

Investigación

THE CONCEPTIONS OF HEALTH SERVICES MANAGERS ABOUT THE NETWORK OF PSYCHOSOCIAL CARE FOR CRACK USERS

LAS CONCEPCIONES DE LOS GERENTES DE SERVICIOS DE SALUD SOBRE LA RED DE ATENCIÓN PSICOSOCIAL PARA USUARIOS DE CRACK

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ABSTRACT

Objective: The objective of this study was to learn the conceptions of health services managers about the network of psychosocial care for crack users. **Methods:** Qualitative and evaluative survey using the Fourth Generation Evaluation framework. The survey was

performed at a center for psychosocial care for alcohol and drug abusers in a municipality of the State of Rio Grande do Sul, Brazil. Data were collected from January to May 2013, through guided interviews using the hermeneutic dialectical circle. **Results and Discussion:** Managers revealed their conceptions about collaboration between sectors in the care network, recognizing the services provided by the psychosocial care network and the coordination of those services. They also displayed understanding of the importance of partnering with mechanisms from other sectors of society. **Conclusions:** Municipal managers have endeavored to build a user-focused mental health policy with coordination between sectors, advocating for the principles of psychiatric reform and psychosocial care.

Keywords: Mental health, health services reform, continued health care network. drug abuse.

RESUMEN

Objetivo: El objetivo de este estudio fue conocer las concepciones de los gerentes de servicios de salud sobre la red de atención psicosocial para usuarios de crack. **Métodos:** encuesta cualitativa y evaluativa utilizando el marco de evaluación de cuarta generación. La encuesta se realizó en un centro de atención psicosocial para los consumidores de alcohol y drogas en un municipio del estado de Rio Grande do Sul, Brasil. Los datos se recopilaron de enero a mayo de 2013, a través de entrevistas guiadas utilizando el círculo dialéctico hermenéutico. **Resultados y discusión:** los gerentes revelaron sus concepciones sobre la colaboración entre sectores en la red de atención, reconociendo los servicios prestados por la red de atención psicosocial y la coordinación de esos servicios. También mostraron comprensión de la importancia de asociarse con mecanismos de otros sectores de la sociedad. **Conclusiones:** los administradores municipales se han esforzado por construir una política de salud mental centrada en el usuario con coordinación entre sectores, abogando por los principios de la reforma psiquiátrica y la atención psicosocial.

Palabras clave: salud mental, reforma de los servicios de salud, Red continua de asistencia sanitaria, abuso de sustancias psicoactivas.

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INTRODUCTION

Important changes have been observed in the last few decades regarding both knowledge and practices in the field of mental health. The consolidation of the global psychiatric reform movement triggered the dismantling of the asylum-focused tradition. Practitioners now advocate for an understanding of mental

health issues that takes into account differences across cultures, care locations and care scenarios. Fostered by the Italian reformist ideology of the 1970s, the psychiatric reform movement came into being as part of a process marked by the ideals of strengthening territory-level networks and changing the psychiatric

The conceptions of health services managers about the network of psychosocial... paradigm supported by institutionalized care in closed institutions.

The main purpose of the reforms was to show that the asylum-centered process was born of an ideology that believed that asylums were the best way of delivering mental health care. The reforms not only broke with the asylum paradigm, but also demanded a new concept of public policy tied to the need to rethink services, relationships and people. The concept of mental health care in the context of contemporary reformist approaches recognizes the importance of understanding the quality and power of patient participation in their own rehabilitation, in contrast to the earlier method of isolating them in asylums. In other words, rehabilitation should be based on plans for care and treatment that respect differences, diversity and individual needs. Treatment becomes a partnership carried out through humanized environments and services that favor patients being empowered and having a voice^(1,2,3,4).

In the Brazilian context, the changes introduced by global reformist movements took place in the 1980s, with the participation of social movements related to the innovative view that care can be delivered outside asylum walls. In this sense, the idea of coordinated service networks emerged as one of the main methods for overcoming the hospital-centered model. Some examples that are crucial in this field are psychosocial care centers (CAPS, in Portuguese), socialization and culture centers, psychiatric beds in general hospitals, opening clinics on the street, and the effective participation of primary care⁽⁵⁾.

These and other care sites have also served as locations of care of drug users for whom, up to then, psychiatric hospitalization or care in large outpatient units were the only options. However, it is observed that such users still suffer due to the moralism and prejudice that still persist in Brazilian culture and that perceive drug users as people who cannot live in society.

In an attempt to consolidate a new perspective to overcome these issues, the Brazilian Mental Health Policy has discussed the specific incorporation of drug abuse in a community-based model. This approach emphasizes that users need freedom to move within cities, but should also have access to treatment in special cases and when the need arises; all treatment should take place in their communities, not separate from their life contexts. In this light, Decree 7179/2010 and Administrative Rule 3088/2011 launched the Integrated Plan to Tackle Crack and other Illegal Drugs and the psychosocial care network (RAPS, in Portuguese)^(6,7).

In line with the premises of the National Health System, which ensures universal access, equal care and humanization, mental health care should be capable of building awareness in different territories and cultures, as well as the individuals who make them up. However, Brazil is such a large and diverse country, with such great inequalities, that municipalities must both comply with national guideline and establish policies based on local health needs. This means that Brazilian municipalities are free to organize their care networks according to actual priorities in regional health agendas.

Thus, health care actions that include drug users demand efforts to integrate care with other local social policies (education, social assistance, health, culture, justice, housing, etc.), which poses yet another challenge to municipal health managers. Therefore, it is relevant to understand conceptions of management and managers regarding networks, since managers are important social actors and their ideas are the basis of effective implementation of guidelines in practice.

In view of this situation, this study aimed to get acquainted with the conceptions of managers of mental health services about the care network for crack users. It was intended to show relevant aspects of the decision-making process regarding social policies that, despite being tailored to the local level, could contribute to rethinking guidance at the regional and national levels.

METHODOLOGY

The present study is part of the research “Qualitative evaluation of network services in mental health care for crack users (Avaliação qualitativa da rede de serviços em saúde mental para atendimento a usuários de crack)”, (ViaREDE) funded by the Brazilian Ministry of Health and the National Council for Scientific and Technological Development (CNPq). The study an evaluative case study in a Brazilian municipality and used the theoretical-methodological framework of Fourth Generation Evaluation⁽⁹⁾.

Fourth Generation Evaluation is constructivist and responsive in nature; it

is built through an interactive process of negotiation among relevant groups directly involved with the object under evaluation. As individuals become involved in the evaluative process, they begin reflecting and come to a better understanding of their reality, expanding the possibilities for intervention⁽⁹⁾.

This study subjects were seven health workers who held managerial positions in mental health services in the municipality under study. The managers were assigned to the following services: a psychosocial care center specifically aimed at providing care for drug users; a psychosocial care center to provide care for children and adolescents; a psychosocial care center to provide care for general psychiatric disorders; the hospital of the municipality; and the primary care technical area. Additionally, the municipal health care coordinator participated in the study.

Data were collected from January to March 2013, through participatory observation and semi-structured interviews using the hermeneutic dialectical circle. The circle is hermeneutic because of its interpretative nature, which makes inferences and interventions. It is dialectical because it allows people to disclose their viewpoints and to be introduced to those of others, so there is a product (summary) based on a diversity of opinions⁽⁹⁾ (Figure 1).

The circle works as follows: an initial respondent (R1) participates in an open-ended interview to establish an initial framework in relation to the focus of the study. The respondent is then questioned and asked to comment on, further describe, and build on that frame-

The conceptions of health services managers about the network of psychosocial... work. At the end of the interview, the respondent is asked to suggest another respondent (R2).

The core topics, conceptions, ideas, values, concerns and questions posed by R1 are analyzed by the researcher, who formulates an initial

construction (C1). The second respondent is then interviewed, and if any of the construction posited by R1 is not accepted by R2, then R2 is invited to comment. The interview with R2 generates information on R2 and also criticism on C1.

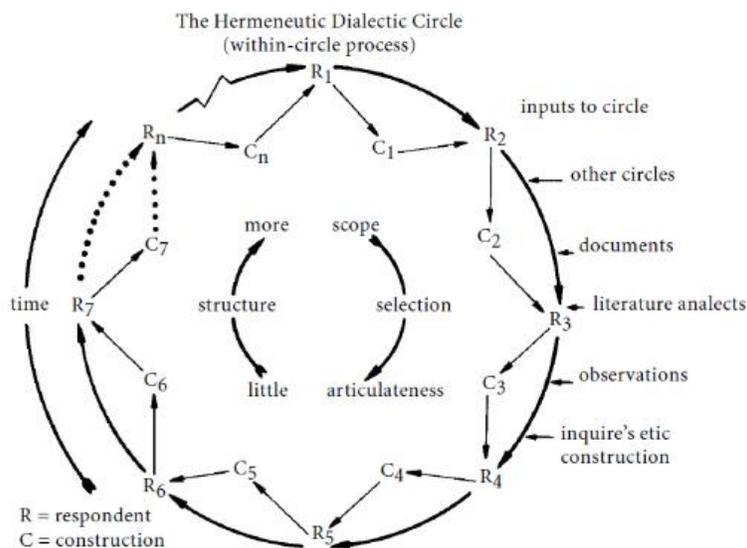


Figure 1. Fourth Generation Evaluation. Source: Guba, E., & Lincoln Y., page 159, 1989, Sage, Newbury Park, CA.

The researcher concludes the second analysis, which results in C2 – a more sophisticated and informed construction – and so on, until data collection is complete.

This method demanded simultaneous analysis and data collection, where one guided the other, based on the constant comparative method⁽¹⁰⁾. After data collection and the organization of each group's constructions, the negotiation stage was started. Respondents assembled and they were presented with the results of the preliminary data analysis, allowing them to change information or restate its reliability⁽⁹⁾.

After debate about the preliminary results, the changes recommended during the discussion were incorporated into the data and the final content was regrouped, allowing for the construction of thematic categories.

The project was submitted to the Committee of Ethics in Research of the Federal University of Rio Grande do Sul (UFRGS) for evaluation, and was approved (Protocol 20157/2011). Likewise, it was evaluated by the National Council of Ethics in Research of the Brazilian Ministry of Health, and was also approved (Opinion 337/2012).

To comply with ethical practices, inter-

viewees were informed about the project and voluntarily agreed to participate, and the agreement was recorded in a specific document. Brazilian ethical rules recommend that researchers present individuals with a document called “Free and Informed Consent Terms.” It summarizes the main instructions regarding ethical requirements (risks, benefits, and potential contributions of the survey, among others) and guides the participation of the respondents. To ensure anonymity and confidentiality, individuals were identified with the letter “G” followed by the order in which they were interviewed (e.g., G3, G1).

It is worth mentioning that in a proposal for participatory evaluation, the process could not be different, as the methodology requires group participation throughout the process in an informed and voluntary way.

RESULTS AND DISCUSSION

The emphasis on the need for care involving different sectors of society was a topic of the 4th National Mental Health Conference of 2010, which discussed cooperation between sectors. The discussion resulted in more mature ideas about the psychosocial care network (RAPS), which aims at building, expanding and coordinating health care units in the Brazilian Unified Health System (SUS) for individuals with mental disorders, including those with needs resulting from crack, alcohol and other illegal drug abuse^(11,12).

In the targeted municipality, the psychosocial care network is made up of a number of components such as:

psychosocial care (CAPS care of adults, children and adolescents, and users of alcohol and other illegal drugs; basic health care (health units, family health strategies and clinics on the street); urgent and emergency care (emergency services); and hospital care (psychiatric beds in general hospitals).

In addition to the CAPS we have the hospital in the municipality [...] the CAPS itself also provide detoxification services. The basic health units, as part of the health network, also support patients when they are stabilized, and also when they are discharged (G2).

CAPS II also performs this task of delivering care, provided that we understand that [the drug] abuse is followed by mental disorders, we have a CAPS i and a CAPS AD. The clinic on the street [...] starts being incorporated into mental care services that will contribute to referring users, approaching them on the streets (G3).

Among these services, clinics on the street are the psychosocial care mechanism most recently implemented in the municipality, and they are recognized as useful in approaching drug users in their territory of circulation. Moreover, managers stated that the psychosocial care centers also provide care for many other kinds of problems involving users, negating the concept that only problems resulting from drug abuse are within the responsibility and competence of specialized services like the CAPS AD.

However, health services are not the only providers in the network of care sites for drug users in the municipality:

We have the network made up of other secretariats, the social assistance

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secretariat, education secretariat, and other areas of culture. So we end up working with social assistance, which is composed of the Social Assistance Reference Centers (CRAS) and Reference Centers Specialized in Social Assistance (CREAS), to monitor closely (G2).

Among other mechanisms external to the health sector that also provide services to drug users, we can highlight the schools, the CRAS and CREAS, the education and culture secretariats, and other civil society sectors.

Coordination of the network of health care service sites is an attempt to provide users with the possibility of social insertion to provide integral care, and this is achieved mainly through joint actions performed by different sectors. In this sense, coordination of managers from different services and sectors is required to draft guidelines, agree on actions, and monitor and evaluate the implementation of policies oriented to drug users.

This is about considering that cooperation between sectors allows a combination of different possibilities for building real-life projects that include user needs⁽¹³⁾. Thus, networking is crucial to providing care to drug users.

I believe networking is crucial, at least to help in the cases. Networking with government, hospitals, with the neighborhood association. After these contacts with the neighborhood association, I'll leave here and see what is happening. Undertake an outdoor activity; hold a workshop in the workplace. I go to streets, to meet the society, the community (G5).

The wide range of care mechanisms in the territory is crucial to

providing care for drug users, and also involves aspects such as housing, work and leisure. However, this concept once again reinforces the need for coordination. Thus, in terms of operations, it should take place based on the engagement of professionals with actions performed in the territory, such as workshops, in-services and out-services, contacts with community mechanisms, and links with civil society.

Networked health care actions remain a great challenge to Brazilian managers, most notably because they are required to carry out enforcement and surveillance of public policies. Those requirements demand that their responses ensure the fundamental rights of citizens, mainly in the context of noticeable social exclusion, as occurs in care for drug users⁽¹⁴⁾.

It was noted that for managers, collaboration between sectors was one of their ideas about the care network for crack users in the municipality. However, the conception of care networks involving institutions and services is not limited to the formal domain of social policies, as it also refers to a network of relationships established by people in their everyday lives, pursuing support for handling the vicissitudes of life:

The care network, apart from public policies, is a challenge posed when I talk about the line of care. It is about perceiving the users' own networks, what would benefit them when they have access to it. [...] This population has its own network, their clubs of mothers, residents' associations, the local church; we should prioritize investments in territories [...] people are the ones to do it (G1).

The network of relationships may vary according to the types of associations that characterize them. Thus, social associations may involve religion, community, youth, sports, women, health, education and information groups. Political associations comprise trade unions, professional associations and political parties. Newer political organizations comprise environmental, peace and animal rights groups and groups of supporters of collective rights and citizenship⁽¹⁵⁾.

It was observed that the emphasis on relationships fostered by managers and probably also by services (workers) is mainly on social associations. This is evidence of the relevance of these kinds of relationships to meeting user needs. At the same time, it shows the need for expanding ways to associate with mechanisms and individuals in the network, seeking for associations at the political level and at the level of new organizations.

When building social networks, individuals establish relations of exchange with their families and others, building expanded and diversified networks. These elements embody a conception of care networks that are also tied to user relationship networks that, although being guided by public policies, should be evaluated, built, strengthened or even weakened, as the case maybe, during the processes of providing care in services, mainly from the professional-user relation⁽¹⁶⁾.

This does not relieve managers of their responsibilities for taking account of users' networks of relationships in the organization of care network mechanisms. We frequently observe that users,

even when they have access to specialized services for treatment, have difficulty with continuity of care because they access parallel networks that are sometimes not part of the formal structure of the services⁽¹⁷⁾. It discloses the importance of understanding that psychosocial care services must be offered through public policies that are capable of being managed with enough vigor and flexibility to absorb user movement within the network, and the relationships initiated by users to solve their difficulties and problems.

In this sense, managers believed that finding mechanisms for agreement among managers of different services in charge of providing care to drug users is crucial to consolidating public policies. In the municipality under study, the solution was to build a protocol for care processes that clearly showed each manager's responsibility in this process:

We built together and implemented a protocol of care processes in the field of mental health. So, several institutions signed the protocol, because partnerships were built. [...] The Prosecutor's Office signed this protocol [...]. We invited the hospital, the SAMU to discuss it. That is what we are trying to do regarding the possibility of shared care, because thinking about network means thinking about shared care (G1).

More than facilitating systematic meetings to discuss problems related to services provided by the network, the protocol for processes for mental health care, as agreed upon by managers, was also endorsed by institutions from different sectors of society (CAPS AD, adult and child CAPS, primary care, the general hospital of the municipality,

The conceptions of health services managers about the network of psychosocial... emergency care, urgent care, mobile services, the prosecutor's office, etc.). This protocol describes the role assigned to each service, highlighting the regulatory role of the CAPS regarding care for users of mental health services. According to the document, this care is driven by the psychosocial care model and proposes actions for prevention, promotion and treatment in health care, and social reinsertion.

Therefore, the managers' conceptions were aligned with building public policy focused on user needs. When the managers of the surveyed facilities support initiatives for building proposals tied to the current assumptions of national policy on mental health, they make clear the commitment of their institutions to the right to care and the valuation of the SUS as a state policy.

CONCLUSIONS

This study revealed some conceptions that provide guidance to health managers in decision-making about the development of an agenda to qualify and expand mental health care. These expanded conceptions recognize the importance and relevance of utilizing different strategies that enable organizing the network based on local needs.

Among the core characteristics that guide managers in the policy-making process, collaboration between services came up as a guideline for trying to coordinate social equipment, other health care sites, and partnerships with other public services and the civil society, in order to consolidate a policy compliant with the premises of the Brazilian National

Health System and its attendant psychiatric reforms. According to the managers, collaboration between sectors is not an initiative but a co-responsibility. This means that, in the case of the phenomenon of abuse of illegal drugs, cross-sectoral composition should align political discourse and trigger an individual-centered care philosophy, i.e., one focused on individual needs and realities.

The managers' understanding of the importance of dialogue with current, innovative approaches to the psychosocial field shows their commitment to providing care free from the prejudices and moralizing that segregate and oppress individuals.

Although the results of the study apply to a local reality, they could contribute to guiding practices and knowledge in the field of psychiatric reform, since the movement has become of one the most well-known global symbols in the fight to build more decent and inclusive societies that are sensitive to individual differences.

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