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Original Article

Psychoactive substance user embracement by the multiprofessional team of the Psychosocial Care Center III*

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The objective of this study was to learn how the multiprofessional team of a Psychosocial Care Center performs psychoactive substance user embracement. Data were collected by participant observation and a semi-structured interview. The categories of analysis were: context of teamwork, anti-relationship with the drug and the relationship with the person. It was concluded that there is distancing of the multiprofessional nursing team, with embracement based on the biomedical model and drug abstinence, and some relation initiatives with the user. The contribution is configured by embracement articulated to relational technology, based on principles such as empathy, guiding attitude, genuineness and congruence, in order to enhance the relationship with the person and minimize the team's anti-relationship with the drug.

Descriptors: User Embracement; Mental Health; Drug Users.

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Acolhimento de usuários de substâncias psicoativas pela equipe multiprofissional do Centro de Atenção Psicossocial III

O objetivo da pesquisa foi verificar como a equipe multiprofissional de um Centro de Atenção Psicossocial acolhe usuários de substâncias psicoativas. Os dados foram coletados por observação participante e entrevista semiestruturada. As categorias de análise foram: contexto do trabalho em equipe, antirrelação com a droga e relação com a pessoa. Concluiu-se que há distanciamento da equipe de enfermagem em relação à equipe multiprofissional, acolhimento pautado no modelo biomédico e na abstinência da droga e algumas iniciativas de relacionamento com o usuário. A contribuição configura-se pelo acolhimento articulado à tecnologia relacional, pautada em princípios como empatia, atitude orientadora, genuinidade e congruência, potencializando a relação com a pessoa e minimizando a antirrelação da equipe com a droga.

Descritores: Acolhimento; Saúde Mental; Usuários de Drogas.

Recepción de usuarios de sustancias psicoactivas por el equipo multiprofesional del Centro de Atención Psicosocial III

Objetivo fue conocer cómo el equipo multidisciplinar de un Centro de Atención Psicosocial realiza la recepción de los consumidores de drogas. Datos fueron recogidos mediante observación participante y entrevista semi-estructurada. Las categorías fueron: contexto de trabajo en equipo, antirrelação con el fármaco y relación con la persona. Se concluyó que existe desprendimiento del personal de enfermería del equipo multidisciplinario, anfitrión guió el modelo biomédico y la retirada del fármaco, y algunas iniciativas de relación con el usuario. La contribución establecida por el anfitrión articulado a la tecnología relacional, basado en principios tales como la empatía, la actitud de guía, la autenticidad y la congruencia, para mejorar la relación con la persona y reducir al mínimo antirrelação personal con la droga.

Descriptores: Acogimiento; Salud Mental; Consumidores de Drogas.

Introduction

The Unified Health System (*SUS*) established principles that legitimize health care in Brazil; they are: access universality, supply equality and care comprehensiveness[1].

In order to establish health policies, it is important to consider both their clinical and social relevance. A pertinent issue at present refers to Psychoactive Substance (PAS) users due to its epidemiological importance[2]. However, it was only in 2003 that a public policy aimed at the care of PAS users was instituted, which through creation of Centers for Psychosocial Care of Alcohol and Drugs (*Caps ad*) and the harm reduction strategy allowed for comprehensive care to be provided to these people, but had been previously marginalized to policies of a medicinal or religious-moral character[3]. Among the mental health devices, the Psychosocial Care Center (*Caps*) oriented by comprehensiveness is strategic for Brazilian Psychiatric Reform. *Caps* is the organizer of the substitute network, it provides daily care and modulates the intensity of care; it promotes the social insertion of people with mental disorders through intersectoral actions and supports mental health

care in basic care[4]. In this context, the health/disease process exposes the idea of multi-causality. Health is understood as quality of life, which includes health promotion[5]. Comprehensiveness must guarantee unrestricted care, contemplating complex attention to demands, which guarantees universality and equity[5]. It is a cross-cutting theme of health needs and enables building the lines of care to meet the demands of the subjects in the health system[6].

Health work requires different skills and technical instruments, however, it is always relational and characterized as light technology[6], meaning technologies that comprise interpersonal or intersubjective relations, and they include the bond, co-responsibility and embracement[7].

Embracement is care technology, a moment of bonding and listening to the needs of the subject, and enables constructing an individualized therapeutic project, allowing the subject to be autonomous in the health production process[7-9]. It proposes recognizing physical, social and cultural comprehensiveness, organization in a user-centered way, guaranteeing accessibility, reordering the work process for a multiprofessional team and qualifying the worker/user relationship[5].

Faced with a complex and multifaceted context in which the PAS user is also inserted, health work needs integration resulting from a synthesis of contradictions based on dialogue between the different actors, workers and users, and their knowledge, enabling a multidimensional vision of the health/disease process[7-9].

It is important that embracement is focused on the particularities of PAS users, since it also deals with moral issues such as the existence of taboos that, even when unconscious, impede dialogue aimed at forming a bond with the subject[8-9]. With regard to the embracement of this comorbidity, studies indicate that this action was reduced to a procedure for nursing professionals, and is confused with the act of referral. On the other hand, it is clear that better results are obtained for SPA users when practices are developed in more longitudinal and interdisciplinary strategies, which may indicate advances in consolidating more comprehensive care strategies and connected to people's daily lives[7,9-10].

Considering the relevance of broadening the understanding on how the *Caps* multiprofessional teams are dealing with the difficulties and particularities of these subjects, analyzing their vulnerability and the use of light care technologies, calling on them to recognize their responsibility in searching for PASs as a way to relate to the world, as well as to produce responsibility in the service user for their health/disease process, it is therefore opportune to investigate the embracement of these users[5-9].

Thus, the objective of this study was to learn how the multiprofessional team of a *Caps* III performs PAS user embracement.

Method

This is a qualitative, descriptive-exploratory study, characterized by an investigation process of an activity from its relational context, and the subjectivity of the observer to the environment in which they are inserted[11]. It was conducted in a *Caps* III located in the North Health District of Campinas, SP, which has a team of 40 professionals, being 25 of medium level and 15 higher level, and composes three reference teams that divide the territory.

This center has 353 enrolled users, accompanied by a team and reference professional, whose purpose is a link and relationship in the context of the service where multidisciplinary logic prevails[9].

From the 40 professionals in the service, only 13 responded to the inclusion criteria of the research subjects: all those professionals who had belonged to the multiprofessional team for at least one year, and who had already performed embracement of PAS users, and were therefore intentionally selected[12].

An interview was carried out with each of the 13 professionals of the three reference teams; they constituted three physicians, four psychologists, two occupational therapists, one nurse, one nursing technician and two nursing assistants, totaling ten higher education professionals and three middle level professionals. The duration was approximately one hour and ten minutes. The interviews were recorded, transcribed and stored, as established on the Informed Consent Form (ICF).

Data collection was conducted in two stages occurring in the period from July to August of 2013 through field observations and interviews. The first stage was related to field observations and totaled 162 hours in order to become familiarized with the study site. Familiarization was carried out by participating in two team meetings to present the research project, thereby enabling a flow to be established in the network of researchers' relations with the professionals before the most intensive work was to be done, and participating observation of user embracement with the use of a field diary for descriptive registration, thus prioritizing the impressions of the researchers without a specific script, and presented in the category that refers to the working context in *Caps*[11].

The second stage of the research referred to the semi-structured interview with the guiding question[11]: "How do you embrace the PAS users?".

The data were analyzed by a pre-analysis of the collected material by attentively reading the speeches, classifying and recording these into units of meanings, added to the reading of the field diary which later originated three categories[13], enabling to learn how the *Caps* III staff received PAS users: the context of teamwork in *Caps* (which deals with the relevant points of the field diary), anti-relation with the drug and the relationship with the user. In order to support the analysis from the theoretical perspective, the concepts of the construction plans of subjectivity which deal with how social relations are given, and some notes on humanistic psychology, specifically Rogers' theory, were used to support the PAS user embracement along with employing empathy, a guiding attitude, listening and genuineness[14-15].

In order to guarantee the anonymity of the participants, the initial of the word interviewee (the letter "I") followed by Arabic numerals were used according to the order in which the interviews took place, "I1" to "I13".

The research project was submitted and approved by the Ethics Committee of the Faculty of Medical Sciences of Unicamp, in accordance with Resolution CNS/MS 466/12, according to the Opinion no. 302.863/2013.

Results and Discussion

The context of teamwork in Caps

The national mental health policy advocates that psychosocial rehabilitation and the construction of care networks be structured based on the logic of the territory, which aims to create an organization for care through understanding the health/disease process, amplified by identifying the social determinants and their relation with the subject and in permanent construction[3-4,14,16-17].

To respond to this complex demand for territory, it is necessary to organize teamwork. The work process in this *Caps* III is organized with 40 mental health professionals, distributed into 3 multiprofessional teams, assuming a reciprocal relationship between the multiple technical interventions and the interaction of the agents of different professional areas. Therefore, each inserted user is accompanied by a team and has one or more reference professionals responsible for designing, applying and evaluating the therapeutic project together with the users. The reference team/professional is based on the principle of comprehensiveness and supports health care in interdisciplinary logic and in constructing a link, in order to respond to their health demands in an expanded way[9].

In order to achieve an interdisciplinary combination, it is necessary that the team organize itself in a way to understand the relationship between different professionals that conform the light technology in the context of their social relations and those with the users, recognizing or not their subjectivities[6,8-9]. This convergence between the reference team's organization in the interdisciplinary perspective is an important element in organizing the work process, which is only possible when taking into account the subjectivity of the subjects, since the way of thinking, feeling and acting interferes in the way to produce health in a service[7,9].

Still regarding the context of teamwork in the *Caps* III studied, integration difficulty has resulted among the professionals. When the observation was made at a meeting of one of the reference teams, the professionals informed us about the distancing of the nursing team, as they observed that this team was not included in the production of the therapeutic processes. To overcome this problem, the possibility of creating reference pairs to include the nursing team was discussed in an attempt to improve the relationship, care and referencing.

In this work perspective, the construction of a relationship between users and professionals is supported by the current community-based health policy and organized in a network which enhances the embracement approach, contemplating the social and subjective determinants, strengthening the care concept from the promotion of life, which results in a joint construction of personalized therapeutic projects for the PAS users[2,4-5,14,17].

Embracement and anti-relation with drugs

The way in which the teams organize themselves in *Caps* enables considering different embracement approaches for PAS users, one of which is highlighted in this study deals with an anti-relation with drugs: the embracement is focused on clinical signs and symptoms and not on comprehensiveness, in addition to the team members emphasizing the need for user abstinence so that they can be attended/cared for in the service.

Regarding the clinical evaluation approach which mainly consists in treating signs and symptoms[18], from the professionals' statements it was possible to observe a tendency to prioritize the clinical approach. *When (the patient) arrives under the effect, embracement is performed by trying to see/determine their usage quantity. If they are very abusive, I take the necessary conduct with medication, and talk* (I12). *I call the nursing team to check vital signs, to observe, to give some medicine, to prescribe hydration, we will observe how they are when abstinent. This is also embracement* (I2).

In modern scientific thinking, the biomedical paradigm is dominant in health practices[18]. Health and disease in this model are seen as polar opposites, and the health professional has the role of eliminating disease, while the person attended in the services and the context in which they live are neglected[18].

In work relations, subjectivity is a dominant factor for constructing the productive process. Subjectivity construction comes from three different planes. In the first, the search for what is desired by the person starts from social relations marked by aggression against the other, which is always considered a potential rival. In the second, the attainment of desire is delayed by the sense of security expressed by accumulation, the other is a potential antagonist, but with whom one must negotiate or submit. In the third, the subjects start from the reality of class dispute, but try to reverse the situation from the articulation of new relations that institute a continuous process of understanding[14].

Thus, it is understood that in the foreground of subjectivity, drugs are commonly understood as a rival to the healing process, and must necessarily be eliminated from the subject's life, not taking into account the social, economic and cultural context that the patient comes from, and which influence the construction of their health/disease process[5,14,19].

The interviewed workers presented themselves, in many moments, according to the biomedical paradigm. *We end up working even more on the symptoms that these drugs can cause, they are psychotic, they become aggressive, we deal with the clinical side rather than the drug side* (I8).

In the second plane of subjectivity, disease continues to appear as a potential rival, but one must consider the other, the user subject of the system, with whom one has to negotiate. However, this process is marked by the power relation and the accumulation of medical knowledge, which leads to the submission of the user in constructing the therapeutic project[14]. Thus, the approach based on the biomedical model is insufficient to meet the demand of people seeking health services, for not taking into account the subjective dimension of users, reducing them to coadjutants in solving their illness[5,7-8,19].

When professionals only offer an evaluation centered on the biological perspective, they are excluding other essential aspects for understanding the symptoms from the therapeutic project, such as individual experiences of gender, class and culture that can be part of the construction of mental suffering[19]. In this way, health professionals are limited to dispensing medications, conducting clinical examinations and controlling symptoms until the medication is effective and tending to repeat the basis of asylum care models[17,19].

This movement may also indicate the exclusion of the worker's subjectivity as a starting point for constituting relationships that contribute to constructing creative user embracement that incorporates the ways of living of those who demand care.

A study carried out in a basic health unit revealed that factors such as feelings and personal characteristics of the workers, lack of capacity to embrace the PAS users, and the perception that mental health professionals would be more effective and adequate than the nursing professionals produced a logic that avoids accountability for care and maintains health care fragmentation. A fragile empowerment of nursing professionals in multiprofessional teams was also observed and the effects of training still based on the biomedical model, which reproduces vertical and hierarchical modes of professional relationships[9].

We emphasize the coexistence of the medical and psychosocial models, since the discourse values health promotion actions, emphasizing the protagonism of the users; however, the observed practice remains linked to the technical procedures and hierarchizing the knowledge. Users rarely appear as members of spaces for planning, operationalizing, controlling and evaluating the performed practices, which may indicate that their potential is little explored as a provider of useful and relevant information that could contribute to consolidating practices that correspond to the needs of each community[9-10].

The professionals presented a vision of the health/disease process in which the treatment of the biological condition makes it difficult to understand the individual in a comprehensive way, suggesting their referral to a more specialized service. *If it is identified that the patient is under the influence of a psychoactive substance, the embracement ... identifies and forwards them, there is no way you can treat a patient if they have classic signs of intoxication. We usually refer them to the PA* (I1).

Expanded clinical treatment can be an alternative that contemplates care comprehensiveness, directing the professionals in performing user embracement in order to enable dialogue between the team and the individual PAS users[7-9,11].

In order for the health process to meet the logic of the expanded clinical treatment, it is necessary for the workers to be integrated as a team and as a service. Fragmentation of the work process, the lack of reflection and dialogue in the teams favor building disintegrated and decontextualized practice[8-10,17].

In the field of study, the principle of comprehensiveness presents itself as a challenge to be reached in the professionals' statements, since when referring to the PAS users, they still position themselves in a medico-

centered way. *A patient of ours arrived visibly altered, had signs and symptoms, dilated pupils, very fast and always denying* (...) *I communicated with the doctor who was on call and together with him we medicated the user* (I13).

From a medical perspective with emphasis on the symptoms and on the first subjectivity plane, comprehensiveness exclusion occurs pointing to anti-relation with drugs[14,19]. Thus, several testimonies indicate the need to take the drug out of the service, it cannot exist in *Caps*, and therefore those who use it cannot be accepted when they are under its influence. *Many times we dismiss the person, we just tolerate their presence here in the environment, given that they have substances* (...) (I5). *Outside it is ok, but when they arrive and you see that they are doing drugs in here, the approach is usually very complicated, what should we do? Are we going to throw out the drug along with the patient? Ask them to leave and keep the drugs and find a way back? Why not, we're not really dealing with it anyways* (I12).

However, this situation is not always simple, since drugs are often included in the subjective dimension and cannot be easily excluded[20]. This fact refers to the question: what to do with the patients that use PASs?

It is important to remember the role that PASs occupy in human societies, since their use has always been present, be it in a religious, ritualistic, medicinal, economic, social or cultural way, and they are widely instituted in our society, above all by their economic bias[21]. From the individual point of view, the PASs are often indispensable for the subject for several reasons, as they bring relief, pleasure, and inclusion in social groups. Thus, excluding the drug from the subject's life is not always a viable option[20-21] because by executing this option, treatment is supported by abstinence, which may imply in a bias for embracing these subjects by an exclusion perspective.

However, abstinence is a care strategy that does not apply to all users, varying according to the different usage patterns and their particularities, and can in many cases lead to a lack of adherence to treatment, to an ineffectiveness of health promotion, also preventing insertion of the subject in the service[20]. One strategy to reverse this situation is harm reduction, which does not turn to abstinence as an objective to be achieved, but rather to the care and insertion of PAS users to the health services[4,8].

Understanding harm reduction from the perspective of extended clinical practice can facilitate the opportunity for the subject to build new relationships, allowing existential composition with different possibilities, enabling them to assume the role of subject rather than object of the drug.

Embracement and the relationship with the person

When analyzing the interviews, it was possible to perceive heterogeneity regarding the embracement performance of PAS users. Some of the professionals were more inclined to listen to the user in their totality and complexity. *Trying to understand what is happening to the person who has come here for some reason, I try to think of the reasons that have brought them here* (I11). *We put the question of suffering, how the subject relates to their life, the drug question is not something I consider, I do not take drug use as a priority, I take the subject as a priority* (I7). *Listening has to be focused on what this individual brings in the sense of social relations, of the implications of family relationships, of what this causes for them* (I3).

Among the subjectivity planes, the third is characterized by the conception that the other is always subject, starting from the reality of the conflict of interests, focused on the attempt to articulate new relations, based on solidarity and a continuous understanding process to resolve such conflicts through negotiation[14]. Listening to the user in their complexity allows an alternative to support embracement in the comprehensive context which can be based on the reference of the person-person relationship, which is characterized as a relation of help under a therapeutic perspective based on humanism[15,21].

Empathy is the ability to intra-inhabit the other, to see and feel the world as it is to them and to articulate what has been learned by doing so. When establishing an empathic relationship, it is possible to open the way to contact that other reality and risk commitment to it, which can support the clinical approach[15], as shown below. *I think this is about this embracement too, about a situation, the moment the person is living, about getting closer to that dimension of what that means for them* (I9).

It is understood that in order to carry out a humanized reception, to build a person-centered therapeutic project, it is important to listen to their requests and to be able to respond to the demands and provide more adequate responses[7-9]. Through empathy associated with the strategies that professional can implement such as a guiding attitude, listening and genuineness, it is possible to build an embracement capacity that allows the person to develop relationships that guarantee their independence.

The guiding attitude is a principle of the person-person relationship that the professional supports and that enables the person to develop resources to deal constructively with all aspects of their life[15]. For this, it is necessary that the worker has a "formative tendency" that can be understood, enabling confidence to listen

to their beliefs, fears and anguish[15]. In the field of study, part of the professionals refer to this attitude in the contact with the substance users. *It is much easier for you to intervene, for you to get some kind of reflection, resignification, to change conduct with the person from the point that you have something built with them (I10). They are the ones who will say the consequences of what they have, what they are feeling, they have to tell me, because they know, they are feeling, they are living and that I am there to help them on this journey* (I4).

Listening in the relationship to help does not only refer to the auditory capacity, it includes all the senses with which one is able to perceive reality, becoming aware of the organism as a whole, body and mind, feeling and thought[15].

A possible reading of the statements from some professionals leads to recognizing that they point out an attempt to re-signify the user's speech, allowing to understand the person in their complexity as a being endowed with thoughts, feelings and autonomy. *So, I think attending a user who uses drugs, I always see the suffering, the issues that the user brings that cause him to suffer, that harm, that causes them to have harm in their daily life (I6). In fact the first thing is to try to understand the dynamics of the case, the structure, what comes from this subject, and I think that thinking about the use of drugs ends up being a consequence of the construction of this case, in what way the drug came into their life, why* (I4).

Authenticity must be present in every help relationship, insofar as any attitude taken by the health professional is accompanied by their awareness of that action, and therefore there is a congruence between the word and act, consistency of action, in order to establish a relationship of trust and bond[15].

Considering that a person who has been hospitalized has a life articulated to PAS use, the possibilities of care are extended from a solidarity perspective and contextualized to their existence, based on the relationship established between the mental health worker and the PAS user, because it recognizes the potentiality of a person to find solutions to their challenges. It withdraws the understanding that the drug is a problem, and one begins to consider the positivity of the relationships established by the person, and consequently their ability to construct their own paths is considered. Congruence depends on the person's perception of the genuineness of the workers, and in this way the professional must seek to align the theory with their daily practices[15].

Therefore, care management in the context of a *Caps* III can be reconstructed considering the way clinical practice is performed, by redefining what is understood by the health/disease process, abstinence and subjectivity of the people involved in the care[14]. This reconstruction depends on new embracement approached agreed on by the team from a theoretical outline that enhances the relationship with the person, from empathy, guiding attitude, genuineness and congruence.

Final Considerations

This study enabled understanding how a multiprofessional team of a *Caps* III embraces PAS users through three categories: the context of teamwork in *Caps*, the anti-relationship with drugs, and the relationship with the person.

In order to embrace PAS users in a *Caps* III, the service organization in the logic of reference teams was identified; however, it was clear that such a strategy is not operative to reconcile the distancing of the nursing team that was not included in producing therapeutic processes. Such scission was also observed in the user embracement when workers prioritize physical signs and symptoms based on the biomedical model and considering the drug as a rival to be fought. At other times, medical knowledge becomes the fundamental point of the power relation and leads to the submission of the user in construction of the therapeutic project, which also excludes their subjectivity. At the same time the workers install the embracement from the relationship with the person, marked by listening and focusing on the attempt to articulate new relationships, supporting the embracement in the context of comprehensiveness.

The contribution of this study is the presentation of an alternative for PAS user embracement that transcends the biomedical model, which is based on the first and second subjective plane, and consolidates the articulated embracement to relational technology, based on principles such as empathy, genuineness and congruence, so as to enhance the relationship with the person and minimize the team's anti-relationship with drugs. This category also showed a challenging issue that refers to the user's acceptance when they are under the effect of PAS, which denotes a change in mental functions, including language itself. As an alternative, it is possible to highlight the development of actions by the multiprofessional team that do not require abstinence, since (as already discussed) the PAS may be indispensable for the subject, including to insert themself to the *Caps*, which may imply in excluding the user in performing the embracement.

This study was limited by the circumscription of the scenario, however what can be taken away is that thee relationship with the person can be a focus of the embracement in other scenarios in which the suffering

is articulated to PAS use. In this way, it is possible to find embracement approaches that consider the third subjective plane, focusing on the person of the PAS user in the context of current public health policies.

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