CARE FOR DRUG USERS IN THE PERSPECTIVE OF FAMILY HEALTH PROFESSIONALS

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ABSTRACT: This qualitative study, using the fourth-generation evaluation, aimed to evaluate the care delivered to drug users in the context of a mental health care network. It was developed in a Family Health Strategy unit in Porto Alegre-RS. Data were collected between September 2010 and March 2011, by means of interviews and field observations. Study participants were 19 Family Health Strategy professionals. The results revealed (dis)connections of the lack of strategies aimed at the care of drug users. This study may lead to the development of devices aimed at a real transformation in health practices and the consolidation of a health care network that considers individuals in their social context.

DESCRIPTORS: Public policy. Substance-related disorders. Mental health. Nursing.

ATENDIMENTO A USUÁRIOS DE DROGAS NA PERSPECTIVA DOS PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO: O artigo objetivou avaliar o atendimento a usuários de drogas no contexto da rede de atenção em saúde mental a partir de uma Estratégia Saúde da Família no município de Porto Alegre-RS. O método foi qualitativo (Pesquisa Avaliativa de Quarta Geração) e os dados foram coletados no período de setembro de 2010 a março de 2011, por meio de entrevistas e observações de campo. Os sujeitos desse estudo foram 19 trabalhadores. Os resultados revelaram (des)conexões do serviço com outros pontos de atenção de saúde mental do município estudado, além de evidenciar precariedade de estratégias voltadas ao atendimento dos usuários de drogas. Este estudo poderá gerar dispositivos que vislumbrem uma real transformação nas práticas em saúde, além da consolidação de uma rede de cuidados que considera os indivíduos em seu contexto social.

DESCRITORES: Políticas públicas. Transtornos relacionados ao uso de substâncias. Saúde mental. Enfermagem.

ATENCIÓN A LOS USUARIOS DE DROGAS EN EL MARCO DE LA ESTRATEGIA SALUD DE LA FAMILIA

RESUMEN: El estudio tiene como objetivo evaluar el cuidado de los usuarios de drogas dentro de la red de atención de salud mental, desde la Estrategia Salud de la Familia del municipio de Porto Alegre-RS. Se trata de un estudio cualitativo, mediante la Evaluación de Cuarta Generación. Los datos fueron colectados entre septiembre de 2010 y marzo de 2011, a través de entrevistas y observaciones de campo. Participaron del estudio 19 profesionales. Los resultados revelaron (des)conexiones de servicios con otras áreas de salud mental del municipio, y también apunta la precariedad de las estrategias para la atención de los usuarios de drogas. Este estudio podría conducir a la aparición de dispositivos que contemplen una verdadera transformación en las prácticas de salud, y la consolidación de una red de atención que considera a los individuos en su contexto social.

DESCRIPTORES: Políticas públicas. Trastornos relacionados con sustancias. Salud mental. Enfermería.

INTRODUCTION

Health care decentralization, with emphasis on the municipalization of the administration of health actions and services, constitutes the most significant change in the political-administrative aspect of the health system reform in Brazil, and its normative definitions have indicated that the base of the health care system should be municipal by attributing to the municipality the responsibility for the direct provision of most of the services. The imperative of a single direction in each sphere of the government showed the need to overcome the disarticulation among the services and to build the coordination of actions under the direction of a single administrator in each political-institutional setting – the municipal health secretary in the scope of the municipality, the state secretary in the scope of the state and the health minister in the scope of the country.[1]

Nevertheless, the decentralization is not limited to the process of municipalization and regionalization of health: its purpose is to distribute care resources more reasonably and equanimously throughout the territory, based on the distribution of the population and promoting the integration of care actions and networks, in order to assure opportune access, continuity of care and economy of scale (organization of the productive process so as to achieve the maximum utilization of the productive factors involved in the process, aimed at low costs of production and the improvement of goods and services).[1]

The Family Health Strategy (FHS), as a policy aimed to induce changes in models, has been presenting important results in the health care process in the scope of the territory. In this strategy, health care is centered in bonding and embracement, so as to provide the professional with a new way of assisting the families and the community.[2] Because these professionals understand the way of living of these people, they may also act more effectively regarding the health needs these individuals present. One of these needs, which is urgent in the public health context, is the problem of drug use.

In the last few years, the world has been searching for answers to the growing detriment (social, cognitive, cultural and political) associated with these harmful habits in society. The use of the most varied psychoactive substances (not only alcohol and those considered "illicit") is a secular practice, but which has been increasing in different regions of the world, especially in developing countries. The cost resulting from the treatment of incapabilities resulting from the use of alcohol (cirrhosis, motor vehicle accidents) represents almost 1% of the GDP, although this number may be higher than 2% in countries like Canada and the United States. In the use of other drugs, the prevalence is between 0.4 and 4%, although the type of drug may vary significantly in each region. Injectable drugs, for instance, are estimated to be used by 5 million people worldwide, and bring along other risks associated, such as infection by HIV and by the virus of hepatitis B and C. This is a critical public health problem, which has been demanding concrete and effective responses from governments.[3]

As evidenced, despite the physical compromising caused to users, the excessive use of drugs generates a series of contradictions in the territory and in the entire health system. Concerned with the social repercussion of the use of drugs, the Ministry of Health has been making significant investments in the constitution of services and devices that may follow up the drug user in the community context. Among these services and devices are the National Care Policy for Drug and Alcohol Users, the Plan for Coping with Crack and the Emergency Plan of Expansion of Access to Treatment against Alcohol and other Drugs at the Unified Health System (*Sistema Único de Saúde* - SUS).[4-5]

According to regulations, the Psychosocial Care Centers for Alcohol and other Drugs (CAPS AD) are strategic services in the process to implement mental health care for users of alcohol and other drugs in the territory. However, it is necessary to invest in the consolidation of a care network that may contemplate the several dimensions of life of the subject, including social strategies and other health devices closer to the life context of the individual, such as the Family Health Strategy.

Therefore, the purpose of this study was to evaluate the care delivered to drug users in the context of the mental health care network, based on a FHS unit.

METHOD

This is an excerpt from "*Avaliação da Saúde Mental na Estratégia Saúde da Família* (MENTAL-ESF)" [Mental Health Evaluation in the Family Health Strategy], an evaluative case study research developed in the municipality of Porto Alegre-RS. The fourth-generation evaluation[6] was used as theoretical-methodological framework. The main

focus of the evaluative process was to learn the routine of the service, its dynamics, the way the subjects interact and the meanings built regarding their own practice.[6]

The fourth-generation evaluation proposes a responsive constructivist evaluation. The term responsive is used to designate a different focus for the evaluation, delimited by means of an interactive process of negotiation that involves groups of interest. The constructivist term, also denominated as interpretative or hermeneutic, is a responsive way of focusing and a constructivist way of doing.[6]

In the MENTALESF study, data were collected by means of observation and interviews with the groups of interest – team, patients and families, in the period between September 2010 and March 2011. The field observations totaled 168 hours, and were registered on a field journal. A total of 39 interviews were performed, of which 19 involved professionals from two FHS teams, ten with patients who receive mental health care and ten with family members who had a relative in follow-up to mental health care in the studied mental unit.

The present study addresses the results found regarding drug use in the perspective of the 19 family health professionals interviewed. The members of the team were identified with the initials EE, followed by the order in which they were interviewed (i.e., EE3, EE10). The inclusion criterion was applied to professionals who worked in the FHS team for at least six months, and all of those who complied with this criterion accepted to participate in the study.

The interviews were performed with the application of the Dialectic Hermeneutic Circle, which is hermeneutic because it is interpretative, and dialectical because it represents the comparison and the contrast of diverging perspectives with the perspective necessary for the development of a high-level synthesis.[6] The guiding question and, the one which triggered the circle, was "What is the mental health care like in the FHS?".

In this sense, the initial respondent R_1 participates in an open interview to determine an initial construct in relation to the focus of the study. This respondent is questioned and invited to build, describe and comment. At the end of the interview, the respondent is asked to indicate another respondent, who is denominated R_2.

The researcher analyzes the central themes, concepts, ideas, values, concerns and questions proposed by R_1, and formulates a construct denominated C_1. The second respondent (R_2) is then interviewed and, in case any construct approached by R_1 is not contemplated by R_2, the second respondent is invited to comment on it. The interview of R_2 produces information from R_2 and a review of the construct of R_1. The researcher concludes the second analysis, resulting in C_2, a more sophisticated and detailed construct, and so forth until the end of data collection.

The method used demanded that the data collection and analysis were parallel processes, one leading the other, based on the Constant Comparative Method.[7]

After the collection of data and the organization of the constructs of each group, the stage of negotiation was developed. Following, the interviewees were gathered and introduced to the provisional result of the data analysis, so that they could have access to all the information and the opportunity to either edit it or certify its credibity.[6]

Based on the negotiation, the researchers proceeded to the final stage of data analysis. In this stage, the questions that emerged were regrouped, allowing the construction of markers. The markers are a certain category that was abstracted from the empirical data and which has the explanatory capability to indicate a certain parameter of evaluation.[8]

The results of this study were organized based on the external marker "management and articulation in network", which contemplated questions regarding the network of mental health care of the FHS. Elements regarding the dis(connections) of the FHS with other mental health care services of Porto Alegre were evidenced, and more general questions regarding mental health care were discussed, pointing to the care for drug users as a critical aspect.

The research proposal was approved by the Research Ethics Committee of Porto Alegre, under the protocol number 001.056577.08.7/2008, and all participants signed the Consent Form as per Resolution number 196/1996.[9]

RESULTS AND DISCUSSION

The recognition and the concern with the theme of drugs, especially crack, as a public health problem is reflected on the current policy, which consists of the reduction in demand, supply of drugs and damages. The possibility of association among these three bases is questionable, considering that the reduction in demand and supply is

outlined mainly in restrictive approaches, whereas the strategies in the perspective of reducing the damages is outlined in the freedom of choice of the individual rather than in his/her moral judgment.[10]

In the perspective of the FHS team, drug users are a problem that belongs to the Unified Health System (SUS), therefore, a general problem of the health care system:

I believe that it is not a problem of the FHS Pitoresca, I think it is a general problem of the health system (EE5).

It is important to highlight the importance of observing this phenomenon from a broader perspective, since the political rationality proposes that the determinants for the consumption of drugs result from social and cultural aspects, and that civil rights and the access to comprehensive health care must be respected.[11] The challenge faced by the public health, which is currently concerned both with the drug abuse and the violence as risk factors for quality of life, is to achieve a referential framework for reflection and action, including the individual and the collective simultaneously.[12]

The policy adopted by the Brazilian Ministry of Health in the scope of the problem of the abuse of alcohol and other drugs is based on the care to the rights of every citizen, understanding that this logic must permeate the entire planning of actions for those involved in the comprehensive care of the patient.[13] The decree 7179, released on May 20 of 2010, established the Integrated Plan for Coping with Crack and other drugs, aimed to institute a public policy in this direction and a national articulation in the "battle against the drugs".[14] However, this national context still seems to be poorly reflected in the scope of the FHS.

In the evaluation of the conditions for the care for drug users, the FHS team highlights the lack of resources in the network and in the territory.

Despite recognizing themselves as co-responsible for the care of patients who use psychoactive substances, the professionals indicate the need for the FHS to have access to a specific care structure to this profile of demand. In this sense, the precariousness of the devices aimed at this care is evidenced:

[...] *regarding drug users, they come here and ask for help* [...] *but there is nothing after this* [...] *there is no treatment for them here, we don't even have conditions to offer one, because there is nothing specific, no program* (EE3).

When people start using drugs they get sick and they need a psychiatrist, follow-up and treatment [...] *They need to be observed and heard, having a therapist to listen to their problems* [...] *sometimes they may go back to the drugs, but the problem is at home and they want to tell someone but there is no one to talk to, sometimes they just want to talk. When they come to talk to the doctor, he often cannot assist them, the doctor is a clinician, there are things he cannot do, things that go beyond... And sometimes we have our hands tied* (EE19).

The team identifies that most of the patients who use psychoactive substances and come to the FHS unit present a chronic pattern of drug use, which demands that the first moment of treatment – the detoxification – occurs at a hospital. At this point, there is the problem of the lack of beds and the difficulties in terms of access to the existing hospital structures:

[...] *there is the CAPS, these groups, but chronic drug users don't usually accept this treatment... there is no cure, at least... a long hospitalization, a detoxification, this is more difficult. I think that for every 30 chemical dependents, you get to institutionalize one* (EE12).

Despite the indication of the need for beds, the importance of a comprehensive mental health care network is recognized, emphasizing that the supply available in the extra-hospital dimension is insufficient and, in the case of the territory assisted by the studied FHS, inexistent.

Drugs users who are institutionalized stay away from their context for a period of time, but later they return to the same territory and relapse due to the lack of continuity in the treatment. In addition, according to the FHS team, once they are discharged they seek their "friends" and resume using drugs:

[...] *they stay away, go to a farm or do something else far from there, but when they return,* [...] *they go back to the same place, meet the same people, follow the same routine, keep doing the same thing, so they end up having a relapse and using drugs again* (EE1).

[...] *their friends also use drugs and then they end up using again. There aren't enough resources, it is far from downtown and it does not offer courses to the young adults. The only thing we have here is a soccer field, and sometimes there is a tournament* [...] *I think it is complicated: idle hands are the devil's tools, and they end up using again* (EE2).

The use of psychoactive substances among young adults has become a worldwide problem as,

among friends, they learn how to combine drugs and use them in groups.[15] In this sense, the authors emphasize the importance for integrating actions between the subsystems composing the health system, assuring the continuity of the care of drug users without compromising the individual's comprehensiveness and needs.

The professionals highlight the lack of articulation with the resources of the local community, such as the churches, teaching facilities, among others. They identify that the resources of the FHS allow an important follow-up, and that two players stand out in the care of these patients: the Community Health Agent (CHA) and the family. This point is highlighted in the speech that follows:

[...] *there are resources in the community, in my point of view, the community agent is the one who brings these situations to us. They play an important role in this area, knowing the area and the people* [...]. *The family could be one of these resources, as well as the health center, aimed to assure the continuity in the treatment, with appointments and regular evaluations* [...]. *The community agents can visit them, follow-up, verify whether they are taking the medications and check on them if they miss an appointment* (EE7).

In the mental health field, professionals, family members, neighbors and all of those who are bonded to the patient are invited, in different ways, to take over part of the duty for the care, being fundamental in the construction of another social destination, partnerships and networks of social support.[16] This shows that the support, family structure and the constitution of new interpersonal relationships are important experiential elements of the abstinence.[17]

An effective intervention, with a community approach, must mobilize all the potential resources, especially those in the health and social networks. During the health reform of Nicaragua, between 1984 and 1988, it was possible to observe visible factors multiplying resources in the support of the social group of patients and the service, in the great ethics of the team and the society and in the high expectation of success of the care. On the other hand, the existing resources may decrease, both due to the high level of conflicts between the team and the community, and to the low motivation and expectation of success.[18]

There are also other questions that must be observed. A mental health care model considering the rights of the patients, the quality of life and the opportunities of work, for instance, must be developed with the community. The care focused on the community allows to identify resources that would remain hidden otherwise, or which would not be properly activated. These resources have the advantage of preventing the non-equipped family from abandoning their duty to take care of the patient, which would cause the already known negative psychosocial consequences for both. On the contrary, the activation of these resources leads to a completely different degree of control over the social and family weight, traditionally assured by the institutional control.[18]

The family is identified as an important resource, but requires a different approach strategy. By focusing on the involvement of the family, the team reported that their approach is difficult, given that people can be reserved, both the patient and the family:

[...] *when I go to a house where there is a chemical dependent, they generally don't tell us, they hide it, and then we sometimes see them here. They come here because of the chemical dependence, but going to their houses and talking about it is generally very difficult, because people close themselves, both the user and the family* (EE2).

The difficulty found by the service in involving the family is considered a limiting factor of the work developed by the FHS teams. It is evidenced that the lack of systematic intervention with the families has reduced the possibility of broadening the intervention developed, which focuses mainly on the demands of the individual who uses drugs.[19]

Studies point to the complex influence of the family, school and the group of friends, in cases of drug use, mainly in adolescence. Most of the treatments are built based on the search for engagement and retention of the individual who uses drugs, either through the significant figures of the family who worry about him/her, or working on the family context therapeutically.[20]

The idea that mental health care is a comprehensive action, and which demands the involvement of the family and the society, leads to the concept of comprehensiveness as an objective image, designating a certain configuration of a situation that some subjects may consider desirable. The objective image starts with a critical thinking, which refuses to reduce the reality to what exists but is never detailed, being expressed through general propositions.[21]

If on the one hand some objective images in the mental health field allow to determine the psychiatric/asylum model, on the other hand it is understood that they demand new care strategies

to be conceived/invented, in the field of practices, considering their singularities.

Observing the care routine, it is possible to perceive that the population is being invited to participate in the management of the public resources in health and, at the same time, encouraged to share responsibilities towards the care. It is the population's duty not only to formulate, but also to execute the guidelines of the public policies, to a certain extent. This ambivalence – between exercising rights and compromising oneself with duties – becomes more intense when the population favored by the public policies is the one protected, with individuals in psychic suffering, individuals who abuse on drugs, children and indigenous people, for instance. The drug user is considered nonresponsible (as well as incapable and dangerous) from the legal point of view, with a fragile engagement with this slow process of participation and accountability.[16]

The drug theme was approached by the professionals as a new situation for the mental health teams, demanding the establishment of partnerships in the mental health care network and in the territory of the FHS:

[...] *we try to work with the units, with the self-help groups in the community. There is an ambulatory for chemical dependents in São Pedro, and there is a support group now in Murialdo, in which the outreach worker and I participate. When they are discharged from a therapeutic facility, from a hospitalization, sometimes unfortunately there is not a CAPS unit, and we have to use other resources. We have already used resources from the therapeutic workshop for some cases, so each case has to be evaluated in order to consider the proposal of treatment* (EE17).

We created this group and it is another open door to start embracing them. The outreach worker came to manage it in October and it is a new situation for us because the harm reduction outreach workers used to stay in Postão da Cruzeiro and now they have been assigned to the management (EE17).

The encounter with the concepts and practice of Harm Reduction (HR) brings along another perspective of performance, different from the usual focus on the abstinence, that is, an open world, whose activity produces a new perspective that counteracts the stable, standardized and normative form. HR may be defined as a set of measures aimed to minimize the harms resulting from the drug use/abuse, without, necessarily, reducing the consumption. The fundamental principle of these actions is the respect to the freedom of choice, since not all users are able or wish to abstain from using drugs, but may develop care towards a possible health condition.[22]

In this context, it is pertinent to recover the participative role of the drug users in their treatment and in the public policies towards them. Awakening forces and promoting the creation of inhabitable territories must be the task of the professionals committed with the production of life of those under their care. However, this is not an easy task, considering that it is necessary to abandon that, which for a long time, they believed to be the only "truth" (biomedical model).[23]

Professionals must perceive HR as a guideline that recognizes and promotes new possibilities of life, new alternatives of resources for the people, groups and communities in which they work, permitting other views of human existence, as a new way to work the questions related with the use of drugs. This guideline is a dynamic exercise, such as the process of psychiatric reform, which is always unfinished and bold.[23]

Therefore, HR may be understood as a realistic guideline of the work at the Unified Health System (SUS), capable of triggering processes of citizenship, encouraging drug users to play leading roles, opening the possibility of transforming lives, removing them from the role of ill subjects, as if they were incapable of making their own choices. Hence, there is the configuration of a micropolicy, which may be understood as the daily acting of the subjects, in the relationship between them and the setting where they are.[24]

As evidenced, there is a need for interventions that contemplate the different contexts implicated in this question, aimed at strengthening the autonomy and contractual power of the individual in favor of maintaining his/her civil exercise. In addition, actions of health promotion by means of practices focused on the community, emphasis on public policies and intersectorial actions are important, since they constitute a strategy to improve quality of life and recover citizenship.[10]

FINAL CONSIDERATIONS

The present study brought to light elements to pose the problem of the operation of the mental health care network. Based on the partnership with the FHS, the area provided with care in the territory is expected to be consolidated and to broaden, deconstructing the model of specialization in the area of care for drug users.

The study allowed for identifying the strategies used by the professionals and the limits and possibilities involved in the care of drug users in the perspective of the FHS.

One of the aspects evidenced concerns the difficulties found in providing access to specialized services, particularly to the institutionalization in face of the identification of a drug user's need for detoxification. In addition to this frail aspect of the network, when this difficulty is overcome, the professionals point to the lack of territorial resources contemplating the continuity of the treatment, which favors the recurrence of relapses. These situations of disarticulation of the network of services and the low supply of activities and actions in the territory reveal the need for reorganizing the mental health care of drug users in the microsocial space, as defended by the mental health policies.

This situation, in the perspective of the professionals, appears as an absence of impact of the mental health policies regarding drug users in the context of the primary health care, especially in the FHS, reinforcing the eminently specialized character of the care delivered to these users in the mental health area, which conflicts with the current principles of the mental health care policies in the SUS.

Therefore, this study revealed (dis)connections of the service with other mental health care points in the studied municipality, also evidencing the overestimation of the specialized service and the precariousness in the supply of actions aimed at the care of drug users in the territory. However, the professionals recognized the need for establishing partnerships with other services and teams, and for adopting new perspectives of action with the proposition of the HR policy.

Furthermore, within the FHS team, the CHA is recognized as the strategic figure in the construction of care for drug users in this context, especially because he/she knows the individuals, identifies cases and follows them up, performs home visits, among other activities. Because he/she shares the geographic and existential territory of that community, the CHA favors the production of bonds.

The present study indicated the need to diversify the supply of actions and activities favoring the continuity in the treatment in the primary health care and to structure partnerships with other sectors, creating opportunities for strategies of social (re)insertion of users – continuation of studies, professional education, courses – that is, projects that go beyond the treatment, allowing to think over the question of the drug use and the actions aimed at this phenomenon in a broader and interdisciplinary dimension.

Therefore, this study evidenced the importance of posing the problem of the theme of mental health care for individuals who use drugs in the FHS, based on the discussion with professionals who face this challenge in their daily practices. This allowed an evaluation based on this group of interest, facing the presuppositions of a participative evaluation.

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