Original Article

Social inclusion of drug users at a Service of Psychosocial Attention and Care to alcohol and drug addiction in a city in the State of São Paulo*

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Objective: was to investigate the social inclusion of users in care on two Psychosocial Care Centers Alcohol and Drugs, of the city Campinas-SP, from the perspective of the professionals who work in them. Method: in this qualitative study, the data were analyzed according to the content analysis method, in the specificity thematic analysis. Results: the analysis allowed for unfolding in three thematic categories: the professional's view on social inclusion of problem drug users; care for social inclusion; and the limits and potentialities for social inclusion of these users. Conclusion: it was concluded that there is influence of assistance models for users in political-ideological positioning of professionals and their consideration to the ethico-political suffering.

Descriptors: Mental Health; Mental Health Services; Social Inclusion; Drug Users.

A inclusão social de usuários dos Centros de Atenção Psicossocial álcool e outras drogas de um município paulista

Objetivo: investigar a inclusão social de usuários em atendimento em dois Centros de Atenção Psicossocial Álcool e Outras Drogas, na cidade de Campinas – SP, sob a perspectiva dos profissionais que neles atuam. Método: neste estudo qualitativo, os dados foram analisados segundo o método de análise de conteúdo, na especificidade análise temática. Resultados: o estudo permitiu desdobramentos em três categorias: 1-) a visão do profissional sobre inclusão social dos usuários problemáticos de drogas; 2-) o cuidado à inclusão social; e 3-) os limites e potencialidades para inclusão social desses usuários. Conclusão: o posicionamento político-ideológico dos profissionais e suas considerações sobre sofrimento ético-político têm influência sobre os modelos de atenção aos usuários.

Descritores: Saúde Mental; Serviços de Saúde Mental; Inclusão Social; Usuários de Drogas.

La inclusión social de los usuários de los Centros de Atención Psicosocial alcohol y otras drogas de un municipio paulista

Objectivo: investigar la inclusión social de usuarios en atención en dos Centros de Atención Psicosocial Alcohol y Drogas, en la ciudad de Campinas - SP, bajo la perspectiva de los profesionales que en ellos actúan. Metodo: en este estudio cualitativo, los datos fueron analizados según el método de análisis de contenido, en la especificidad de análisis temática. Resultados: el análisis permitió desdoblamientos en tres categorías temáticas: la visión del profesional sobre inclusión social de los usuarios problemáticos de drogas; el cuidado a la inclusión social; y los límites y potencialidades para la inclusión social de esos usuarios. Conclusión: es que hay influencia de los modelos de asistencia para usuarios en el posicionamiento político-ideológico de los profesionales y su consideración al sufrimiento ético-político.

Descriptores: Salud Mental; Servicios de Salud Mental; Inclusión Social; Usuarios de Drogas.

Introduction

There are different discussions within the health field about the care provided to the problematic drug user population. In particular concerning health care models for problematic users of alcohol and other drugs in Brazil they are based on two main paradigms: the prohibitionist and the harm reduction approach[1]. One of the objectives of the first one is to reduce the supply and demand of drugs through interventions to repression and criminalize the production, trafficking, possession, and consumption of illicit drugs. The objectives of the second approach are: promoting actions aimed at minimizing the health, social, and economic damages related to drug use, without first restraining them.

It reflects here on the practices in mental health to the problematic users of alcohol and other drugs, about social inclusion of these people, since it is understood that the social inclusion is an essential foundation of care. The assumption is that the professionals' perspective on social inclusion of users expresses to which models of care to users of alcohol and other drugs their practices are based on and, consequently, their political-ideological perspective on the phenomenon of drugs.

It is understood that health is a right, and in the Brazilian Constitution of 1988 it mentions, in its article 196, the right to health for all, being the duty of the State to guarantee it, and considering it also responsible for creating public policies and their applications. Also, the same article establishes that the right to health must be ensured through social and economic policies aimed at reducing risks of diseases and other harms, and access must be universal and equal for actions and services that promote promotion, protection, and recovery[2].

When analyzing universal and equal access to health for problematic drug users, a significant consideration is needed: despite criticisms in the public discourse regarding the insufficient operationalization of the public health system, there are also flaws in the implementation of these principles, especially to this population, as there is the social stigma imposed on them, and a difficult understanding about the phenomenon of drugs by public opinion.

About this consideration there is significant stigmatization about drugs and their users[3]. For the author, the absence of public debate and the repetition of a false, biased, and authoritarian idea about drugs and their users reduce the real structural problems of society. Maintaining this situation, on the other hand, would be useful to society, since it assists in maintaining the status quo, even though it increases the marginalization of users. Thus, it imposes, for the author, a distancing in the construction of a health care model for the drug user that is exempt from actions that marginalize and/or exclude them socially.

Therefore, this article presents a research whose objective was to investigate the social inclusion of users in care in the Psychosocial Care Centers for Alcohol and Other Drugs (CAPS Ad), located in Campinas - SP, under the perspective of the professionals. Also, to do so, there was a need to outline three specific objectives: to describe the actions performed by the CAPS Ad professionals; to identify the actions that favor the social inclusion of the users of these services; and finally, to identify the institutional limits and potential for social inclusion of these users.

Method

It is an exploratory descriptive research with a qualitative approach of the data, due to the nature of the object of study and proposed objective. To investigate the professionals' perspective on social inclusion of problematic users of alcohol and other drugs, a qualitative method of social health research was chosen, since the object of the study is historical, and therefore, changeable in space and time, which may undergo transformations according to its context[4].

To perform this empirical record, whose theoretical constitution will be described in this article, the combination of semi-structured interviews, participant observation, and bibliographical documents that confirmed the assumptions were established, according to Minayo[4], to continue with the study.

It is considered that the social inclusion of problematic users of alcohol and other drugs can be seen from several perspectives, being: users of services and their professionals, by public and private institutions, and by society in general. However, it is the professionals of the CAPS Ad services who are directly linked to the specific care of this population, to the work processes adapted to this logic, and situated in a strategic position for possible analyzes on the complexity that the drug phenomenon comprises. Thus, these professionals are facing the reality of problematic users of alcohol and other drugs and their phenomena, instrumented for a care, that can understand it under different political-ideological perspectives regarding the specificity of this type of care, besides analyzing which in fact is being offered to this population, in a city that is considered a reference in mental health care.

The data collection was carried out from September to November of 2014 in two CAPS Ad of the city of Campinas, and with the use of a field journal, to record the experiences lived.

We interviewed 17 professionals from the high and middle levels, who worked on the direct care to the users of the service. For the semi-structured interview, a script was elaborated with three guiding questions: what are your activities in this service and how are

they carried out?; describe, among your actions, which favor the social inclusion of the user of this service; what are the limits and potentialities of CAPS Ad for the social inclusion of the user of this service? It is worth remembering that all the interviewees signed the Free and Informed Consent Form, and the research was authorized by the Research Ethics Committee of the Ribeirão Preto College of Nursing/University of São Paulo (EERP/USP), approved on May 27, 2014.

Based on the information collected, the data were organized and analyzed according to the content analysis method, in the specificity of thematic analysis.

Results

The professionals of CAPS Ad studied described their activities in a very similar way, specifying them in internal and external actions, the first being those performed within the service and the second in the territory where the services are inserted.

In this way, they mentioned as external activities: home visits, activities of harm reduction in the field, matrix-based strategies, active search, therapeutic follow-up, meetings (such as that between representatives of the networks of primary care and mental health, meetings of health districts; council-manager and municipal health council, and some workshops - for example, sports).

Among the activities performed within the service, mentioned by the participants, are: activities of the center, that is, specific to a particular professional category (at the psychology center, it would be individual or group psychotherapeutic appointments, at the occupational therapy center, workshops, in the nursing center, those related to nursing care, in the harm reduction center, those aimed at harm reduction actions in the ambience, in the medical center, activities related to individual care, in the the pharmacy center, pertinent to storage and dispensing of medicines and materials, and in the social work center, those of individual assistance of social work).

Besides these, others were mentioned, common to all centers: activities of reception or duty, duty change, assembly, workshops, and activities of reference professional or reference technician (being described as actions performed by a particular professional to a user, which has as a reference of negotiations and therapeutic care).

The analysis of the data was based on the construction of three themes. These were created from the importance and frequency with which some data emerged, as well as from the need in which the study covers according to the methodology chosen.

The first theme was "The visions of professionals on the social inclusion of problematic users of alcohol and other drugs"; the second, "Care for social inclusion"; and the third "The limits and potentialities for social inclusion of problematic users of alcohol and other drugs."

The views of the professionals on the social inclusion of problematic users of alcohol and other drugs were diverse, mentioning one or more of them, but never all to say their perception. In this sense, social inclusion would be: through the insertion in the labor market or educational activities; circulation in the health network and other community equipment; by the exercise of autonomy; by the treatment of the professional with the user; the non-association of the problematic user of alcohol and other drugs with a criminal; and finally, the improvement of the self-esteem and social appearance of the user.

Regarding inclusion care, interviewees, in general, affirmed that they carry out social inclusion actions for this population. Among the actions, they came in three different forms. The first would be of full care, not restricted to clinic or actions in the territory, and which should still be contained in the logic of the harm reduction model. The second would be inclusion care, which is possible, according to the analysis, if there were more medical-centered rather than harm reduction actions, as exemplified below: *I think if there was a psychiatrist here and a practitioner, at least things would be different! We would be much more successful in reinserting the individual into society with a treatment that he could take more seriously because no one here takes the treatment of the patient seriously.* (Interviewee A8); *in my opinion, we work here with more harm reduction. We do not work with the total recovery of the individual. I think this* (Interviewee A8).

The third would be social inclusion not as the focus of their work since it would be an ideal and utopian situation: *I can say that it is a therapeutic success that is not necessarily social reinsertion as we imagine and idealize* (Interviewee A9); *the cocaine user, who has schizophrenia, what the prognosis this guy has, you know? Am I going to wait for this guy to return to the formal job market?* (Interviewee A9).

In the third theme, among the limits and potentialities for the social inclusion of problematic users of alcohol and other drugs, the participants pointed out not only their limits and their potentialities for social inclusion actions, but also the limits and potentialities of the institution CAPS Ad, as well as those that extrapolate to this institution.

The professionals reported the lack of training and preparation of professionals for social inclusion actions as the main limiting factor for the inclusion, as well as the lack of appropriation of the political-ideological discussions related to user care. In this regard, they considered as potentiality the specific knowledge for the care of this population and the presence of a political-ideological positioning regarding the problematic use of drugs and, consequently, the model of care that is appropriated.

When asked about the limits of the CAPS Ad for the social inclusion of the users, the interviewees pointed out the lack of human resources and institutional transportation. Besides, they mentioned the political difficulties between the City Hall of Campinas and the Health Service Dr. Cândido Ferreira, this partnership of co-management of the mental health care of the city.

We are in a complicated moment with the politics... that the agreement Cândido Ferreira, who is the one who sustains the mental health in Campinas, then... it is always... city hall does not want this partnership with Candido much, but it also does not have the courage to say... and, with that, the scrapping of the services is very important, it is limiting even more (Interviewee A1).

Concerning the institutional strengthening factors, the following were highlighted: the existence of the nocturnal rearguard in the CAPS Ad, called night bed, and the workshop center, which would be labor activities, with low remuneration, but with market competitiveness, managed by the Health Service Dr. Candido Ferreira itself.

Additionally, other limiting factors on social inclusion were mentioned, however, that extrapolate services, such as the moralistic perspective of society towards the problematic user of alcohol and other drugs; and the misalignment of policies on alcohol and other drugs. Still, regarding the potential that extrapolates the institution, they emphasize that the CAPS Ad receives new users without the need for referral or any other type of bureaucracy, according to the ordinance that regulates these services.

Discussion

During the research, it is exposed the breadth of the study, which allows a discussion in different levels, from micro to macro, on factors that influence the social inclusion of problematic users of alcohol and other drugs treated in specialized services, such as CAPS Ad, as well as the public policies that regulate them.

Within the analysis of the concepts used, it is worth mentioning the discussion of the concepts of inclusion and social exclusion. The concept of exclusion can be considered a "case or tram concept," since it can be attributed to any social phenomenon, without knowing for sure what the meanings are[5]. The author also points out that many scholars prefer to replace it with a more precise expression, although it considers that the term is often understood as synonymous with poverty, which minimizes the central issue that lies in it: social injustice[5].

In this perspective, social injustice is understood as part of the constitution of capitalist social organization, since, to be "included," the existence of "excluded" is necessary. Thus, society excludes to include and, therefore, inclusion becomes merely illusory from the

economic point of view, however, they all are included, even if in insufficiencies and deprivations[5].

Therefore, it is proposed a perspective which is of ethics and subjectivity in the sociological analysis of inequality, which favors a broad view on "inclusion", in this case not circumscribed to the need of State actions before social injustices and the employability system, but rather in the sense of being disengaged from the political suffering of the other[5].

Despite the use of the expression "social inclusion," it refers to the conception employed by this same author, which is the term "dialectic of inclusion/exclusion." In this way, it unlocks the idea of inclusion as normatization or social standardization and approaches the feeling included, which is "manifested in everyday life as identity, sociability, affectivity, consciousness, and unconsciousness"[5].

Therefore, the professionals indicate a broad perspective, from the marketing to the affections in daily life, about what would be social inclusion of the population that they attend. However, these different conceptions pointed out by the interviewees, seen in an isolated, decontextualized way, can still be considered perverse alternatives of inclusion[5].

In this sense, the perverse inclusion described by the same author would be a masked form of inclusion, which denotes the appropriation of materials or symbols that only illusively make them feel part of the whole. It would be a frustrated attempt of inclusion, because it excludes to include, keeping these users in a form of dependence on the State (or services), especially with regard to freedom, a situation that generates the false idea of satisfaction according to the market logic[6].

From the professionals' statements, it is analyzed that some inclusion actions as insertion of the labor market can be considered market when it is thought that social inclusion is only possible when the user is placed in the labor market. Social inclusion is present in the ethics of subjectivity, and it is not confined to the actions of the State towards the injustices of the employability system, but rather when there is care for its ethical-political suffering[5].

Also, when considering the perspectives of social inclusion through the development of autonomy, the circulation of these users through health care networks (such as the Psychosocial Care Network and the Health Care Network) are inclusion actions that in fact allow the consideration for the user's ethical-political suffering, and consequently, the possibility of social inclusion.

The conceptions of the treatment of the professional with the user in an affective way in the daily life are to consider their ethical-political suffering, and therefore, also not to consider a moralistic perception of the user, as the perspective of a criminal. In this way, it allows the

verification that the professionals' view on problematic drug use is inserted in the harm reduction model since it considers the user not from a moral/criminal aspect, but as a public health problem[1].

The situations of vulnerability to which users are exposed so that they can use drugs can be minimized when the State, through public policies, enables the reduction of these vulnerabilities for consumption, which suggests a safe and non-stigmatized consumption, which leads the user to approach a relationship of health care.

Although a good part of the professionals is in favor of the model of harm reduction care, there is still a position on their part that is favorable to the prohibitionist care model. This look is very emblematic to understand how some professionals position themselves before the care to social inclusion. In this case, one can note great frustration on the part of the professionals, understandably, since the objective imposed by them is of abstinence, not including other equally essential facets related to drug consumption.

Still, the positioning of professionals about social inclusion care is not the focus of their work, considering it a utopian action; in this way, it expresses the non-identification of their actions, albeit subtly, they opportunize social inclusion, which suggests an expropriation of their health actions aimed at inclusion.

Based on the considerations presented, it is understood that social inclusion is not yet a well-defined subject by the teams and thus requires many discussions regarding the potential of a seemingly simple action of affection in the genesis of care for ethical-political suffering and hence the promotion of dignity and social inclusion[5].

And the limits and potentialities for social inclusion of the users, the participants pointed out their preparation for the care with drug users as limits and potentialities related to it. Thus, they can offer their knowledge and qualification for social inclusion. Still, the main limiting factor would be the absence of this training.

The appropriation of the professional in relation to the public policies in health makes possible the social inclusion, since even through indirect care actions, such as referral to basic health services, matrix-based strategies, among other actions in the territory, need prior knowledge of health policies, as well as the mental health policies and their flows, since, in this way, they perform health actions directed to the territory and not unnecessarily outpatient or hospital health actions. Therefore, the theoretical and practical appropriation of health policies lead these professionals to actions of social inclusion to their users, and the non-appropriation of their exclusion, and therefore a limiting factor to inclusion.

Still as a limiting factor for social inclusion actions pointed out by the participants is the absence or scarcity of institutional supports or material resources that discourage the accomplishment of activities in the territory (example, the absence of institutional transportation), such as home visits, matrix-based strategies, among others. However, these actions, which also encourage social inclusion, should be a priority, since they are advocated by health policies for integral care in the territory, and in a network[7].

Institutional weaknesses directly interfere in the Psychosocial Care to problematic users of drugs and, consequently, in actions of social inclusion. The low qualification of healthcare provided by SUS is evidenced not only by financial, material, and technological problems, but when they add to it bureaucratic apathy, corporatism and/or professional omission, lack of ethics, and respect to professionals and users[8]. These situations, in turn, generate little productivity, low coverage of services and, in particular, suffering. Thus, the quality management of public services based on SUS policies represents the primary challenge to the Brazilian health reform[8] and, consequently, to the Psychiatric Reform, with repercussions on assisting users.

On the other hand, the factors related to CAPS Ad that enhance social inclusion would be the structures of the psychosocial care network of Campinas, such as the bed-night device and the Work Workshops Center (NOT) used to care for the user in the territory, but the use of these devices without the sensitivity of the professional to the ethical-political suffering of users is no longer sufficient for their social inclusion.

In general, although the Unified Health System (SUS) has expanded access to health care for the Brazilian population, including problematic users of alcohol and other drugs, problems remain in the fairness of this right. There is, in this sense, a struggle to ensure universal and equitable coverage, considering that the participation of the private sector grows and contradictions emerge, especially about ideologies and objectives - the search for universal access in opposition to the segmentation of the market[9].

Besides the participation of the private sector in the elaboration of policies and their negative interference in the underlying assumptions of SUS, regarding the health policies for problematic users of alcohol and other drugs, there is also the complexity that the phenomenon of drugs adds to this discussion, since, from a historical, social, and economic perspective, different visions of the phenomenon could be traced, a fact that directly interferes in the consolidation of healthcare models.

The discussion on the issue of drug use is, in fact, quite broad. The consumption of these substances is millenarian, and it was present in many cultures, with different purposes: medical, religious, and for sociability purposes[10]. It is important to clarify that the author

refers not only to alcohol, considered indispensable in the rites of healing, devotion, consolation, and pleasure. The differentiation that is made in the history of humanity about consumption lies in the different forms of use and social control.

As far as social control is concerned, still according to the author, formal drug regulation began in the twentieth century, when some substances were accepted and some not, being the criterion for such a distinction based on cultural and economic impositions. In the same way, in the contemporary world, drug consumption is distinguished by the form of use and regulation, which allows us to infer, with regard to care to problematic users of alcohol and other drugs, that different models of health care are created for this population.

In this way, it is possible to infer that the problematic consumption of alcohol and drugs is closely related to the way we organize socially. Today, our organization is based on the capitalist mode of production, which synchronizes with the individual and compulsive movements of satisfying desires as fast as possible and not feeling the pain whatever it is. The drug, in this context, may have the anesthetic effect[11] of a liquid life[12].

Thus, linking so many spheres of knowledge and considering them intrinsic phenomena to one another constitutes an important step towards the construction of new knowledge in mental health and public health. Likewise, for the production of mental health care actions aimed at the integrality of the suffering subject, or "user of the service," new knowledge is necessary, previously linked to a citizen's perspective of rights, in this case not only the citizen with consumer power but the producer of knowledge and history.

Based on the considerations above and based on the readings made regarding health policies on drugs, some contradictions are observed regarding an ideology of psychosocial care for drug users. In Brazil, despite health policies aimed at harm reduction, there is still a prohibitionist position, which makes it possible to open different forms of action in the field of health, especially those performed for the care of problematic drug users.

In this regard, the Ministry of Health recognizes that there is a gap in relation to public health policies on drugs, thus attributing responsibility for the issue to institutions of justice, public safety, pedagogy, merit and religious associations, which led to the dissemination of a predominantly medical, disciplinary, and religious practice[13]. In this context, the model of treatment exclusively focused on abstinence prevails, which contributes to reinforcing the social isolation and stigma associated with drug use.

It is also worth remembering that for this reflection, even with the decriminalization of drugs, the system will remain perverse with the user, because even if it is no longer seen as a criminal when consuming drugs, he will have to expose himself to buy them in an illegal system, such as drug trafficking. Therefore, it is suggested that with the legalization of drugs the user will no longer be seen as a criminal before the law and, consequently, he will be able to use in a way that does not corroborate a system that generates vulnerabilities and suffering, such as drug trafficking.

From this perspective violence is much more linked to trafficking and police repression than to drug use[14]. Also according to him, violence (the inclusion of users and workers in trafficking) is related mainly to social exclusion and tradition of masculinity.

Therefore, from the perspective of professionals, the actions of social inclusion depend on social factors, related to the contemporary socio-historical context; it is added that the Brazilian legislative framework for drug users is still quite conservative, promoting exclusions since drug trafficking seems to be mostly responsible for vulnerabilities.

Conclusion

The results show that mental health practices aimed at the social inclusion of problematic users of alcohol and drugs in the CAPS Ad studied are still superficial regarding the complexity in which the social inclusion of these users cover.

According to the participants, actions of social inclusion occur to users, but to be truly effective, they depend on how the professional positions themselves politically and ideologically in relation to the problematic use of drugs and the consonance of factors external to the services that favor them, such as national public policies on health and municipal agreements between institution and city hall.

In fact, the professionals' perspective on social inclusion reveals that the model of harm reduction care guides most of them, but there are still poorly clarified positions regarding the model of qualified care to this population, as well as being more consistent with the prohibitionist model.

It is important to emphasize that this research presents a structure and qualitative analysis and, therefore, it should be considered for other analyzes, from this study, the historical and cultural context of the region studied. Still, for the analysis on social inclusion, this research started from the perspective of the professionals of the CAPSad services, for a deeper understanding on social inclusion of this population it would require qualitative studies from the perspective of other professionals of the Network of Psychosocial Care and Health Care Network, as well as the users themselves and society.

It is understood, therefore, that public debates and social and health research on the phenomenon of drugs are still necessary; and especially with regard to health care for this population, since it is important to consider the harm reduction model not only as a care strategy, but as a political-ideological position, exclusively, but as a clinical and national institutional model of care.

Still, permanent discussions in substitute service teams, such as CAPS Ad, and also in other health network devices for care to problematic users of alcohol and other drugs, need to consider the ethical-political suffering of this population, since they are ways of enabling the development of mental health practices that promote social inclusion in all its complexity.

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