

The role of primary care in the assistance to crack user: opinion from users, collaborators and managers of the system¹

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The objective of this study was to understand the opinion from users of the system, collaborators and managers on the role of primary care in the assistance of crack users. This is part of an evaluative study, developed in Viamão-RS with users, family members, mental health mental health and managers. It was used theoretical and methodological framework of the Fourth Generation Evaluation. Interviews were conducted using the application of the Hermeneutic Dialectic Circle. The Constant Comparative Method was used as analysis. The difficulty of articulation of specialized services with the basic network was pointed out, hindering access and continuity of care. The shortage of trained professionals to work with the drug phenomenon stood out, limiting the inventive potential of the network. The importance of investing in matrix support as integration mechanism and continuing education in mental health is emphasized.

Descriptors: Primary Health Care; Mental Health; Crack Cocaine.

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O papel da atenção básica no cuidado ao usuário de crack: opinião de usuários, trabalhadores e gestores do sistema

Objetivou-se conhecer a opinião de usuários do sistema, trabalhadores e gestores sobre o papel da atenção básica no cuidado ao usuário de crack. Recorte de estudo avaliativo, desenvolvido em Viamão-RS, com usuários, familiares, trabalhadores de saúde mental e gestores. Utilizou o referencial teórico e metodológico da Avaliação de Quarta Geração. Foram realizadas entrevistas com a aplicação do Círculo Hermenêutico e Dialético. O método de análise foi o Método Comparativo Constante. Apontou-se a dificuldade de articulação dos serviços especializados com a rede básica, prejudicando acesso e continuidade do cuidado. Destacou-se a escassez de profissionais capacitados para trabalhar com o fenômeno das drogas, limitando o potencial inventivo da rede. Ressalta-se a relevância de investir no matriciamento como mecanismo de integração e educação permanente em saúde mental.

Descritores: Atenção Primária à Saúde; Saúde Mental; Cocaína Crack.

El papel de la atención básica en el cuidado al usuario de crack: opinión de usuarios, trabajadores y gestores del sistema

Se objetivó conocer la opinión de usuarios del sistema, trabajadores y gestores sobre el papel de la atención básica en el cuidado al usuario de crack. Recorte de estudio evaluativo, desarrollado en Viamão-RS, con usuarios, familiares, trabajadores de salud mental y gestores. Utilizó el referencial teórico y metodológico de la Evaluación de Cuarta Generación. Fueron realizadas entrevistas con la aplicación del Círculo Hermenéutico y Dialético. El método de análisis fue el Método Comparativo Constante. Se apuntó la dificultad de articulación de los servicios especializados con la red básica, perjudicando acceso y continuidad del cuidado. Se destacó la escasez de profesionales capacitados para trabajar con el fenómeno de las drogas, limitando el potencial inventivo de la red. Se resalta la relevancia de invertir en el apoyo matricial como mecanismo de integración y educación permanente en salud mental.

Descriptorios: Atención Primaria de Salud; Salud Mental; Cocaína Crack.

Introduction

Within the assumptions that support the psychiatric reform with regard to the care paradigm in the psychosocial field, one can realize the importance of understanding that insanity cannot be reduced to just a single glance, considering that it has multifactorial influence. In this sense, different from the truths established over the age of traditional psychiatry, the expansion of care devices to ensure quality and

valorization of the subjects and their differences are gaining voice⁽¹⁾.

If we consider the current services of the mental health system as those seeking to rupture with the psychiatric ward circuit, responsible for iatrogenic and anti-therapeutic character, analysis of accessibility is configured by considering the instrument to understand the quality and the potential of the service to produce care transformations⁽²⁾.

In this important dialogue, drug use is not detached, considering real need to rethink the health area. We understand that any intervention in this area is mostly based on the certainty of the damage caused by its consumption; this view is almost universal. Among the drug user exclusion or the abstention adoption as the only treatment alternative, the best thing to do would be to understand the relationship with the drug or its demand, in an attempt to rescue the power of the subject in this relationship. It is as if the mystery in solving drug use problems were in existing negativity between aseptic, standardized policies, and disregard of individual and unique styles⁽³⁾.

In this context, there are also the most current trends (and not less contradictory) regarding the care to the *crack* user. We understand the magnitude of the impact caused by the substance use in the users' life⁽⁴⁾, in the families' everyday⁽⁵⁾ and the creation of more sensitive and specific public policies on the demand⁽⁶⁾. However, we understand that in a care setting based on integrity, we must invest in different territorial possibilities, because the drug use phenomenon is part of our society.

Therefore, we emphasize the evidence of a psychosocial care network as a strategy capable to provide access to care for individuals with problems resulting from drug use. A network not only consists of Psychosocial Care Centers (CAPS, in Portuguese), but also of basic network, because when articulated to specialized service, it can strengthen care in freedom⁽⁷⁾. In addition, we understand, in this composition, that matrix support emerges as the device that can ensure this connection in order to encourage continuity of care outside the traditional walls of the services.

Given the above, the objective of this study is to analyze the opinion from users of the system, collaborators and managers on the role of primary care in the assistance of *crack* users.

Method

It is part of the research "Qualitative evaluation of network services in mental health care for *crack* users (ViaREDE)", funded by CNPq/Ministry of Health. It is an evaluative case study developed in the municipality of Viamão-RS. It is based on the use of the Fourth Generation Evaluation⁽⁸⁾ as a theoretical and methodological framework.

The Fourth Generation Evaluation proposes a constructivist evaluation responsive. Responsive is a term to designate a different way of focusing the evaluation, delimited by an interactive process

and negotiation involving interest groups. The term constructivism, also called interpretive or hermeneutic, is a responsive way to focus and constructivist way to perform⁽⁸⁾.

The study subjects were eight collaborators of the Psychosocial Care Center – Alcohol and other Drugs (CAPS AD), ten users of the service, eleven family members and seven managers of the system. The inclusion criteria of professionals and managers were the fact that they worked at CAPS AD and at mental health management of the municipality for at least six months, respectively. The criteria to include users were attending the CAPS AD or having attended another service, at that time, of mental health system due to *crack* use; were in good condition for communication and who were willing to voluntarily participate in the research, and not be under clinical conditions that spoil their interview. In relation to the family members, the criteria consisted of accompanying or accompanied a *crack* user relative, at CAPS AD and elsewhere in the mental health services network.

With regard to the exclusion criteria, collaborators and managers could not be sick leave or on vacation during the collection period. With regard to users and family members, they did not participate if were in psychotic state or had no cognitive conditions to participate in the interview.

Team members were identified with the initial "E", managers with the initial "G", users with the initial "U", and family members with the initial "F", being the initials followed by the order in which they appeared in interviews, for example, E3, F4, U2, G5.

Data collection occurred from January to March 2013, through field observations and interviews. Field observations totaled 189 hours, recorded in a field diary. Regarding interviews, 36 happened.

Interviews were conducted using the application of the Hermeneutic Dialectic Circle. Hermeneutic because it is interpretive and dialectic, for representing the comparison and contrast of visions for the realization of a high-level synthesis⁽⁸⁾. The method required that analysis and data collection were parallel processes, one driving the other, based on the Constant Comparative Method⁽⁹⁾.

After data collection and organization of each group construction, the negotiation stage occurred. Respondents were assembled, when they had access to interim result of the data analysis, so they could verify all the information and have the opportunity to modify them or to assert their credibility⁽⁸⁾.

From the negotiation, the researchers conducted the final data analysis stage. In it, the issues raised

have been regrouped, allowing the construction of thematic categories. The results of this study were organized from the theme “network access” in which issues related to the role of primary care and matrix support converged in the composition of psychosocial care networks for care to *crack* user.

The project was submitted and approved by the Ethics Committee of the Federal University of Rio Grande do Sul (UFRGS) (Protocol 20157/2011). It was also, at the request of CEP/UFRGS, evaluated by CONEP/MS, receiving a favorable opinion for its implementation (337/ 2012).

Results

Primary care was evaluated by interest groups as one of the weak points of the network in relation to the care to *crack* users, especially by the difficulty of referral to specialized services and the lack of trained professionals to understand and intervene on the drug phenomenon, as exemplified in the following lines:

[...] This, indeed, because if there were in the centers [trained professionals to assist drug addicts], you have means to referral to CAPS. [...] In the centers, in case of a sudden emergency, we can be assisted before someone who needed more, but if we in the centers it would help a lot (U2)

[...] There is not such a thing there (professionals who have understanding about drugs). I think it would be better they had it there, rather than come straight to CAPS. (U3)

Family members also point out that primary care in the city is one of the resources with which they can rely less if they need. In general, they point out that this happens more when it involves the use of health services in emergencies. According to them, health centers do not work, and when they do, the operation is typical of traditional models, “by password”, such as statements indicated:

[...] the health center, which is near my house, we have to sleep there in order to get a password, which is terrible because you cannot even stay in line because of the assaults, and at the time we get a password we are well assisted, but until you can make it there is a lot of work before you get a password to get in. (F2)

[...] Health center does not really work, it does not work. (F10)

The idea of change of model, linked to Primary Care, specifically to the Family Health Strategy, still seems a challenge to Viamão, which has some of the Family Health Units operating in the logic of traditional models of Basic Health Units (BHU). An important user access mechanism to the mental health system is lost, since the *crack* user has an operating routine different from territorial health units:

[...] And then the crack user, the way they deal with time, will never use it, because he/she has to go there at 3 am and this time

he/she is going to obtain drug, not going to the center to get the password; and in the morning he/she sleeps, and maybe will look for the center at 4 pm. (E7)

Another important issue that interest groups assess is the need to invest in collaborators’ continuing education so they can understand the users’ operation and their needs. This is what U9 points out in the following statement:

[...] every village should have a Psychosocial Care Center, because the villages are horrible. Where I live there is a place to get drugs 24 hours a day, it is a 24 hour-smokehouse because there is no one to support these people. Many persons want to be helped, many do not, unfortunately it happens. [...] Or someone does this kind of work in the centers, in health centers it would be better [...] Send to health care centers who has worked with addicted people, to get to the center and talk and instruct; a lot of time I went to the center and told the person I was a drug addicted and I felt prejudice, I felt the prejudice of that person at that time. [...] People trained to treat this kind of people in the centers, that would be good. (U9)

Interest groups evaluate the need to invest in these continuing education activities, in order to reduce prejudices, stigmas, reorienting models and acting in situations of technical unpreparedness of the professional. For collaborators in the CAPS ad, the greatest difficulty with primary care teams is that treatment in the user’s life scenarios, since the network professional gets “scared” with the *crack* reality and referrals the person to specialized services, such as observed in these testimonials:

[...] When they are from the BHU I think they get too scared; the team referrals straight away, there is something about referrals... It’s quite hard, we go and come back, when we go there. We often discharge, send them to BHU, the user ends up using it again to access the service once more because they feel accepted here but not there... (E3)

Interviewed G3, for example, believes that continuing education activities occur on the network to reduce the distortion of these referrals or refusals, although he thinks that they need to be leveraged and made more visible in the city’s reality, as shown:

[...] We are already doing continuing education in these services so we can understand this movement that exists on Mental Health of this care of Mental Health care of the country. [...] I think that continuing education exists so we can understand better, become better informed about it, the prejudice to the use of this particular substance... (G3)

Contributing to minimize this issue, we highlight the matrix support, considering composite device of these connections between the specialized services and basic health services. However, in Viamão, the matrix support still has an organization focused on care traditional protocols. The only professional who was part of the team at the time of data collection

was a psychiatrist who gave advice to basic health units, providing assistance, when the logic would co-responsibility.

One of the issues during the circle application was the fact that the matrix support still needs to structure, considering care strategy in the network. Small actions would still be focused on the most common psychiatric disorders; according to the collaborators' testimony, without longitudinality with respect to problems with alcohol and other drugs:

[...] Another [matrix support] important tool, but that would never manage to structure, or because people did not want to be part of it, right?... (E3)

[...] So we know the doctor does the matrix support, which is the psychiatrist at CAPS II, but I don't think it is something related to AD [Alcohol and Drugs] ... (E4)

[...] I think it might be one of the most expensive and deep problems here, the matrix support. Nowadays, in Mental Health, there is a responsible for matrix support, the physician [...], who performs the matrix support on Mental Health. Not that I think that matrix support is done only with a matrix support team, our matrix support is every day. But I think the matrix support needs a team that can do that work with the units and with the network. Nowadays this is very incipient in Viamão, the work done is quite little and often misleading; soon the responsible for the matrix support will be sent to the units to attend rather than to perform matrix support. [...]. (G3)

There is no matrix support in Viamão. [...] the matrix support directed to us is basic and contextual. Our matrix support [CAPSi] is not equal to them [adult CAPS]; we should observe in the neighborhood what we have, the schools, although we centralize, everybody in Viamão comes here. Because this matrix support, you know, has to have a commission, they have come here a hundred times and it never worked. Matrix support means speaking, performing training with the center staff. I think an objective commission of what we need is necessary: where are we? How does Viamão work? How does colonization take place? Why is matrix support necessary? Who are those people from the center? The matrix support has to be contextualized and constantly requires a specialized team. You cannot get 12 people there, and no, we need a matrix support team outside, you know, a matrix support department, something like the Family Health Program or even do this matrix support with the Program. (G4)

Although there are rare and specific actions in health, with the need to strengthen being a consensus in the interest groups of workers and managers, the matrix support is understood as a network trigger and an integration device, which must be carefully planned and rethought in municipal health policy:

[...] I think matrix support is very important and I don't see it as a foreground in the office. Their interest is to strengthen primary care and I see that only strengthen primary care is not enough, there is a whole context, because primary care is connected with everything. (E6)

[...] He then visits the Units or the Family Strategies to talk about that with the teams of the basic units and with the users. I would say that today in the municipality the matrix support is still not implemented the way it should be. We have given much thought as a collegiate, as coordinators we get more involved with the CAPS teams as a whole so it can be a CAPS proposal that works, not only on Thursdays afternoon, but that it could occur any time there is a need to work with the proposed matrix support. So I still think matrix support should receive more attention. Very little happens, little is given, but I think it could happen, I believe there is a lot of work to do. By the time we can go every two weeks in a basic unit, with a group proposal, a space for mental health education, prevention, promotion, I think that's pretty cool. (G2)

Discussion

The quality of care related directly to the ability to welcome and the user's satisfaction. It is not enough to carry out technical procedures, ask about the complaints and guide. The user wishes to be understood regarding the problem, the user wants a solution. In this sense, the collaborator should be allowed to be affected by the user's problems, easing the clinic and providing real change model⁽¹⁰⁻¹¹⁾.

Continuing education of collaborators is a pedagogical strategy for dealing with the individuals and collective health problems. In several studies⁽¹²⁻¹⁴⁾ in the primary care and mental health context, this issue also appears as a technology of the health work process, capable of causing tensions and transformations in care reality.

We understand that there are different possibilities for continuing education offer to collaborators of the health system in Viamão. Considering that primary care is critical in that network, we observe that the matrix support can be incorporated into the primary care routine in order to provide and support the collaborators' performance, to make "matrix support" instead of "care" as the respondent G3 emphasized. After reconstituted with other work methods, such as discussion of shared cases and composition of mini support teams of CAPS to the network, the matrix support will strengthen primary care and will allow the user to not go to specialized services, except in essential cases. Thus, we consider that putting the network together will be promoted, facilitating the user' path.

Matrix support in health is, by nature, a strategy that aims to ensure specialized backup-support to professionals and teams responsible for care in the health area. It is defined as a work methodology complement to hierarchical systems that use referral

and counter-reference mechanisms, control centers and protocols. The objective of matrix support is to offer educational technical support and backup-support to specialized reference teams, depending on the shared construction of sanitary and clinical guidelines⁽¹⁵⁾.

In a network proposal, the matrix support comes as a device that allows interlocution between the health care equipment and other internal and external services to the network⁽¹⁶⁾. It is a strategy that optimizes the work process, organizing it in all the services and seeking to promote horizontality in work relations, involving the responsibility of all actors in the construction of therapeutic projects.

The professional engaged in the matrix support practice should be prepared to work with diverse groups and possibilities that go beyond actions focused in the health field. He/She should be open to new discoveries that lie in the sharing of power and knowledge, considering the complexity of the users' experiences towards illness and creating, therefore, multidisciplinary prevention and health promotion actions⁽¹⁷⁾.

Collaborators and managers have the understanding that the matrix support can help in the integration of different points in the network, especially primary care, still fragile in the city. Complemented by patients' and user's assessment, which signal the access restrictions to the basic network, we consider it necessary to rethink this articulation in loco-regional context.

In the alcohol and other drugs field, matrix support should be developed even more in this scope. It should be understood as a work process strategy, not only be reduced to the work of a team member. Matrix support is done on a daily basis, in a phone call, in an educational guidance with the various facets of the network, as a continuing education strategy on mental health. Only then, we realize it is possible to value the drug use as a multifactorial phenomenon and that, as a rule, lacks comprehensive care and is tied to the assumptions of psychosocial care.

Final considerations

It is known that primary care often sets up as a gateway to the mental health user in his/her path in the search for problem solving. However, the weaknesses in that gateway often translate into interventions focused on specialized service, separating the wide character idea of network care.

The results of this study point to the need for health professionals training that work in the basic network, promoting intersectoral dialogue through matrix support and continuing education actions, as technologies that can resize the work processes and care within the premises of the psychosocial field.

The development of shared actions, directed to team interaction and creation of strategic spaces so this interaction can occur, emerges as a need within the municipality. Therefore, we believe that expanding these actions that can show the sense of co-responsibility is necessary, in order not only to consider the complexity of *crack* use phenomenon in the contemporary world, but also the need to rethink the process of working in mental health, facing fragmentation.

It seems clear that the articulation difficulty in network is a glowing concern for the group of managers and collaborators, which is nonetheless positive. The reflection of the need for this partnership brings new possibilities for the city, showing that the technical and political debate is committed and articulate with the current care trends in the psychosocial field.

Regarding the limits of the study, we believe that it is necessary to go further on the possibility of intervening in reality, in partnership with interest groups, as recommended by the Fourth Generation Evaluation. Despite the importance of the descriptive plan, as presented here, one needs to build a better agenda of committed ideas and foundations with social changes on mental health policies. Only then, we will close a cycle in which the participatory assessment will bring substantive contributions to the scenario, to the relations and subjects.

We hope this study can bring a more precise dimension of the different facets involving *crack* use, more specifically on the phenomenon impact in the work processes in mental health and local public policies.

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