, were retrieved. There was agreement on the contents presented and new elements were added from the reflection and discussion when the participants answered the question: do you feel that your views were considered in the synthesis of the previous workshop?

The workshops were conducted by a facilitator and a collaborator, lasting two hours on average, and followed the phases: presentation, development, socialization, synthesis and evaluation[12]. They were recorded and later transcribed.

The discourse analysis technique, according to Fiorin, was used to analyze the empirical material. Discourse analysis is a practice and a field of linguistics and communication that specializes in analyzing ideological constructions in a text. The phases proposed by the author were followed: reading the text and finding the figures and themes that conducted the signification block; understanding partial themes and organization by convergence in meaning units; constructing subcategories and their respective core empirical categories[14].

The study complied with Resolution no. 466/2012 and was approved by the Ethics Committee, according to resolution no. 0008/141014. In order to ensure anonymity, the participants were identified according to the condition of user (U1 ...) or professional (P1 ...).

RESULTS AND DISCUSSION

Of the group of users, the majority were males, married, elementary school graduates with a mean age of 42 years. The period of time during which they had been attending CAPSad ranged from 5 months to 9 years. Regarding drug use, six reported using alcohol exclusively, and the others reported using two or more substances, primarily marijuana, cocaine and crack.

In the group of professionals, the following participated in the study: a social worker, a nurse, a psychiatrist, a pharmacist, psychologists (2), a receptionist, a doorkeeper and a cook. Most of them were females, single, with a mean age of 38 years. Their length of employment ranged from 5 months to 9 years.

The two thematic categories emerging from the analysis of the participants' discourse are discussed below.

Sensitive listening potentializing subjectivity

At CAPSad, individuals with problems related to drug use move from the feeling of abandonment to that of protection. This condition is materialized in the access, accessibility and embracement provided by professionals available to listen, and this represents a rupture from the model on which traditional psychiatry was based, whose focus of interest was exclusively mental illness.

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The professional-user relationship, free of mistaken historical ties, enables therapeutic processes that give way to freedom, with possibilities that reach beyond professional agendas and institutional walls, which encourages self-esteem and autonomy.

Thus, the team's commitment and responsibility to predispose new perspectives to people with drug problems account for positive outcomes.

> *The staff helped me here; it didn't work out anywhere else; I've been to five rehab centers. Embracement is heartfelt here; you are respected despite your addictions (U1).*
>
> *Here, each employee makes us believe in ourselves. We realize that they really get along, because this area of mental health requires humility (U4).*

In meetings of users and professionals, listening permeates caregiving actions, without the imposition of programming, but by adding spontaneous demands with affection.

> *When I need to talk, I say: 'Doctor, I want to talk to you'; when I leave, I am completely relieved. I have this freedom; whenever I need it, they are so ready to listen (U3).*
>
> *There are times when I feel depressed, and I come to CAPS to unburden; I look for a professional; I leave here with an answer (U2).*

In this reality, professionals adapt protocols and schedules to people's life contexts, acknowledging socioeconomic and family issues, meeting the logic of integrality, which requires reconstructive practices that facilitate the approach of users to services and professionals.

The inclusion of spontaneous demands to the daily schedule reflects the team's availability to guarantee embracement. In this logic, users' satisfaction about therapeutic processes includes less strict and bureaucratic interventions, which broadens the meaning of caregiving. Thus, the users' and professionals' discourses converge as they reveal the team's availability

> *Such embracement is important. Sometimes, we are very busy and they want to talk to us, and we listen. It's their time to express themselves! (P1).*
>
> *CAPS is a place where people are listened to; it's not just about the health problem. It's different from other places. CAPS makes a difference (P2).*

The analysis of the participants' discourses reveals that, at CAPSad, care is given by actions and affection, which can strengthen subjectivity, create bonds and accountability and exercise users' protagonism in such a way that care provision is qualified and integrality is accomplished.

Bonding and accountability accrediting care provision

Respect and accountability are set as conditions for the success of the activities, granting a defining ethics of new practices that redefines teamwork and points to a horizon of paradigmatic overcoming.

> *I am the entrance door; everything comes in through this first door (reception); I welcome them, then they come in; if they are not welcomed, my work goes down the drain (P9).*

Collaboration among professionals enables organization in the work process, which offers different modalities/intensities of care provision, according to the level of autonomy and response pattern of each user during treatment[8,9].

> *When patients choose intensive care, most of the time, they don't have any other ties out there; in general, they don't work anymore; their families have left them, so we seek those bonds here (P3).*

The loss of social bonds as a result of drug use moves users away from that which is idealized as a refuge and emotional shelter. Thus, the encounter with CAPSad represents a possibility of new bonds and new opportunities to see life, in a citizenship experience that is no longer universal and abstract.

Problematic drug use is considered multicausal. Breaking this cycle is very difficult and delicate, as people experience intense physical and mental suffering, and every aspect of their lives is affected[15].

In this proposition, the DR strategy becomes an innovative opportunity to (re)design ways of providing care, which does not exclude other perspectives, given the singularity of people in successive therapeutic flows[16].

Thus, this task is assumed responsibly by professionals who daily reflect on and evaluate possibilities.

> *Many times a person comes and warns, 'I can't be here every day'. And CAPS' function is this: to enable all these accommodations (P3).*

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> *I always think that I'm not giving the best care possible, so sometimes I wonder: 'could I have done anything else?' (P1).*
>
> *Providing care is a constant reflection; at times, there is the impression that everything has been done and, at others, that you could have done a little more (P4).*

Embracement is a bond that positively influences treatments. When it is experienced in the presence of professionals, users feel protected. This safeguard is expressed when they are facing difficult times, as for instance, during a withdrawal crisis, they know that they will find protection.

> *Before, when I was depressed because of the lack of drugs, I tried to isolate myself, but not now; I have given the CAPS phone to my wife, so I am calmer (U1).*

In this tuning fork, strong bonds and relationships of trust support therapeutic processes characterized as resolutive, which are destabilized with the removal of professionals.

> *The only negative experience here is when professionals go away. They leave a very large gap because we are already used to them; we already have an intimacy, and it takes a long time to regain that trust with another one (U4).*

Once the relationship of trust is built, the attachment that creates the bond is also established. Therefore, professionals' leaving represents a rupture and loss, which has repercussions on therapeutic processes that are experienced with suffering, thus sometimes leading users to abandon treatment.

Attachment is understood as a bond established between a person and his or her primary caregiver. It is formed early in life, but reverberates in adulthood relationships through distinct social functions and relationships. The comfort experienced in the presence of the trusted person provides a secure base in threating situations, which provides a feeling of security and underpins the therapeutic alliance[17,18].

The rupture of this coexistence due to a professional's leaving produces tension on the collaborative relationship between the team and users.

> *Trust is very important, so much so that when a professional leaves, they really resent it. It happened with the nurse before me; when she left, some people stayed away from CAPS (P1).*

Losing the established bond can modify the user's motivation regarding treatment. Thus, it is understood that bonds are important for treatment continuity. When treatment is continued, spaces for exchange can be created, which is so important in mental health care[19]. Motivation is mentioned as one of the most important determinants in the therapeutic process, and it is up to the professional to provide the necessary conditions to arouse these affections[20] by empathically embracing users.

Our study corroborates other investigations on mental health in Spain showing that, in the public health system, it is very likely that professionals will go through the service without completing some people's treatment. This often unpredictable turnover prevents users and professionals from sharing with other professionals, thus causing severe damage[8].

At times when it is necessary to refer users to another service, embracement enables the referral to be shared between professionals, users, family members and the service that will receive them, thus preventing referral and counter-reference, which are configured as a problem transfer[5].

As CAPSad becomes the pillar that produces bonds and overcoming, it can also reduce the enclosure motivated by the user's accommodation that leads him to become uninterested in being discharged, in cases that can be followed by other network devices.

> *This is my refuge, where I have found myself to break free of drugs; I like everyone here; I like the treatment; I have been here for about ten years (U10).*
>
> *I've been here for eight years; I feel good; everyone takes care of me; I'm well treated; the professionals help me a lot (U11).*

In order to achieve integrality, which influences the continuity of treatment[21], other RAPS services need to be triggered, as they will provide support to CAPSad and vice versa. CAPSs have an entrance door through which those who need its services are welcomed; however, it is crucial that they also have an exit, otherwise there is a risk for remanicomialization in a new fashion[22].

CONCLUSION

The practices of embracing individuals using drugs were expressed in two thematic categories that emerged from the analysis of the participants' discourse and were entitled: Sensitive Listening Potentializing Subjectivity and Bonding and Accountability Accrediting Care Provision

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Embracement is a potent device to the multiplicities of the care provided at CAPSad, where reliability is established and sustained on therapeutic processes characterized as resolutive. The team's commitment and availability to embrace and listen produces bonds and horizontalizes intersubjective relationships.

Users' satisfaction results from the accessibility to less bureaucratic interventions, which improves work processes and broadens the meanings of integrality. Their confidence stems from the professionals' attempts to acknowledge singularities and work on daily demands according to the service's and the team's possibilities, calming anxieties and seeking more effective and affective forms of care provision, which implies flexibilizing protocols and activity schedules, thus making the difference in psychosocial care.

This study broadens the debate and reaffirms the current mental health policies, showing that it is possible to produce positive results in antimanicomial services, thus rejecting setbacks based on incentives for treatment in psychiatric hospitals or therapeutic communities that violate rights and where people are subjected to moral and reclusive treatment.

In incorporating the integrality proposal, which needs to be thought of as a care-provision solidarity network, this study has limitations because it was developed in only one RAPS device, which prevents the generalization of its findings. However, because it reflects a local reality, it serves as stimulus and support for the development of new research.

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