

CRACK AND CARE MANAGEMENT IN THE TERRITORY: CHALLENGES ON WORK EVERYDAY IN MENTAL HEALTH¹

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ABSTRACT

This article aims to analyze the challenges faced by mental health professionals in the management of care that crack users in the territory. It is a qualitative and descriptive research. The field of study was a Psychosocial Care Center Alcohol and Other Drugs (CAPS AD) of a city of the metropolitan region of Porto Alegre / RS. Semi-structured interviews were conducted with eight mental health service workers. Data were analyzed from the thematic modality content analysis. The results show difficulties and limitations that are presented in the health care of the everyday, the management of territories in the context of the user, the need for territorial delimitation and activities that address the knowledge and the live user, reinforcing the professional output to the EU. It also points out the need for strengthened inter-sectoral network that corresponsabilize together with mental health care, removing the CAPS paper only reference. It concludes that the care management in the territory is multifaceted, also being held by the employee in the daily service and to the relationship of social actors to the plot of the territory.

Keywords: Mental health. Mental health services. Crack cocaine.

INTRODUCTION

The crack appeared between 1984 and 1985 in poor and marginalized neighborhoods of Los Angeles, New York and Miami. The profile of the users was formed by young, refined cocaine users who were attracted by the low cost of the substance, and even users of marijuana and poliusuários who added the crack to their consumption patterns. The scenario of the consumption of crack widens in Europe and in emerging countries, Brazil is the largest consumer of South America^(1,2).

Aspects related to the social context of consumption of crack damage related to the health of the user. The beginning of the usage has association with other psychoactive substances, with social consumption models of society and the low cost of the drug. Access is facilitated by ineffective public policies, social values that stimulate consumption and easy access. In addition, the terrible quality of the drug enhances the standard compulsive use, having consequences on the physical, mental and social health of users⁽³⁾.

In this perspective, the use of crack can be considered as a social and public health problem,

involving not only the physiological aspects of addiction, but also all the context that surrounds it. Going to meet those issues, the Ministry of Health launched in 2011, a proposal for the establishment of a network of psychosocial care (RAPS), responsible for the care for people with recurring drug abuse needs, having in the territory, the main space for interventions related to social reintegration of drug user⁽⁴⁾.

The territory is qualified by the subject space. And it's not just physical, but also political, social. In it are the historical and social brands of populations and is where are the networks and relationships of subject⁽⁵⁾. The territory is discontinuous, being a force field, a Web of relations, composed of different territorialities which constitute and transform this space, giving it a standalone character and dynamic⁽⁶⁾.

Thinking the user care crack based on the territory, a care management in the territory that is not limited to a design only linked to technical and administrative issues, the power of the State over the unified health system (SUS) and the role of managers in the construction of strategies for improvement of services. The management proposal widens as it is built by various social actors, incorporating the daily life of workers, and social network users. Is made up of

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autonomous territorialities, and considers that each subject that belongs to a certain space has the power to territory.

In this sense, it is possible to discuss a multifaceted management, with several dimensions, namely: individual, family, organizational, professional, and corporate. Individual management depends on each subject, is the "spoil yourself", considering that every individual can make choices in life, move, have the autonomy to take care of yourself. The family dimension is important in different moments in the life of the individual, where he has relatives, neighbors, friends, health care⁽⁷⁾.

The professional dimension is one that gives the encounter between professionals and users, and takes care of micropolitics in health. The organizational dimension is marked by worker process, dependent on the cooperative action of several actors to reach the territories marked. The systemic dimension are the movements of the users by the Health system, their routes across the network. And, finally, the corporate dimension is the role of the State in society, in the construction of public policies and social policies. These dimensions do not occur separately; There are connections between several dimensions, producing a complex network of points, shortcuts, ways and possibilities⁽⁷⁾.

Imagine if a careful management in the territory for the crack user taking into account psycho-social attention need to be thought of in different territories, on various dimensions of care, the micropolitics for the micropolitics and vice versa, in order to build health networks that recognize the existence of a rich territory of living forces and autonomy. In this regard, the need for discussion of a management that recognizes the user's territory of crack as a social space, movement, history, being multifaceted. This recognition extends looks for a management that articulate with the community and who view the needs of the subject.

Thus, the objective of this article is to analyze the challenges faced by mental health professionals in the management of care to crack in the territory.

METHODOLOGY

This is a qualitative study, descriptive. Used, as theoretical-philosophical, the concept of territorial network⁽⁶⁾. The territory comprises a discontinuous territory network, formed by the diversity of social relations and power. Is a network made up of different territories, with varied shapes and different territorialities?

This concept is appropriate for understanding the care when crack user, once, in the field, the network is organized psychosocial from the projects of people's lives and the way they experience their territory. In this way, the network must be thought of in their dynamism and diversity of social relations that make up this articulation of territorial networks. In the case in question, i.e. the management of care in the territory, we discussed a multifaceted field that respects this dynamic built by territorial population.

The field of study was the center of psychosocial care alcohol and other drugs (CAPS) of a city in the metropolitan region of Porto Alegre/RS. The subjects investigated were eight service professionals from the following inclusion criteria: 1) be working for at least six months in the AD CAPS; 2) wasn't, at the time of the interviews, away from work (vacation, licenses, among others) and 3) participate voluntarily, allowing the publication of results, enshrined the issues related to confidentiality and anonymity.

An interview was held open with the following guiding question: "tell me what you mean by territory in care to crack". The interviews had lasting 20 to 30 minutes. The data collection was time of February 20 to March 7, 2013.

Data analysis occurred through the analysis of thematic mode content consists in discovering the nuclei of meaning that make up a communication whose presence or frequent as meaning something to the analytic object to be studied⁽⁹⁾. Has three phases, which are: the pre-analysis, material exploration and processing of empirical data.

In the first phase, the Constitution of the *corpus*, from the transcription of the information obtained from the interviews. It was held a reading of floating material, seeking to find, in your content, that answer the research objective.⁽⁹⁾

The second phase is the exploration of the material, which consists of the encoding operation, from what is considered as being the "creation of cores for the comprehension of the text". This familiarity has provided the development of "information drives", which indicated information and specific ideas in every interview. Was created a theoretical framework with the "information units" that grouped, formed "units of meaning", that, finally, two categories of analysis.⁽⁹⁾

The third and final phase consisted in the treatment of the obtained results and interpretation, in which the raw results were analyzed and discussed in the light of the theoretical framework and the literature of the area. With this, there were two categories of analysis. In this article, however, will be analyzed and described the results of the second category, which was the management of care in the territory.⁽⁹⁾

The project was submitted for evaluation by the Committee of ethics in research at the Federal University of Rio Grande do Sul (UFRGS), receiving a favorable opinion on the execution (20157 Protocol/2011). It was also, at the request of CEP/UFRGS, evaluated by CONEP/MS, receiving a favorable opinion on the execution (337/2012).

We follow the Protocol established by resolution 466/2012 National Health Council⁸, which deals with informed consent. To remain anonymous, the team members were identified with the initial "E", followed by the order in which they appeared in the interview. Example: E6, E3.

RESULTS AND DISCUSSION

Thinking the territory as a place of performance of services, composed of multiple dimensions, workers discuss how challenging the need for territorial delimitation for actions on mental health and improving user access to the service:

[...] Territory are subdivisions of the territory, which is a dimension. Is a territory inside the other: we're in a municipality, which is Rio Grande do Sul, which is inside of a macro-region? These territories of health do not respect borders, which are administrative boundaries, which are

the policies, but you have to delimit in some way for you to be able to conduct any action within that territory [...] (E8).

First you know that region and that territory and then you see what you need to do health actions to promote what is the demand in a particular area [...] For example, we know that particular place has a "mouth", using the example of our service of alcohol and drugs, and we know that there will be more people with a propensity for problems with substance use [...] (E8).

I think territory would be our area of coverage (E3).

Statements of E8 and E3, it is clear that the territorial delimitation is a strategy for the management of the territory, in which the Organization micropolitics of the network, in which divide the territories of comprehensiveness, interferes with the conduct of actions in the daily life of the service, that is, in its micropolitics. A "multifaceted", composed by these two dimensions, needs the delimitation of zones and places where the services will operate. It is the need to think "everyday", i.e. not just terms health services without considering the target population, their way of life and the regions in which this service will act. It is in this sense that we understand that a territorial delimitation inadequate could harm the performance of the services, making it difficult to understand the reality of the user.

Currently, the management Pact reaffirms the regionalization as fundamental guideline of the SUS, and should recognize the health regions and their singularities in each State and the Federal District. The health region should organize the health network to meet and ensure the universality, integrality and fairness⁽¹⁰⁾.

One of the instruments of regionalization is the territorialization in health, which allows the perception of health and living conditions of the population of an area assigned. This is one of the basic tools for the Situational strategic planning, which allows specializer and analyze the key elements and relations existing in a population, in addition to determining the degree of their health and social needs. So, for the organization of networks and work processes of health services territorialized tools requires the recognition of the territory and of its context of use, because they embody human interactions

and problems, giving subsidies to the health planning⁽¹¹⁾.

The importance of territorialization is brought by E3 and E8 in the CAPS effective AD. This service, inserted in a defined territory, must work in the light of needs observed in the context of the user. When E8 States that there are places that have the greatest propensity for drug users, demonstrates that the process of territorialization of SUS needs to incorporate the existence of territorial diversity and develop work processes to analyze these particularities.

In psychosocial care, we emphasize the territorialization of regionalization as an instrument essential for implementation of actions of the substitute services. The challenges to effective a territorialization with users ' needs are to recognize the territory as a movement, incorporating new practices capable of meeting the user, their way of life, their demands and their relationships.

The following statement demonstrates the multiple care management field in the territory, where the macropolitical organizations and micropolitics are closely linked to natural needs of each user:

We can act. Is that sometimes having the home visits that we see that particular place has more areas which we go more with the VD's and have certain sites that people can access more easy CAPS. For example, here in the central region, the guys can come easier for the CAPS of the people of the neighborhoods. Have to be made so that no local joints that territory be discovered [...] (E8).

Y8 reflects on users ' access to the service, pointing out that there are differences in access depending on the locale and the user's dwelling. When the user resides in a distant region, need the coverage and service connections to the network for the improvement of the service. In the case of users who are away from the service, and often do not access (or access difficulties) due to the large geographical displacement or of consequential economic barriers. It is necessary, therefore, to be coherence between offers and service coverage and the desires of users, going to meet the fundamental premise of equity to ensure health in SUS⁽¹²⁾.

In this way, the management of care in the territory mental health need to consider user access to the service, the barriers and the

facilities to do so. Access from the Constitution of the geographical space to the socioeconomic context of users, their individual needs, their beliefs and cultures and to adapt the services to these demands. Observing these factors, we realize the need of the composition of a network responsible and committed to the user.

In this perspective, the user's access to the service, as well as the professional user's territory is covered by other employees of the team, which demonstrate the need to occupy and meet the territory of life of subjects:

When he goes to get a treatment, hence the territory expands. He doesn't know all the services he can use, such as, for example, culture, education, health and sometimes when it does a health treatment, he met, passes to attend. So I think basically the territory is, in fact, it is our territory, but sometimes we don't know all of it, then it's basically braked the territory he lives that life their neighborhood works [...] (E6).

[...] The territory of who's user, and heavy user, and you've got an entire closed circuit, the circuit is part of it, but he does not encode the territory. Have some areas where there's another kind of relationship and are at times that we demand to be dwelling, giving strength to this increase, this circuit lose strength. Because if it comes to CAPS or accept the help out of here is because he accepts it has something better for his life and that's what everyone emphasizes, we try to work, what are the lines of fire of that circuit, right [...] (E1).

We talk much, we spoke of the case pro user to access the CAPS, it's geographically placed [...] Then, the user, we can understand that he has difficulties to access the CAPS, but while the CAPS in this territory is not subjective question, the territory will not be inhabited, won't be attended, the CAPS will not be part of the territory, he won't be part of being territory when it is subjectively placed the subject [...] (E7).

E6, E1 and E7 discuss the articulation between the territories, related both to the occupation health service by the user, as the occupation of the territory by the service. An interface that provokes improvements and quality on the user access to the service, the design of the service is part of this network of relations.

However, E6 proposes access to the service as an option for the user to enlarge his territory,

meet other devices and transform its relationship with the drug. On the other hand, E1 and E7 assess not only the need for the user to inhabit the space, as well as the service of the professionals living in the user's context, building a relationship of exchanges between different environments. So, the biggest challenge is to go beyond access to geographical barriers, realizing the need of the professional access to the subjective, symbolic and social territory, so therefore can build strategies of care to talk with the needs, desires and the realities of each subject.

This debate requires a connection with the prerogatives of psychosocial care. In one study⁽¹³⁾ was appointed to the "House" is the reference of the daily lives of people, based on his life story, his emotional and social construction. Health services can build a "bridge" for new social relationships, helping to organize the daily life of the user. In this way, will be working on social reintegration in exercising a function of mediation, preparation and training for life in the territory. Although often bring a character of dependence, the services can generate autonomy.

The "Street" is the biggest space users' trading, composed also by established relations with neighbors and merchants. The health service is a "good place", which users "like", but it is a place of complacency, where professionals evaluate their psychosocial vulnerabilities within a community of equals: users of the CAPS. On the street, social relationships require other types of exchanges, expanding its space trading⁽¹⁴⁾.

It is important to understand the necessary articulation between the different territories, since the House and the street are pointed as important spaces of social exchanges. Regarding the use of crack cocaine, many users use the street as their home, to the extent that inhabit and make use of the drug in public spaces. So, to that user who is under the influence of drugs, mental health service could represent a more aseptic space, which may cause estrangement.

Thus, the relationship that the individual has with your social space is essential in the construction of the watch. The CAPS have a challenge to produce a relationship and a social place different for the drug user and invent another way to work, to organize and articulate with the city, seeking inclusion in the symbolic

territory while user place of practice⁽¹⁴⁾. This is what we can see of the talk of E1 and E7, say that the CAPS still need to find a strategy to meet this reality and get close to the user's context.

While recognizing the need for a careful management in the territory, with an interface with the user's reality, the workers indicate that the fact not to move forward on the Constitution of a practice out of its walls still is a result of the "tunnel" of CAPS:

But I, speaking as a service, and how specific and unique service in the municipality, it is difficult to meet the territory, access the other places, I don't know, quilombola, native. [...] many times, you have to wait for someone to access the service you can get start some work there occasionally. There's plenty beyond that our microterritory, right, day in and day out, I mean, you take much so here and the outside you can't see [...] (E3).

The territory of CAPS is still inside, wrapped [...] (E1).

E1 uses the term "encapsulated" to mark the CAPS as an area restricted to the context of the service, with little coordination with the community. This term refers to a feeling of imprisonment of health team "within" the service, little is articulating with the community. Demonstrates the need for more careful not to be played old model features asylum practices and the pursuit of therapeutic projects that incorporate the uniqueness of the users and its relationship with its territory⁽¹⁵⁾.

E3 highlights the lack of a defined territory as the central problem of difficulty of exit from CAPS to the external context, causing an increase in service demand and the impotence of the worker in search of other strategies. The professional recognizes the CAPS as a "microterritory" formed by the relation user-worker and his working process even internalized.

The actions of the workers of the CAPS still seem restricted to the service space, leading often to the perception of what is outside of its jurisdiction would not be. In this way, the movement of "inclusion in community" ends up reverting to "inclusion in service", being that more compatible with traditional models that cronificam and institutionalize the user mental health⁽¹⁶⁾.

The proposed relationship between the CAPS and other spaces, like the community and intersectoral health network, is a need of psychosocial mode, which causes the service extends to the territory. In practice, the difficulty of relationship between the CAPS and the territory, which reinforces the reproduction of a model cronicador, characteristic of the asylum way⁽¹⁶⁾.

The concern of the CAPS in not "wrap" is presented in a search, which brings the experience of a city in the interior of Rio Grande do Sul which constantly search an internal organization of the service which causes more "out" outputs. Initiatives such as the community projects, participation in events, tours, parties, trips and exhibitions of the work of the users show up as strategies that cause movements of the service with the purpose of inclusion in the context of the society⁽¹⁷⁾.

The Ministry of health in the year of 2002 proposes that CAPS is the "originator" of the network. However, this term can refer to an ambiguous relationship with the network, because, while it can be set as strategic to managing resources, can also Center the care, in a pyramidal relationship of hierarchy⁽¹⁸⁾.

In addition to the need to articulate more CAPS with the community, it is important that the intersectoral network work together, giving coverage to their actions and having a shared responsibility on attention to crack user. We believe that the NET can also cause the "tunnel" of CAPS, to refer to him as the "Center" in mental health care, as if it were the only reference, the "originator of the network". A challenge inherent to the establishment of new ways of knowing/doing, in constant motion and experimentation.

FINAL CONSIDERATIONS

Think the care in the territory is to reflect on the difficulties and limitations that are presented

in the daily life of health care, the administration of the territories, in the context of the user, and on which the strategies we can perform in and out of the services so as to promote the psychosocial rehabilitation.

In this sense, this research presents as main evidence to think this care, the challenges of user access to the service, that go beyond geographical barriers, as well as the professional access to the user's subjective territory. In addition, the lack of an internal organization of the services working in the perspective of the territory as a living force, developing activities that contemplate the know and live and work processes that seek to strengthen the professional output for the EU.

Another challenge found refers to the need for an intersectoral network strengthened that corresponsabilize in conjunction with the mental health attention, removing the CAPS on the role of the only reference. Even if this is the strategic service in this process, should not be solely responsible or the Centralizer of caution.

The management of care in the territory is, therefore, a multifaceted field, composed of several dimensions, which should not be reviewed separately. Thus, the micropolitics in the daily lives of service and on the user's relationship with the employee interferes in the macropolítico context, i.e., in public policies and in the Organization of care. So, it is important that the territory is perceived as a space consisting of the brands of the population, their movements, power relations and the historical, cultural and social context of the subject. This realization helps with planning and territory management, influencing the daily life of health.

In relation to the challenges of the study, the future investment to meet the user's vision on the management of care in the territory, since the focus of this research was with the professionals who do this daily management.

CRACK E GESTÃO DE CUIDADOS NO TERRITÓRIO: DESAFIOS NO COTIDIANO DO TRABALHO EM SAÚDE MENTAL

RESUMO

Este artigo objetiva analisar os desafios enfrentados por profissionais de saúde mental na gestão do cuidado ao usuário de crack no território. Trata-se de uma pesquisa qualitativa e descritiva. O campo de estudo foi um Centro de Atenção Psicossocial álcool e outras drogas (CAPS AD) de uma cidade da região metropolitana de Porto Alegre/RS. Foram realizadas entrevistas semiestruturadas com oito trabalhadores de saúde mental do

serviço. Os dados foram analisados a partir da análise de conteúdo modalidade temática. Os resultados apontam dificuldades e limites que são apresentados no cotidiano da atenção em saúde, na gestão dos territórios, no contexto do usuário, na necessidade de delimitação territorial e em atividades que contemplem o saber e o viver do usuário, reforçando a saída do profissional para o espaço comunitário. Aponta-se também a necessidade de uma rede intersetorial fortalecida que se corresponsabilize em conjunto com a atenção em saúde mental, retirando do CAPS a centralidade no cuidado. Conclui-se que a gestão do cuidado no território é multifacetária, sendo realizada também pelo trabalhador no cotidiano do serviço e no contexto das relações dos atores sociais com a trama do território.

Palavras-chave: Saúde mental. Serviços de saúde mental. Cocaína crack.

CRACK Y GESTIÓN DEL CUIDADO EN EL TERRITORIO: DESAFÍOS EN EL COTIDIANO DEL TRABAJO EN SALUD MENTAL

RESUMEN

En este artículo se analizan los desafíos que enfrentan los profesionales de la salud mental en la gestión de la atención a los usuarios de crack en el territorio. El método propuesto es una investigación cualitativa y descriptiva. El campo de estudio fue un Centro de Atención Psicosocial de alcohol y otras drogas (CAPS AD) de una ciudad en la región metropolitana de Porto Alegre/RS. Fueron realizadas entrevistas semiestructuradas, con ocho profesionales del equipo de salud mental del servicio. El análisis de los datos se realizó mediante el análisis temático. Los resultados muestran las dificultades y limitaciones que se presentan en la atención de la salud de la vida cotidiana, en la gestión de los territorios en el contexto del usuario, la necesidad de delimitación y en actividades que contemplen los usuarios, fortaleciendo la salida del profesional hacia la comunidad. También señala la necesidad de que la red intersectorial se corresponsabilice junto con la atención en salud mental, retirándole del CAPS su papel de único servicio de referencia. Llegamos a la conclusión de que la gestión de la atención en el territorio es multifacética, realizada también por el trabajador en el cotidiano del servicio y de las relaciones de todos envueltos en el territorio.

Palabras clave: Salud mental. Servicios de salud mental. Cocaína crack..

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