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ANALYSIS OF THE ARTICULATION OF THE CARE NETWORK FOR CRACK USERS

ANÁLISE DA ARTICULAÇÃO DA REDE PARA O CUIDADO AO USUÁRIO DE *CRACK*

ANÁLISIS DE LA ARTICULACIÓN DE LA RED PARA EL CUIDADO DEL CONSUMIDOR DE *CRACK*

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Objective: to analyze the articulation of the network of care for crack users. Method: evaluative study with case study design developed in a city in the metropolitan region of Porto Alegre, Rio Grande do Sul, Brazil. The Fourth Generation Evaluation was used as methodological-theoretical framework. Data were collected from January to March 2013 by means of field observations and interviews. Results: a fragmented and invisible network was found, with difficulties of communication between the care components. A strong point evidenced was the existence of an intersectoral forum of discussion among the members of the network, aiming at overcoming some of these weaknesses. Conclusion: more spaces for communication and continuing education of teams are needed, as well as better infrastructure of the services, and care strategies aimed at the territory of crack users.

Descriptors: Crack cocaine; Mental health; Delivery of health care; Qualitative research.

Objetivo: analisar a articulação da rede para o cuidado ao usuário de crack. Método: pesquisa avaliativa, do tipo estudo de caso, desenvolvida em um município da região metropolitana de Porto Alegre, Rio Grande do Sul, Brasil. Baseou-se na utilização da Avaliação de Quarta Geração como referencial teórico-metodológico. A coleta de dados ocorreu de janeiro a março de 2013, mediante observações de campo e entrevistas. Resultados: apontou-se a existência de uma rede fragmentada e invisível, com dificuldades de comunicação entre os dispositivos de cuidado que a compõem. Como ponto potente, evidenciou-se a existência de um fórum intersetorial de discussão entre os membros dessa rede, visando superar algumas dessas fragilidades. Conclusão: avalia-se a necessidade de mais espaços para comunicação e educação permanente das equipes, necessidade de infraestrutura dos serviços e de estratégias de cuidado que trabalhem o território do usuário de crack.

Descritores: Cocaína. Crack; Saúde Mental; Rede de Cuidados Continuados de Saúde; Pesquisa Qualitativa.

Objetivo: analizar la articulación de la red para el cuidado del consumidor de crack. Método: investigación evaluativa, del tipo estudio de caso, desarrollada en un municipio metropolitano de Porto Alegre, Rio Grande do Sul, Brasil. Estuvo basado en la utilización de la Evaluación de Cuarta Generación como referencial teórico-metodológico. Datos recolectados de enero a marzo de 2013, mediante observaciones de campo y entrevistas. Resultados: se determinó la existencia de una red fragmentada e invisible, con dificultades de comunicación entre los dispositivos de cuidado

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que la integran. Como fortaleza, se evidenció la existencia de un foro intersectorial de discusión entre miembros de dicha red, apuntando a superar algunas de esas fragilidades. Conclusión: cabe considerarse la necesidad de más espacios de comunicación y educación continua de los equipos, la necesidad de infraestructura de los servicios y de estrategias de cuidado que trabajen en el territorio del consumidor de crack.

Descriptores: Cocaína Crack, Salud Mental; Prestación de Atención de Salud; Investigación Cualitativa.

Introduction

Significant changes in mental health care have clearly happened in the last 30 years. While the care used to be organized around a single service with exclusionary character in former days, now the focus is turned to the extra-hospital network, that is, the care away from hospice walls. The expansion of the network is, therefore, essential to review the prevalent idea about the crazy and insane persons[1].

In Brazil, this expansion has been followed by a lengthy debate on the phenomenon of madness. This madness has multiple dimensions and a single facility is unable to understand it. For this reason, it is not possible to practice care without taking into account the various facilities that compose this network. They include, for example, strategic mental health services such as Psychosocial Care Centers (CAPS). In addition to these, there also psychiatric beds in general hospitals, centers of coexistence and culture, the Family Health Strategy, street consultation offices, among others[2].

In this movement, the Ministry of Health has been placing large investments in the structure of mental health services. The Ordinance nº 3.088/2011, which established the Psychosocial Care Network (RAPS) for people with mental suffering and need for recurrent use of *crack* and other drugs, is an example. One of the objectives of RAPS is the need to coordinate and integrate the different points in the network, as well as the perception of the territory as a space to practice care, bringing this network for the circulation and life space of users[3].

Within the RAPS' strategy, the services would represent the network nodes. Without the connection and coordination of these nodes/points, there is no network. This is because, before prioritizing the provision of services, it is necessary to understand how they are related, their communication and the care and management models that they are producing. Thus, the construction of a network is a complex task, as it involves the structure, the work processes and the construction of a new conception of completeness[4].

In the case of drug users, the country has experienced a problem that shifts the discussion on the network also towards the territory where users meet. Currently, *crack* has gained much attention in national health agendas, with broad social impact, reaching the different social strata and incorporating the everyday functioning of users and families.

Crack dependence can be considered one of the most serious problems of drug use, because of its almost immediate physiological effects. The user experiences a pleasant feeling during the use, increasing it in an attempt to get more intense effects. The greater the amounts used, the more violent become the behavior of users, with the presence of tremors and paranoid ideation, prompting situations of aggressiveness[5].

However, it is important to take into account in the discussion that users not only experience physiological effects of the drug, but they are also affected by economic, social and cultural issues. Families and communities witness at first hand the problems when the user loses control over his actions. They get involved with trafficking and, due to lack of social opportunities, start stealing objects in order to maintain the drug consumption, with eventual episodes of aggression within the family[6].

At the same time, if the closest support networks are weakened, users start hanging around with other drug users in the territory, forming new contact networks, which, in most cases, further encourage the consumption of the substance. In this case, *crack* operates a new sociability, as it is consumed among groups of people who have common interests. As the drug is the central element in these groups, these networks get increasingly strong[7].

In 2010, Brazil started a process of raising more intense awareness on the need for dialogue and incentives aimed at knowing the phenomena related to *crack* addiction. Activities of promotion, prevention, treatment and education on abuse of alcohol and other drugs, considering them as serious public health problems, gained emphasis in the National Policy of Comprehensive Care to Alcohol and Drug Users, the Emergency Plan for Expansion of Access to the Treatment of Alcohol and Other Drugs in the SUS and the Integrated Plan to Combat *crack* and other drugs[8].

The provision of health services and actions at all levels of care is a challenge. In this sense, the importance of the network stands out, with clear involvement of Psychosocial Care Centers for Alcohol and Other Drugs (CAPS AD), of the Family Health Strategy, the Reference Hospital Services on Alcohol and Drugs, the Harm Reduction Policy, street consultation offices, centers of coexistence and culture and the so-called "beds of comprehensive care", especially those linked to CAPS III (operating 24 hours) and general hospital services[8].

It is understood that it is not possible to address the care to *crack* users without considering the importance of analyzing the care network that surrounds them. That is, it is necessary to detect the weak points in the coordination, as well as the movements of users in the territory, that the service needs to follow, and the problems in the life of close family members. The analysis must start with people who care for the drug users or who are daily affected by them because. They are key social actors, and are in the position of giving an opinion on the issue, suggesting new care strategies and new management mechanisms, including the diversity of perspectives that surround this theme.

Thus, this article aims to analyze the coordination of the care network for *crack* users. It is understood that this analysis may allow a broader understanding of the role of mental health care services, reflecting on the strong points and weaknesses and problematizing the establishment of public policies for care in the territory.

Method

The study is part of the research entitled "Qualitative Assessment of the Service Network for Mental Health Care for *crack* users (ViaREDE)", funded by the National Council for Scientific and Technological Development (CNPq)/Ministry of Health. This is a case study with evaluative nature and qualitative approach. It was developed in a city of the metropolitan region of the state of Rio Grande do Sul. The theoretical and methodological framework was the Fourth Generation Evaluation[9].

The Fourth Generation Evaluation proposes a constructivist responsive evaluation. The term "responsive" is used to assign a different way of focusing the evaluation, outlined/framed by means of an interactive and negotiation process involving the target groups. The term "constructivist", also called interpretive or hermeneutic, is a responsive way of focusing and a constructive way of doing[5].

Study subjects included eight workers of the CAPS AD, 10 patients of this service, 11 family members of patients and seven managers of the system. The inclusion criterion for professionals and managers was the time working in the CAPS AD and in mental health management of the municipality that should be at least 6 months.

The inclusion criteria for users were: having been attending the CAPS-AD or another service of the mental health system due to the use of *crack*; being in good condition for communication and being willing to participate in the research; not being under clinical conditions that could negatively affect interviews. The inclusion criteria

for family members were being following or having followed a relative who is a *crack* user to the CAPS AD and any else mental health service.

Team members were identified with the initial "T", managers with the initial "M", users with the initial "U", and family members with the initial "F" followed by a number that indicated the order they were interviewed. Example: T3, F4, U2, M5.

Data collection occurred by means of field observations and interviews, which took place between January and March 2013. Field observations totaled 189 hours and were recorded in a field journal. A total of 36 interviews were conducted with application of the Hermeneutic Dialectic Circle. This tool is called hermeneutic because it is interpretive, and dialectical because it represents the comparison and contrast of views applied in the preparation of a high-level synthesis[9-10]. The method used requires collection and analysis of data as parallel processes, one driving the other, based on the Constant Comparative Method[9-10].

After collecting data and organizing the construction of each group, the negotiation stage took place. In this stage, all respondents were brought together and the interim results of the data analysis were presented so that they could have complete access to the whole information and had the opportunity to modify it or attest its credibility[9].

The negotiation allowed researchers to conduct the final stage of data analysis. In this stage, the questions raised were regrouped, thereby enabling the construction of thematic categories. The results of this study were organized under the theme "coordination of the network", to which converged issues related to fragmentation of the care network proposal, invisibility and lack of structure of the network of care for *crack* users.

The study underwent evaluation by the Research Ethics Committee (REC) of the Federal University of Rio Grande do Sul (UFRGS), which issued a favorable opinion on its execution (protocol n. 20157/2011). It was also evaluated by the National Research Ethics Committee (CONEP) under the Ministry of Health (MOH), at the request of the REC/UFRGS, and received favorable Opinion for its implementation (n. 337/2012).

Results and Discussion

As noted, much investment has been placed in a communication that may reduce the barriers imposed to the user and expand the potential of care services and their articulation. In this case, it is understood that it is necessary to look at what the subjects build in their daily lives, what they experience regarding the problem or working tools in this process.

The idea of expanded and articulated health network imposes the need to consider one of the main paradigms that sustain it, namely, the intersectoriality. Intersectoriality involves a set of actions integrated by different sectors and tools, considering the subjects' requirements as the main care strategy. Intersectoriality is particularly urgent in mental health services dealing with the issue of alcohol and other drugs. This is because isolated services cannot meet the demands and complexities of subjects, which range from simultaneous or complementary care in other health services up to social and protection issues[11-12].

Although the idea that intersectorality is necessary, while discussing the care network coordination for *crack* users, target groups indicated that their reality is still centered in a fragmented and invisible network. This means that, for them, the articulation of health services and the intersectoral care network is still punctual, with actions based on isolated needs, and fall short of the complex demands involving the theme:

> *I think each one takes care of a part. Assistance takes care of assistance, gives the ranch and the ticket, not even the bath they can give, because they have no physical space for them. And the mental health cares for mental health. I think that's it. Each one, you do not commit with the person, right?* (T3).

> *The assistance follows the logic that mental illnesses represent a health problem, not a social problem [...] Service resources are denied for people with mental illnesses or with AD problems. So, this is the struggle [...]* (T7).

> *There is a weakness in the care network for users of substances [crack]; there is lack of investment from the management: social care, primary care, culture and leisure, specialist orientation, general hospital, socioeconomic context, job and income generation*. (M1).

> *The articulation of network services is punctual. It is necessary that the collegial management in mental health promote the implementation of specialist orientation and continuing education on the network*. (M3).

Weakness in the link between health services with other network components such as social care and primary care is notable in the statements. This link is fundamental within the expanding conception of the drug use phenomenon. The main difficulty faced may be related to the understanding that mental health and drug-related problems should be addressed in specialized services and not in partnership with all the actors of this network.

In the assessment of managers, who best understand the constitution and formulation of public policies, the lack of network articulation and the fragmentation of care represent a management and monitoring/evaluation problem. To avoid this, stronger partnership in primary care, the main gateway in the system, is suggested. In addition, managers mention the need for a more consistent relationship between social and mental health services, since most of the drug users live in precarious and vulnerable social situations, as already discussed in other studies[13-15]. This arrangement also involves tools and intermediate but no less important strategies in this construction of networks such as the Continuing Education of network workers, specialist orientation and social tools.

The network fragmentation would be the reflection of a health care system geared to acute conditions or agglutination of chronic health conditions. This shows isolated systems in the national and international context that do not communicate with their points of attention, and are unable to produce a continuous care to the user. Its features include the difficulty of communication between levels of care (primary, secondary and tertiary), focus on the treatment of acute conditions, such as emergencies and specialized services, passivity from the part of users and interventions based on the curative model[16]. This fragmented view of health with the establishment of priorities that have curative focus prevents articulation and the extension of the options of practices with other services and resources in an intersectoral manner.

Another issue is the (lack of) partnership with the National Institute of Social Security (INSS). In the opinion of the U7, the INSS is responsible for granting social benefits and CAPS should be articulated to it, leading the process:

> *They could interfere with the INSS, because the guy is doing treatment. There's a guy who made four evaluations and the benefit was denied. I have been contributing for 18 years, there are madman who have 24, 30 years of contribution, when he comes here he is treated like an animal. If you have contributed to the government all these years, you should be cared for. They make up endless excuses, how is it that you will provide for your family, for yourself. You go to the INSS, then 4, 5 evaluations are needed, then you have to hire a lawyer [...] Then we go and we are deceived, the government deceives us [...] If you are doing the treatment with the city, the CAPS is a service of the town hall, how is it that they see the medical report and they refuse it?* (U7).

The lack of coordination between the health services and other network components, such as social assistance and basic care is one of the great weaknesses of the local network. In the testimony of professionals of the CAPS AD, the most discussed elements are the missing link between mental health and other network services, which may be related to the understanding, by network professionals, that mental health and drug-related problems should be addressed in mental health services. With this respect, some managers underscore the need for intersectorality and resources such as education, housing and family. According to them, these factors strengthens the care outside the network, in conjunction with the reality closer to the user, as can be seen in the following lines:

> *It is necessary to expand access beyond the structure and staff*. (M1).

> *An important factor for strengthening the care network for* crack *users is family involvement, and the CAPS is a special space to work with both the user and the family*. (G2).

In the opinion of workers, there seems to be a difficulty in agreement among network professionals about the importance of working

together, in order to provide a comprehensive care, avoiding fragmentation. As demonstrated T3, when he says that social assistance should take care of the social aspects and health services, of health problems. There seems to be a sense that this network still operates in pieces and not as a whole. When care is fragmented, there is the risk of seeing the user also in fragments.

The development of shared actions, directed to team interaction and the creation of strategic spaces for this interaction, emerge as a need within the county. Expanding matricial actions, continuing education tools and inter-relationships can help in combating the fragmentation and allow greater visibility of services. Opposite to M1's testimony, the following shows the argument that partnership in this shared care can make the network more powerful and sophisticated, reducing the concentration of care to specific services:

> *The daily construction of spaces to discuss management and to implement shared care are important strategies to get better results in the attention to users, especially when it comes to listening to the uniqueness and creativity of workers contextualized in the social environment.* (M1).

The joint team work through communication, case discussion, knowledge sharing and accountability, among other strategies, assists professional to feel more confident in the development of their actions and consequently strengthened to better deal with complex situations. Thus, in services where teams establish a closer relationship and maintain better contact with each other, mental health care becomes less problematic. Thus, it is understood that a care network depends on the people who work in the services, on the connections and links established between each other to achieve a common goal[17].

Mental health meetings provide moments of discussion among professionals from different health institutions, and are of great importance to the dialogue between them. In this sense, this moment of dialogue makes it possible to know the network, promote visibility of services and of people who compose them, discuss their constitution and seek strategies to deal with the reality in the municipality[18].

Thus, it is evident that managers bring up the importance of discussing tools for the improvement of the work processes. In contrast, it is observed that professionals experience no much of this idea in practice, but bring up criticism about the need for more exchange of experiences of the services:

> *[...] I think that something simple like this, these meetings that we do in the network, mental health network, each meeting with another service for us to start building a dialogue.* (T8).

> *This is in line with that issue that people do not know the services, right? as we too do not know what they do, right? Much less than ours, right? Of how to refer the person.* (T3).

In the testimonials of T3 and T8 is seen the need to revitalize and strengthen joint and shared spaces of action and intervention in the spirit of teamwork to avoid ignorance and fragmentation. However, there seems to be an agreement between managers on that work in mental health is recognized by all, showing an excellent field of knowledge and practices related to a care line connected to national policies:

> *The work of mental health has been recognized by the municipality (prosecutors ask for evaluations of the CAPS team of professionals to make decisions about mental health issues) and other municipalities and by the state (to share successful experiences in the mental health field - e.g. compulsory admission, assistance to situations of crisis in CAPS).* (G2).

> *CAPS is recognized by the population. All already know how it works and what it does, but there is still need to move forward, especially with respect to assistance to situations of crisis, urgencies, the most serious cases.* (G5).

> *The mental health service Viamão is clearly visible in the city, as people know the service (CAPS AD).* (G6).

This opinion of managers, that services are visible and recognized, is not consistent with the evaluation of other target groups, who point out deficiency not only in the arrangement, but also in the structure, both in human and material resources:

> *[...] there are people who don't even know of the existence of CAPS. There are people who are getting to know now, by indication of some health units, through referrals, and then people come.* (U2).

> *There should be a lot of cool stuff here, music workshop, a computer, to entertain the person. That is missing here.* (U5).

> *So many things. I think the whole service has to improve. They have to hire more doctors, we need more, it's just that I do not know how to explain you. A lot of things, because when we need it, we don't have it.* (F6).

The lack of material and human resources, the need for training staff and to invest in infrastructure is essential to the advancement of the Psychiatric Reform and to the strategies of inclusion of users. This is because the resources are used in the composition of therapeutic groups, workshops and consultations aimed at improving the self-esteem and autonomy of users[19].

Regarding the articulation of the network, this is often unprepared to welcome, assist, treat and create links with the demands of mental health. Drug users represent, currently, one of the major obstacles, particularly *crack* users, because they do not usually seek treatment and attend services. When they come, they may quickly change their mind, and present various difficulties to establish bond with the teams[20].

If crack users have a distinct profile from that of mental health where there is a constant alternation between wants and desires, services should propose a new, responsible, committed and, more than ever, shared way of caring. The dialogue between the services and workers is the first important step to make the network visible and to develop new pacts, for then meet the needs and contradictions of users.

The invisibility of the local network in addition to its lack of structure leads users and families to seek resources outside of the city, such as health services from the state capital:

> *She was admitted there and she was hospitalized* [Psychiatric Hospital in the capital] *20 days there [...] she was three times in the* [Psychiatric Hospital in the capital]. (F8).

> *Then we went there* [Name of the Health Center]. *That was when we met that doctor, but I that was so many people there, very bad. Drugged.* (F10).

Patients and families report that the network of the state capital offers support services and medical care for situations of emergency and hospitalization of drug users. In contrast, the service received is considered bad by some of them, for the conduct of professionals is guided by excessive medication of users and also there is delay in the service due to queues:

> *The assistance I received was very bad really. We left* [Psychiatric Hospital in the capital] *disappointed [...] there he said [...] here we only receive people who are in crisis [...]* (F10).

> *There, the only thing that is bad is the queue, when you are really in need of a hospital stay, because I no longer can control it. It's bad because you have to wait in that queue there [...]* (U2).

> [In the Psychiatric Hospital in the capital] *They helped me, but they gave me medication all the time.* (U3).

This reality was also observed in another study. In this case, the organization of services through forms and schedules to give assistance imposes barriers to access to services. Moreover, with the current configuration, it is necessary to arrive early in the health facility and face long queues, which further impedes access for users[21].

Another issue raised concerns the medicalization. Despite the idea that the Psychiatric Hospital seems to be part of local policy in cases of crisis, it is possible to see the contradictory nature of the health problems presented by users and the solutions offered by public administration. The logic behind the psychiatric hospital is this; it will not change. What needs to change is the orientation of attention to the crisis in the context of psychiatric reform, one of the obstacles to a genuine articulated network in the moment when the user needs it[22].

In this sense, the essential reflection on the actions in mental health, with a view to an articulated intersectoral network is critical to the production of a space and scenarios committed with the comprehensive care to *crack* users. The strategies already implemented in partnership in the municipality, as well as the challenges still to be faced, are part of the complex reality and dialectic of psychosocial attention in Brazil. To care in freedom, it is necessary to discuss the management of public policies, the knowing/doing of workers, and the relationships they

establish with the context, with the scenario and with the networks of relationships of users.

Despite the innovative strategies developed by the municipality, such as the Intersectoral Forum, it is necessary to keep investing and rethinking the care and system management that merge all the protagonists in this relationship. Thus, we can move forward in the creation of mental health public policies and lines of care capable of understanding that it is impossible to make mental health only in the specialized network services, but this must be done especially where users live, with their choices, their relationships and their wishes.

Conclusion

The results show many aspects involving the articulation of the mental health network for *crack* users in the city studied. The target groups evaluated some limitations and weaknesses of the network, pointing to the fragmentation of care, the difficulty of intersectoral coordination between the components and co-responsibility for the care of *crack* users, leaving it to specialized services like CAPS AD only.

The study led to the conclusion that there is need for more spaces for communication and continuing education of the teams, as well as better infrastructure of services and care strategies that work the territory of *crack* users.

The Intersectoral Forum in the municipality stood out as a strong point, a powerful space for exchanges between the various actors on the theme of *crack*. However, the need to invest in continuing education and matricial policies to improve and expand the shared and co-responsible care among care components is still evident.

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