

THE THERAPEUTIC ITINERARIES OF ELDERLY PEOPLE THAT MAKE A PROBLEMATIC USE OF ALCOHOL

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ABSTRACT

This study aimed to know the therapeutic itinerary of elderly people who make a problematic use of alcohol. This is a descriptive research, with a qualitative approach, carried out with 08 elderly people accompanied by the Center for Psychosocial Care Alcohol and Drugs III. The data were produced through a semi-structured interview and analyzed according to the Bardin content analysis. The door services listed by the elderly people were a psychiatric hospital, Emergency Care Unit, general hospital, Basic Health Unit and the support house. Each elderly person had a form of access and accessibility to the health services or support network. Some elderly people were stigmatized as drug users and suffered severe restrictions on their insertion and access to care. In general, the professionals did not seek to know their personal and family history, their relationship with the drug, nor did they take responsibility for referring the elderly person to another health service that makes up the Psychosocial Care Network. It is concluded that each elderly person establishes a unique relationship with alcohol and they have their own therapeutic itinerary. Thus, it is necessary to formulate adequate strategies of care through individual therapeutic plans.

Keywords: Health of the elderly. Alcohol-related disorders. Health Services Accessibility.

INTRODUCTION

The process of human aging involves biological, functional, environmental, social and psychic changes that result from a series of events that have occurred throughout the course of life⁽¹⁾.

Population aging is considered a process and gradual phenomenon that has drawn the attention of health authorities worldwide because it is a life cycle that presents unique needs. There is a forecast that there will be one billion elderly people by 2020 and, among them, 710 million will live in developing countries like Brazil⁽²⁾.

This is a challenge for society in general, especially for family caregivers and professionals in the health services. Among a set of health needs manifested at this stage of life, in the last decades, those related to the mental health area and, in particular, the problematic use of alcohol and other drugs have been highlighted^(1,3).

When the use of alcohol and other drugs has adversely affected, in an occasional or chronic way, in one or more areas of a person's life, such as their health, family, friends, work, study and relationships with the law are considered as problematic⁽⁴⁾.

The use of alcoholic beverages usually begins in adolescence and continues or reaches its peak in adulthood, often with periods of abstinence and recurrence of overuse. It is observed that there is a concern with this age group at the level of Health Care; this is also reflected in the research that still has a priority focus on young people and adults, which in a way neglects the occurrence of this problem in the elderly people⁽³⁾.

Also, it is believed that the identification of elderly people who make excessive use of alcoholic beverages is impaired as a consequence of difficulties in the clinical evaluation performed by health professionals since some complications of the consumption of these psychoactive substances present similarities with the

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symptoms of other chronic diseases prevalent at this stage of life. There is also the difficulty of the elderly person to talk about his relationship with drugs and family prejudice^(2,3).

The health services and the care network are constituted and organized according to a distinct health profile, aimed at attending to acute problems, and not to follow-up and to provide care on an ongoing and prolonged basis⁽⁵⁾. All this contributes to low adherence by the elderly person who uses alcohol to the therapeutic proposals offered by the Psychosocial Care Network (RAPS).

Ordinance Nº 3.088/2011, which establishes RAPS, advocates the care of people with mental disorders and/or needs arising from the use and abuse of drugs, from basic care to general hospitals, in an articulated and integrated manner based on the territory⁽⁶⁾. However, this ordinance does not indicate a direction of a clinic focused on comprehensive care that addresses the choices regarding the care and use of health services, which will constitute its therapeutic itinerary.

The therapeutic itinerary is understood as the path made by users in the search for care to solve the health problem, considering individual and socio-cultural practices. It is the care-seeking drawing that emerges from the narratives told by the subjects. The therapeutic itinerary is based on the evidence that individuals find different ways of solving their health problems⁽⁷⁾. Thus, the question is: How was the course of the elderly person who makes problematic use of alcohol to seek care?

Knowing the therapeutic itinerary of the elderly person who uses alcohol enables to formulate strategies of care, policies and mental health programs that contemplate promotion, prevention and rehabilitation actions, in a continuous way, opening possibilities of care, through individual therapeutic plans and which allow the participation of users and their families in the care, incorporating the elderly within their treatment⁽⁸⁾. This study aims to know the therapeutic itinerary of elderly people who use problematic alcohol.

METHODOLOGY

A descriptive study of a qualitative approach that had as background the Center for Psychosocial Care Alcohol and Other Drugs - CAPSad III of a municipality in the interior of Rio Grande do Norte; the same was chosen because it is the service of reference

in attending users who make or have made use of alcohol.

The study included 08 elderly people who met the proposed inclusion criteria: being 60 or older; have used and/or use of alcohol and being assisted by CAPSad III. Those who were hospitalized and those who missed two consecutive data collection meetings were excluded.

A semi-structured interview was used with the following guiding question: How was your path for searching for treatment in the health services and support network due to the consequences of alcohol use? The interviews were previously scheduled and performed individually according to the availability and concession of the elderly through the Term of Free and Informed Consent (TCLE), from February to May 2016, in a reserved place of the service. The subjects' speeches were recorded, transcribed in full and coded with the letter "E" of "Elderly", followed by the Arabic number related to the order in which they were performed.

Bardin's content analysis was used, which consists of a process the interviewees' statements are given order, structure, and meaning. A more in-depth reading of the material to be analyzed was carried out, which enabled the definition of the categories around which the lines were organized. Also, the interpretations of the analyzed material were made and the inferences established, relating them to the authors that help in the discussion of the study⁽⁹⁾.

This study was approved by the Ethics Committee in Research of the State University of Rio Grande do Norte with opinion nº 011851 and CAAE nº 42086115.1.0000.5294.

RESULTS AND DISCUSSION

The elderly participants interviewed were males. Six of them said they were separated or divorced and only two reported being in a stable relationship. As for age, the predominance of the age group was 60 to 70 years old, with a mean age of 64 years old. Regarding the education level, four participants have incomplete primary education and four participants have no education. As for housing, six elderly people reported living in a house and two said they live in a street situation.

During the relationship with alcohol, the elderly people initiate their therapeutic itinerary, which is singular and unique⁽⁷⁾. They come to the service in an attempt to care, to solve their health problems or to

alleviate their distress from the consequences of using alcohol.

From the analysis of the interviews, the services listed as a gateway to the CAPSad III were identified: psychiatric hospital, Emergency Care Unit (UPA), general hospital, support house and Basic Health Unit (UBS). The paths covered by the elderly person are diverse, ranging from primary care to tertiary care. Each elderly person had a form of access and accessibility to the health services or support network.

Therefore, it is necessary to understand the similarity and difference between access and accessibility. The similarities are linked to the ability to obtain health care in an easy and convenient way⁽¹⁰⁾. The differences in accessibility refer to the characteristics of the offer of health services and also indicates the degree of adjustment between the services offered and the population in a given territory. The term access, in general, is centered in the initial entrance of the health services. Accessibility also indicates the level of adjustment or even mismatch between the health needs of the population and the services and resources available and used⁽¹¹⁾.

Next, E5 highlights how access and accessibility were given in the psychiatric hospital before being admitted to CAPSad III:

I showed the paper to the woman in the Psychiatric hospital from here when I arrived from Sao Paulo and she said: "I will contact you to the Social Worker". I went to the social worker who referred me to the doctor and he said: "If I admit you here, do you want to stay? Because a lot of people say that it's a crazy place here, but you're not crazy here." I had 14 entrances there in the psychiatric hospital, then they did not let me in there anymore, so I came here for CAPSad III (E5).

The interviewee's speech records his admission to the psychiatric hospital and the characteristics of accessibility that correspond to the resources available in that service to respond to his health needs. The service organization and professionals must be prepared and designed to meet their demand so the accessibility can take place in an effective and adequate manner⁽¹⁰⁾.

Other elderly people also sought out psychiatric hospitals in their search for care:

I went to the "crazy" hospital there in Natal, but I did not want to stay there. When I arrived here, the person who took me to the psychiatric hospital was my wife. She was the one who took me all my life. I was hospitalized and, for a weekend, she came looking for me. In this hospital, I've had 106 entries. I've been through a lot of doctors. I had a doctor who had a lot of

patience with me, but after a while, he could not stand it any longer and said, "look, find another doctor, I do not want you anymore" (E3).

I looked for the psychiatric hospital. The hospitalizations varied from 30, 40, 45 days, depended on my behavior, when I started to get fat and better I had discharge, but I came back again (E4).

The following hospitalizations and the lack of perspective of the professionals regarding the recovery of the users demonstrate weaknesses in the accessibility of this service. Health professionals, given their proximity to users and knowing the relationship between their health needs and the offer of services, are important evaluators of accessibility. Thus, this evaluation should consider the users, their journey within the service and, especially, the health professionals' view⁽¹¹⁾.

The elderly report on their long periods of hospitalization closed during the week in the psychiatric hospital and open regime at the weekend with their family. However, if the elderly person used some drug or attempted to escape during the closed regime, he could not have those moments with the family.

It is observed that there are recurrent hospitalizations to the psychiatric hospital, which demonstrates the inefficiency of this type of treatment, also marked by prejudice and exclusion from social life. People with problems resulting from alcohol and other drugs still seek psychiatric hospitals as one of the first treatment options⁽¹²⁾.

In the current model of mental health care, it is recommended a careful evaluation of the supposed need for hospital admission. It could be possible by knowing the life history of the elderly person and his relationship with drugs, ensuring continuity of treatment in community care services, strengthening the social support network and family ties⁽¹³⁾.

The elderly had access to the Emergency Care Unit (UPA) as an option to care for acute episodes due to the use of large amounts of alcohol, such as tremors, dizziness, fainting, and vomiting:

I went to the UPA when I felt bad, they took me twice. Once I drank a little extra, I took a serum and injection because I got very tired and hands shaking, then I went home alone. The second time, it was when I felt death coming near me, I began to ask God, I was dizzy and I passed out, glad that someone came and took me to UPA again (E5).

It is observed the difficulty of access in the speech of E5 because it is a person alone and without

knowledge about other health services or social support. The elderly report that UPA professionals did not show interest in referral to other services and did not seek to know about their personal and family history. As a consequence, there is no continuity in the care provided in the UPA, making it recurrent to the service.

The UPA is part of the urgency and emergency care units that integrate RAPS for people with alcohol and other drug use needs. They are responsible for the reception, risk classification and care in urgency and emergency situations of these individuals⁽⁶⁾.

Considering the constitution of Health Care Networks and the principle of integral care, these services should guide the referral of these patients to other levels of care. This articulation can enable the continuity of care and the strengthening of care links with this level of care⁽¹⁴⁾.

Another health service mentioned by the interviewees was the general hospital:

I was going a lot to the hospital because of drinks. I was dizzy, with tremors, vomiting, when I got a little better, I went home. I went there so much that I had a few times that they did not even want to pick me up when I got drunk, only when I was really sick (E2).

This report represents the relapses of problematic alcohol use by the elderly in search of care in the general hospital. After hospital discharges as a consequence of recovery from the acute phase, the elderly person did not reach the establishment of continuity of care at the RAPS level⁽¹⁴⁾.

Mental health users many times face some barriers to having access to care in a very peculiar way. This is repeated in many points of access to health services, as well as in the Psychosocial Care Network, in which, for a stigmatized subject, considered as "drug-addicted, marginal, drunk or homeless", strong restrictions are created for their insertion and availability of service offered to this user⁽¹⁵⁾.

Hospital care as well as the attention points of the Emergency Care Network should not be an isolated point of attention but should function in a network with other points of attention⁽⁶⁾.

Another health service covered by the elderly person in search of care was the house of support, as can be identified from the speech of E8:

The support house of the charity sisters was my first place before coming to this CAPSad III. I lived in São Paulo. I live the day in the street, I work as car washer and I go at night to eat and sleep there. There are days I

spend all day in CAPSad III too. The nuns who told me to come here (E8).

The support houses are social facilities for street adults and in the case of the support house reported by the elderly participants, it serves as a shelter, which provides shelter at night, serving to support individuals with needs arising from the use of alcohol in street situation.

Alcohol and other drugs are part of the reality of the streets, so it is important that these services, besides to shelter, are the gateway to society and refer these individuals to other services that meet the needs arising from the use of alcohol, as well as help stabilization and reintegration of these subjects into formal society⁽¹⁶⁾.

It is also observed that the Basic Health Units - UBS are reported by the elderly as health services that are part of their therapeutic itinerary:

In the street, it is always very cold and to warm me I always had one. After drinking so much, I began to tremble. I went to the health center near there, very early, I stayed on the sidewalk and they put me inside. There they told me that I should go to CAPSad III. From there, I went to CAPSad III after that decay (E7).

The elderly person was invited to enter the UBS by the professional who welcomed him on the street, carried out immediate care and then referred him to CAPSad III. The UBS teams is a strategic resource of RAPS, promoting and preventing the damages caused by harmful use of alcohol and preventing the onset of use. At this point of attention, actions are developed in a geographically known territory, enabling health professionals to be close to knowing the life history of people and establishing links with the community⁽⁸⁾.

However, the inefficiency of articulating mental health in Primary Health Care aimed at receiving and taking responsibility for people who use drugs requires knowledge and preparation by family health teams about the approaches, treatment and possible referrals⁽¹⁷⁾. From the report of E3, it is perceived this disarticulation between the services, that is, the sharing of the actions of the elderly person who uses alcohol did not occur:

I always go to the health center and no professional had talked about CAPSad III. I came to seek treatment here because my friends, whom I met at the psychiatric hospital, called me here (E3).

The elderly people go through and cross the various points of the RAPS, cross teams and health equipment, they can articulate from a UBS to a

CAPSad III or from this to an Urgency and Emergency Care Unit. Finally, the paths to be traveled are always destined from each case and based on the users' needs⁽¹⁷⁾.

It is necessary to integrate and articulate the health services that make up the RAPS, in their levels of complexity, with the purpose of guaranteeing the integrality of health care to individuals with necessities resulting from the use of alcohol and other drugs⁽¹⁸⁾.

As for CAPSad III, it was initially identified that the elderly people were only referred to this level of care after having been cared in other health services. It is an open community service that works according to the logic of the territory and provides continuous attention to people with needs related to the consumption of alcohol and other drugs. It is based on the patient's treatment-seeking their social reintegration and offering a daily care, which allows the therapeutic planning within an individualized perspective of continuous evolution⁽⁸⁾.

During his journey, E1 had frequent consultations with the medical professional and received medication as part of his treatment in CAPSad III:

The first help I sought was CAPSad III, I did not look for any other. I've improved a lot since the beginning I got here so far. There's a lot of people here, I have treatment. Here I go to the doctor every month, I receive and take my medicines, I take a pill to sleep, I compress for pain because sometimes it hurts a lot (E1).

Medicines are still the central bets as tools of health professionals to meet the needs of each user. However, resources used in CAPSad III and other RAPS health services also need to go beyond medicines. The proposal of public policies on drugs is care from the perspective of territorial networks of attention, the concept of expanded health and the logic of risk and harm reduction⁽¹⁹⁾.

For the interviewees, CAPSad III became a place of protection and security, with great challenges for professionals in the construction of therapeutic activities capable of reconciling the uniqueness of the elderly and the collective impact of interventions.

After a while, I started to enjoy CAPSad III, I have a family here today. I like to dance, to prostrate, to sing, to help the brothers to sing. I like to respect because I was taught to respect the people here (E2).

I like the group activities of CAPSad III. I like to learn, we learn to read and write. There are also some talks, conversation, dancing. I like people here (E4).

The activities in groups constitute in moments of

socialization, recreation, learning, and welcoming. Groups are considered spaces of production, subjectivity management, link building, as well as reflection on life situations and their relationship with alcohol⁽²⁰⁾.

Another important aspect in the CAPSad III is the follow-up of the elderly person by the family:

The family is everything, my support. If I had not taken the action of looking for the family to ask for help, I had ended up in this bad life, I could not stand being alone anymore. They help me a lot to come here (E5).

The family should not only accompany the person who uses drugs to the health service but is more involved in the care done demonstrating zeal, support, and affection. It is necessary to welcome and treat family members, strengthening their ties, minimizing emotional overload and reorganizing family functions⁽¹³⁾.

FINAL CONSIDERATIONS

Each elderly person had a unique relationship with alcohol and formulated his own therapeutic itinerary considering their access and accessibility to health services. The barriers found in access and accessibility to services are established by the fragmentation of the care network. They are also related to the limitations imposed by age, such as prejudice by their families and even by health professionals.

Among the health services interviewed by the elderly people in search of care, there were: Psychiatric Hospitals, UPA, General Hospitals, Casa de Apoio, UBS and CAPSad III. This research brings its contribution in the area of mental health by highlighting the therapeutic itineraries of the elderly person who uses alcohol to formulate adequate strategies of care through individual therapeutic plans, considering the life histories of each elderly person. Also, there is the possibility of using instruments to identify the use of alcohol and other drugs in this age group, besides their consequences in the individual and social aspects.

The limits of the research concern the sample and the fact that the data collection was performed in only one health service. This is because it is the only one assisting these users. However, this reflects the need to develop more research on this problem, aiming at the construction of a relevant knowledge for a comprehensive care for the elderly person who uses alcohol in a problematic way.

OS ITINERÁRIOS TERAPÊUTICOS DE IDOSOS QUE FAZEM USO PROBLEMÁTICO DE ÁLCOOL

RESUMO

Este estudo teve como objetivo conhecer o itinerário terapêutico de idosos que fazem uso problemático de álcool. Trata-se de uma pesquisa descritiva, com abordagem qualitativa, realizada com 08 idosos acompanhados pelo Centro de Atenção Psicossocial Álcool e Drogas III. Os dados foram produzidos através de entrevista semiestruturada e analisados conforme análise de conteúdo de Bardin. Os serviços de porta de entrada elencados pelos idosos foram hospital psiquiátrico, Unidade de Pronto Atendimento, hospital geral, Unidade Básica de Saúde e casa de apoio. Cada idoso teve uma forma de acesso e de acessibilidade aos serviços de saúde ou rede de apoio. Alguns idosos foram estigmatizados por serem usuários de drogas e sofreram fortes restrições para sua inserção e disponibilidade de acesso aos cuidados. Em geral, os profissionais não buscaram conhecer a sua história pessoal e familiar, sua relação com a droga, bem como não se responsabilizaram pelo encaminhamento do idoso para outro serviço de saúde que compõe a Rede de Atenção Psicossocial. Conclui-se que cada idoso estabelece uma relação singular com o álcool e tem seu próprio itinerário terapêutico. Assim, torna-se necessário formular estratégias de cuidado adequadas através de planos terapêuticos individuais.

Palavras-chave: Saúde do Idoso. Transtornos Relacionados ao Uso de Álcool. Acesso aos Serviços de Saúde.

LOS ITINERARIOS TERAPÉUTICOS DE ANCIANOS QUE HACEN USO PROBLEMÁTICO DE ALCOHOL

RESUMEN

Este estudio tuvo como objetivo conocer el itinerario terapéutico de ancianos que hacen uso problemático de alcohol. Se trata de una investigación descriptiva, con abordaje cualitativo, realizada con 08 ancianos acompañados por el Centro de Atención Psicossocial Alcohol y Drogas III. Los datos fueron producidos a través de entrevista semiestruturada y analizados según análisis de contenido de Bardin. Los servicios de puerta de entrada enumerados por los ancianos fueron: hospital psiquiátrico, Unidad de Pronta Atención, hospital general, Unidad Básica de Salud y casa de apoyo. Cada anciano tuvo una forma de acceso y de accesibilidad a los servicios de salud o red de apoyo. Algunos ancianos fueron tachados por ser usuarios de drogas y sufrieron fuertes restricciones para su inserción y disponibilidad de acceso a los cuidados. En general, los profesionales no buscaron conocer su historia personal y familiar, su relación con la droga, así como no se responsabilizaron por el encaminhamiento del anciano para otro servicio de salud que compone la Red de Atención Psicossocial. Se concluye que cada anciano establece una relación singular con el alcohol y tiene su propio itinerario terapéutico. Así, se vuelve necesario formular estrategias de cuidado adecuadas a través de planificaciones terapéuticas individuales.

Palabras clave: Salud del Anciano. Trastornos Relacionados al Uso de Alcohol. Acceso a los Servicios de Salud.

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