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Operation of a psychosocial care center for the treatment of crack users

Funcionamento de um Centro de Atenção Psicossocial para o atendimento a usuários de *crack*

Funcionamiento de un centro de atención psicosocial para tratamiento de los usuarios de *crack*

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ABSTRACT

Objective: to analyze the operation of a Psychosocial Care Center for Alcohol and other Drugs (PCC AD) for the treatment of crack users. **Methods**: This is a part of the research "ViaREDE". It has an evaluative nature, case study type, based on the use of the Fourth Generation Evaluation as theoretical-methodological framework. **Results**: PCC AD PCC AD is pointed as a powerful service in the service network to the crack user. It highlights the importance of open doors of service to guarantee universal access and committed to the user. Other issues discussed are the need to strengthen the intersectorial network and extension of operation hours of the service. **Conclusion**: the analysis of the service operation contributed to the customary constitution of the network, as well as the reforming capacities of care devices.
Descriptors: Mental health, crack, cocaine, health services, deinstitutionalization, nursing.

RESUMO

Objetivo: analisar o funcionamento de um Centro de Atenção Psicossocial para Álcool e outras Drogas (CAPS AD) para o atendimento a usuários de crack. **Métodos:** trata-se de um recorte da pesquisa "ViaREDE". Possui natureza avaliativa, do tipo estudo de caso, baseando-se na utilização da Avaliação de Quarta Geração como referencial teórico-metodológico. **Resultados:** o CAPS AD é apontado enquanto um serviço potente na rede de atendimento ao usuário de crack. Destaca-se a importância da porta aberta do serviço para garantia do acesso universal e comprometido com o usuário. Outras questões discutidas são a necessidade de fortalecimento da rede

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intersetorial e ampliação de horários de funcionamento do serviço. **Conclusão:** a análise do funcionamento do serviço contribuiu para pensarmos a constituição cotidiana da rede, bem como a capacidade reformadora dos dispositivos de cuidado.

Descritores: Saúde mental, cocaína, crack, serviços de saúde, desinstitucionalização, enfermagem.

RESUMEN

Objetivo: analizar el funcionamiento de un Centro de Atención Psicosocial para el consumo de alcohol y otras drogas (CAPS AD) para el tratamiento de los usuarios de crack. **Métodos:** se trata de una parte de la investigación "ViaREDE". Tiene un carácter evaluativo, el tipo estudio de caso, basado en el uso de la evaluación de cuarta generación como marco teórico-metodológico. **Resultados:** el CAPS AD mientras un potente servicio en la red de servicio a los usuarios de cocaína crack. Subrayamos la importancia de la puerta de servicio para garantizar el acceso universal y comprometido con el usuario. Otros temas discutidos son: la necesidad de reforzar la red intersectorial y ampliación del horario de funcionamiento del servicio. **Conclusión:** el análisis de la operación del servicio ayudó a pensar a través de la constitución de la red de diarios, así como la capacidad de emprender la reforma de la atención.

Descriptores: Salud Mental, crack, servicios de salud, desinstitucionalización, enfermería.

INTRODUCTION

The recent introduction of innovative devices in the composition of psychosocial care networks in Brazil has been stressing the know-how within the psychiatric field. As a result of the consolidation of the psychiatric reform movement,[1] today the territory is the locus of care, far from the previous configurations of a crystallized model, centered on the manicomial structures, of exclusionary character and that prevented the exercise of the individual's autonomy.

It is in this sense that psychiatric reform can be conceived as an open field and provides the visualization of a new paradigm in mental health. It is to say that the reform impresses, in the Brazilian reality, new work processes and an organization of health services in the form of networks. Networks capable of working not only with the individual aspects of the subject, but also with the premise that one can inhabit his/her social circuit, circulate through this vast and complex territory.[2] But even in the face of the innovations witnessed, there are specificities of the mental field still challenging the health system, as in the case of drug use.

Within this context, we highlight the use of crack as an urgent need within mental health policies. It is a drug that generates numerous social damages to the user, among them loss of employment, promiscuity, rupture of bonds, violence and other important cognitive damages, putting one at risk and vulnerability.[3] However, despite the specificity of the substance, we envisage that any approach to crack users is no different from interventions related to other drugs.

It is worth mentioning that, since 2010, Brazil has been raising awareness to the need to establish dialogues on care for individuals with problems arising from drug use and, in our case, from crack. The National Policy for Comprehensive Care for Alcohol and Drug Users, the Emergency Plan to Expand Access to Treatment in Alcohol and Other Drugs in the Unified Health System (UHS), and the Integrated Plan to Combat Crack and Other Drugs are examples of initiatives for the development of promotion, prevention, treatment and education of the user. These instruments consider that the phenomenon of drug use is complex, multi-factorial, and it is essential to strengthen the network of mental health services with the participation of different devices, such as the Psychosocial Care Centers for Alcohol and other Drugs (PCC AD).[4]

As strategic devices in mental health care are regulated by Ministry of Health Ordinance 336/2002, PCC is responsible for offering care to individuals with severe and persistent mental disorders. In the case of drug use, PCC AD is the referral service, emerging as the articulator of the substitutive network to the asylum and working with the subject, also in the sense of problematizing the reflexes of the use of the substance, besides its relation that the individual establishes with it.[5]

In this sense, we consider that it is necessary to invest heavily in a care that contemplates the multiple facets related to the use of crack. One cannot deny that there are symbolisms, desires, choices and risks involved in this process. But it is important to escape from an organicist discourse, which often insists on reducing this use and associating it with the compulsive and disorganized behavior of the user.

The discussion we propose in this study runs through a perspective that problematizes the relationship between the individual and the drug, valuing the subject, his choice and his desire. We signal the need to avoid focused interventions, expanding our know-how. It is in this sense that the plural and the singular are valued, which consequently involves a series of transformations and relevant changes in the daily life of mental health services, introducing new looks, new forms of organization and functioning.

In view of the above, this study aims to analyze the functioning of a Psychosocial Care Center for Alcohol and other Drugs (PCC AD) for the care of crack users.

METHODS

This is a clipping of the research "Qualitative evaluation of the network of mental health services for users of crack (ViaREDE)", funded by CNPq / Ministry of Health. It has an evaluative, case-study nature, based in the use of the Fourth Generation Evaluation as a theoretical-methodological reference.[6]

The Fourth Generation Evaluation is a constructivist and responsive assessment that, through an interactive process, seeks to discover and analyze the different points of view, in order to be able to interpret the consensus and dissent of the interest groups.[6]

The study scenario was the Psychosocial Care Center for Alcohol and Other Drugs (PCC AD) in the city of Viamão / RS. It is a PCC AD II, which runs from 8h to

18h on weekdays. It is the service of reference for service to users of crack in the municipality.

The subjects of the study were eight PCC AD workers, ten service users, eleven family members and seven system managers. They were chosen from the definition of inclusion criteria, being:

- Managers and workers - Work at PCC AD and mental health management in the municipality for at least six months.
- Users - Attend PCC AD or have already attended another mental health network service due to the use of crack, are in good clinical and communication conditions and who voluntarily participated in the research.
- Family members - Follow or have accompanied a relative, a crack user, in care at PCC AD and at another point in the mental health services network.

Data collection took place from January to March 2013, through field observations and interviews. Field observations totaled 189 hours and were recorded in a field diary. Regarding the interviews, 36 were performed in total.

The interviews were carried out with the application of the Dialectic Hermeneutical Circle. It is hermeneutic because it is interpretive, and dialectical because it represents the comparison and contrast of the visions, for the accomplishment of a high level of synthesis.[6] Each interest group responded to a previous script, following the general guiding question of the project, which was: What is the assessment that interest groups make about the mental health services network for the care of the crack user?

Thus, the initial respondent R_1 participates in an open interview to determine an initial construct in relation to the focus of the research. He is questioned and invited to construct, describe and comment. At the end of the interview, the respondent is asked to indicate another respondent, called R_2.[6]

The central themes, conceptions, ideas, values, concerns and questions proposed by R_1 are analyzed by the researcher, formulating a construction called C_1. The second respondent (R_2) is interviewed and, if any construction addressed by R_1 is not contemplated by R_2, R_2 is invited to comment on it. The R_2 interview yields information from R_2 and a critique of the construction of R_1. The researcher completes the second analysis resulting in C_2, a more sophisticated and informed construction, and so on until finalizing the data collection.[6]

The method used required that the analysis and data collection be parallel processes, one directing the other, based on the Constant Comparative Method.[7]

After the data collection and the organization of the constructions of each group, the negotiation stage was carried out. Respondents were assembled, and presented the interim results of the analysis of the data, so they could have access to all the information and have the opportunity to modify them or assert their credibility.[6]

From the negotiation, the researchers proceeded to the final step of data analysis. In it, the issues raised were regrouped, allowing the construction of thematic categories. The results of this study were organized from the theme “Network access” in which issues related to the operation of services and the assessment of individual components of psychosocial care network converged. At that point, the PCC AD was evaluated in relation to its functioning within this composition. We will present the results of this analysis.

The project was submitted to the Ethics Committee of the Federal University of Rio Grande do Sul (UFRGS), receiving assent to the execution (Protocol 20157/2011). It was also, at the request of the CEP / UFRGS, evaluated by CONEP / MH, receiving an opinion favorable to its execution (opinion 337/2012).

It was also guaranteed the anonymity of the subjects of the study and respected all the ethical and legal precepts that govern the research with human beings, as recommended by Resolution 466/2012 of the National Health Council, as well as respecting the decision of withdrawal by part of the respondents, according to the Free and Informed Consent Term. For this, the team members were identified with the initial E, the managers with the initial G, the users with the initial U and the family members with the initial F, followed by the order in which they appeared in the interview. Example: E6, U3, F11, G4.

RESULTS AND DISCUSSION

Some aspects regarding the functioning of the PCC AD for the care of crack users make sense in the very form of organization of the practices. The study showed that there are two main pillars in this context: the use of technologies that reveal the importance of the subject in the care process and the facilitation of access, with the guarantee of open door functioning.

Regarding the care technologies offered by the PCC, the interest groups mentioned that it is the main reference for the care of crack users in Viamão, considering it as the gateway to the network.

> *As a gateway for crack users, I go back to say that we have today in the municipality the PCC AD, in many moments they end up going in other PCC because it ends up in some cases thus having disorder and dependence together, then sometimes the PCC II’s own PCC, which address mental disorder, end up being a gateway, but we always focus on the PCC AD gateway. And then, well, there are other branches that we call, right, that’s the unit of the county hospital. [...] I think that one of the factors as a gateway is the service of the PCC and the hospital itself that is happening within the municipality. (G2).*

> *Well, in Viamão the main care device, attention is the PCC, it is a reference service, I think it is already in that place of reference, it is not yet placed as a regulator service, which I*

think is a breakthrough that we need to build, because the PCC I think is a regulator of the service. (E7).

She directed me here. That's where I come from. Already made the welcome and already started to do (treatment). It was the first place we searched. (F3).

I believe that the gateway to crack users is the PCC. [...] I cannot say that the entrance door is the entrance of the units, the entrance door is the PCC because of this because, if I face the entrance door as a welcome, as an appropriate listener and a guidance for problems, the gateway is the PCC here. (G3).

In being the gateway, the PCC itself is strained to organize itself from different logics of service. Evaluated as a service that goes beyond the organic issue, PCC hears, welcomes the user and understands the relationship he establishes with the drug, without precipitated judgments or prescriptive plans.

Here these users are welcomed as a subject who comes in search for help, who has, ah… is seen within the complexity of life, but has this specificity that is seeking help for this specific question, which is the injury that the use of some substances are causing in your life and this injury usually does not come as an organic issue like people say. (E1).

I was taken care of well here [at PCC]. They were at my home too. They visited and everything. (F1).

How many times the PCC left here, went there to visit [user's name] in São Pedro. [...] So it is, a chain, the PCC and the Hospital where the patient will be. If the patient is going to be treating himself here, PCC has never abandoned him. [...] The PCCwould call there. They stopped doing other things to take him. They supported us a lot. (F5).

Here they try to know how you are, your day to day, how you are managing to keep up, talk with you. Where else we try to learn something is in the group, where each one speaks a little of himself, is when you analyze it or is often recorded what the colleague said, then you are thoughtful if this happened from there with him I'd go, try to do differently, if I can deviate from that path I will not go there. However your head automatically goes in that direction, you go against it, try to do something or occupy your head, I talk a lot with people. (U2).

I think it's good [...] It's the best way they treat patients: talking [...] Here I do my strategic activity and group behavior. (U5).

We [PCC] work and prioritize working on the logic of reduction and not abstinence as something totalitarian that it has to happen immediately, that all our interventions are ruled right. This,not onlyas a great action, but as a life project of each subject because we also believe that we all have when we get in touch with our desires, with life, the challenges that life puts, depending on the moment people can get in the way of this, and sometimes lose our desire, our project. (G1).

Psychiatric reform comes with the purpose of transforming the psychiatric paradigm, creating changes in care, in the cultural, political, conceptual and care context.[8] In this sense, the impression of new characteristics of mental health care practice must be articulated to the adoption of new models, corresponding to the subject's need, his / her understanding of the process that leads to the use of the drug, far from tutelary processes that castrate the potential of the subject.[9]

In this way, the invention is the most outstanding feature of the new mental health services, we consider that, in the face of this, new technologies emerge that establish more precise and lasting bonds with the subjects. In this case, sensitive listening, "good attendance," and institutional commitment to the individual shifts from the disease-centered care to that which respects the individual's uniqueness.[10] This is how it is possible to produce health as an inherent capacity of health services, adaptable to the new reality to generate life-forming networks, operating new contours in work processes.[9]

This reality is translated into the E1 dialogue. For the professional, it is necessary to know the complexity that circulates the life of the individual. In the case of U2, U4 and F1, the PCC has professionals with a peculiar characteristic, because they attend well, are respectful and committed. The fact that it allows the generation of new meetings and the expansion of the productive potential of the service, naturally allows us to think that drug use enters the work process of the PCC AD as a "to be discovered" element along the bonding with the user, yet the drug, although important, is not the first object of intervention of the worker.

In this way, listening, welcoming and bonding with the user reveal a whole new way of caring. Not only as a concern, but also as an attitude of implication of the worker: it helps to reduce distancing with the user and dilutes merely institutional relations. Using relational technologies in work processes includes an ethical and philosophical commitment to value life, putting into effect a practice of encouraging the subject's awareness of his or her problem or its difficulty, as opposed to the inauthentic and technical / prescriptive care typical of the hospital hegemonic model.[11]

In this sense, it is relevant to consider that listening and bonding behave as new relationships and perspectives in mental health care. It is to say that without them, the very relationship that the subject establishes with the drug does not change. Respecting limits and desires, hardships, working with human potentials, can become an excellent exercise to rediscuss the role that PCC plays in the life of the drug user. It is in this sense that we understand that the work of the team approaches the premises of the reform

and the psychosocial attention, being a great advance in terms of the operation of this service in the studied reality.

Within the issues that involve the functioning of the PCC, we highlight the open door as one of the main strategies used by the service to guarantee the bond with the drug user. The following testimonies highlight this issue:

> *[...] The other issue I think is fundamental, is the open door that we have also built here. It is still not 24 hours, the open door is from 8 a.m. to 5 p.m., but it is something that does not require routing, it does not require users to have documents, it does not require the user to come accompanied, or if the individual is drunk, or under the effect of drugs or not, he/she will be welcomed, he/she will be taken care of and will be thought a care. (E7).*

> *Oh, I'm sorry to interrupt you, but that's the one thing I forgot to mention and that's one of the best things in Viamão, you know, let's talk about good things too, that the work is very recent like that, open welcome, there it that, this is something that has to be imitated in the whole service. We know how it works, not only the user of crack, every chemical dependent, every person who has a mental health claim needs to be heard at that moment so you understand a little, understand the tip of the iceberg that is there and there that will start to build the bond, it's here at the reception "look I needed a [...]" "ah, come back next week". That's it, but next week it's already in the "boca de fumo" (place where drugs are sold) again, that's it. So this is an achievement, two things that Viamão has better than than Porto Alegre is that and Risperidone on the net, well, Risperidone is you having to subject the guys to having to use haldol. (E8).*

> *At the time we had already met with the psychologist. (F3).*

In a study on a PCC in the southern region of Brazil,[12] one of the most innovative strategies highlighted in the composition of psychosocial care networks is the open door. For the author, the open door represents a social and sanitary commitment that promotes a revitalization of the relations between services and people. In addition, the open door would reveal new work processes that, in fact, positively affect the resolubility potential of a service. In a highly specialized service such as PCC, it is assumed that the open door is capable of providing reception and easy access to people in a situation of suffering, helping to consolidate the ideals of psychiatric reform.

With the question of open door services, one comes to the conclusion that those who stay away from services, whether due to a difficulty in reorganizing practices or by repressed demand, are increasingly dependent on the traditional clinic with its medicalizing aspect . With the creation of more precise and lasting bonds between the worker and the user, it is possible to arrive at strategies that generate autonomy in the treatment spaces. Although the opening of a service to receive demand may initially be seen as a problem, it is worth remembering that customer aggregation can be a good indicator of interpersonal ties, receptivity to receive new demands and satisfaction due to easy access.[13]

We understand that the open door recovers and revitalizes something inherent in the conformation of the substitutive proposal of mental health care, which is the valuation of individual demands. Bringing up the need for a new organization of practices, it also intersects a new model to think about drug use, since it causes a tensioning that care goes beyond the relationship between the worker and the user. It is in this context that we understand how PCC becomes a creative, innovative service when investing in projects committed to the real situation of the subject, without disregarding the look of the worker in this construction.

E8 also reveals another innovation from the municipality of Viamão, which is the availability of antipsychotic medication different from traditional options, such as Haloperidol. In the case, Risperidone is an antipsychotic that offers side effects in a smaller proportion and easier handling of the users.

Risperidone's offer is not covered in the National Relation of Official Medicines (RENAME in Portuguese), which makes it optional for its acquisition by the municipality. However, by giving the psychiatrist the opportunity to diversify psychotropic medication, without having to reduce pharmacological treatment to only one option (usually haloperidol), Viamão repositions its gaze on a mental health model that guarantees clinical care from an singular experience,without the need for standardization.

Open door operation, despite its innovative potential, also has limitations. E7, for example, ponders that there is an open door, but restricted to the day, since PCC does not work 24h.

The workers cite the need to extend the PCC AD timetable, in particular to respond to crisis situations coming in shift opposite to their normal working hours. Faced with the relevance of the theme, the researchers understood that it was necessary to know the positioning of other interest groups. Thus, this question was immediately incorporated into the circle of users, managers and family members, who pointed out the importance of this continuous care, as well as that workers circulate more throughout the territory, thus avoiding that the service is restricted to PCC.

> *I think the extension of access is for yesterday. It was already approved by the ministry of health. Now, just for us, you do not have to do the homework, I think we need to have another way of organizing and expanding this access here in the service. I think we need it and we have been discussing it, the possibility of enlarging it, we will expand by the time we have a 24 hour period, but we also have to have an investment so that we can also be more out of PCC, interactions in different spaces of the city, I think one builds a strategy, but I always say*

is not a strategy for the crack user, it is a mental health strategy. (G1).

Knowing I do not know, there are many who are adrift waiting for Monday. There are many street dwellers, who come here just to have care and also to be able to feed themselves, as I was talking to you, right? But they wander around the street, many are in the squares. (U1).

When PCC happens at the end of the week, it has already happened, I hope it will never happen again (crisis), we needed it so we did not have PCC, Saturday or Sunday or at night, so we had to appeal to 192, SAMU, but sometimes had, sometimes did not. But when had, then with the brigade they took to the Hospital of Viamão, and of the Hospital of Viamão they went to the San Pedro Psychiatric Hospital. [...] When you do not have the PCC, for example, in the weekend has to be the Hospital, at night it has to be the Hospital. It has no other place, it leads straight to San Pedro, there is no way. [...] the appeal here in Viamão is the PCC, from Monday to Friday until 17h. Then we can no longer count on health in Viamão. With SAMU and Viamão Hospital no! (F5).

I think it's essential because if we manage to do this it will radically change the access, the user, not only crack user, but they have a different relationship with the times, at nightright, they report a lot that is a time of greater fissure, of greater anguish, it is from late afternoon to night and their routine, in the great majority, is nocturnal. (E7).

Any relationship with the user in crisis requires a certain immediate effort of action, which goes beyond the threshold of containment. As a result of a set of factors inherent to the constitution of the subject, its relations and its context, the crisis once again demarcates the need for investment in the relational dimension between the worker and the user. But also permanent institutional investment, with opening of services 24 hours and creation of "spaces of dialogue", for exchange, dialogue and shared discussion between the teams.[14-15]

Despite the urgent efforts to redirect Brazilian psychiatric care, structuring service networks, it is still difficult to reverse the pyramid that places the hospital as a privileged space of care. It is in him, often, that situations of crisis arrive and stagnate, due to the insufficiency of the network. If the idea is to reconfigure the crisis in the psychiatric context, this same psychiatry must win the streets and the people. One must understand that the crisis is when the person most needs help, going beyond a simple diagnosis because it involves stories. Thus, it would be easier to establish a bond, as long as this bond happens when the need really appears.[16]

In this context, it is necessary to rethink the strategies used by the municipality to guarantee continuity of psychosocial care to the crack user, burdened, in terms, by the fissure and drug effects. We understand that the structuring of a network with an effective "open door" requires a discussion based on urgency as one of the pillars of this support.

Interest groups are, in fact, exposing an urgent issue in the context of public mental health policies in Viamão, which, despite the difficulties, must see care beyond the offer and coverage of the services, also reaching the modes of functioning of people. It is to say that there is an urgency to solve the question of the weekends and the night attendance, since the outbreak or the fissure "have no scheduled, no time to happen".

During the data collection, Viamão intensified the constitution of a working group that could build the implementation of PCC III 24h. Relatives and users, in general, pointed out that the structuring of a 24h PCC would be fundamental.

I think here we could have a PCC 24h, because the worst period is at night for us. At this moment we need someone, at this time we do not have PCC open. (U9).

It's lacking. I think it has to have a PCC 24HS as it has, I do not know if in São Paulo or Rio de Janeiro. [...] I think it would have to have, because here it is really lacking, including me, my friends died of crack overdose, from so much smoking, and never got care. (U7).

When he's too crazy to take an injection, I do not know, to stay for two or three days ... I could have, at least to get you and have a care for this specialty, because here [in PCC] it's not all days it is open, the weekend is not open, holidays are not open. (F2).

Managers and workers also evaluated this need, discussing the potential of having a PCC III functioning in Viamão:

I think it's very important to expand to 24 hours, as proposed by the municipality, if you have PCC III, I think it's going to be very important for us, we can offer this service closer to the user, when extending this service 24 hours, I think access will also be differentiated. (G2).

And this idea of PCC III we are really waiting for it to be implanted, it will make a lot of difference for the users here. Not only for those who do not have, not only for those who are in street situation, but for those who have their homes also, sometimes be able to be coming and stay until a little later and get to go home closer to bedtime, to just lie, bathe and sleep and not to stay here thinking, not being alone during these hours. (E4).

I think the PCC III is extremely necessary because of the whole problem with the emergency we have in the municipality withf alcohol and other drugs, but we really have these fears, but the moment they start to be built, start being disclosed to who will have a PCC III, we have clear to us how to proceed to the care of these people, which we know at most will be short term hospitalization that we would do. (E6).

However, some workers see that it is necessary to better define the philosophy and purposes of PCC III. Despite the recognition of institutional relevance, care must be taken to ensure that the service does not become a shelter, a moment of passage, since, due to its 24-hour operation, it can be accessed by the user to eat and sleep.

> *I also do not know if PCC 24 h project will not be a shot in the foot, the network itself will turn to a hostel, right the guys are going to come here, eat but something's missing right, because proper health care… I don't know if it will have.* (E3).

The PCC III is a service that, according to Ordinance 336/2002[17], is intended for the care of people with mental disorders or problems related to the use of alcohol and other drugs for 24 hours, seven days a week. It can be installed in municipalities with a population coverage of more than 200,000 people and must have a specialized team that offers daily activities and nighttime reception to the crisis.

Being an innovative service, with territorial coverage throughout the day and also on weekends, it is important to emphasize the importance of its constitution in the reality of Viamão. However, we must consider that the PCC III alone should not be the only and absolute responsible for meeting the demands that appear outside the traditional hours. We do not want a possible "danger of diversion"[18] to occur in Viamão of the dialectical character of the reform, that is, the indiscriminate creation of PCC or its modernization to absorb demands that can (and should) be distributed through the network. For this reason, in addition to the PCC III, it is necessary to invest in strengthening the articulation with the General Hospital, with the services of the basic network and also with the traditional emergency network.

We believe that the issues raised by interest groups on Viamão PCC AD exceed the on-site functioning of the service, since they involve the structuring of the network, diverse conceptions of the clinic and the involvement with the user, their life project and their relationships. The unique dimension of care in the psychosocial field permeates not only the internal functioning of the PCC, but also its environment, contemplating scenarios, contexts and processes. In the path of psychosocial attention, this problematization innovates and enriches the practice, giving new contours to the relationship established between the network, services and the care to the user.

CONCLUSION

The study showed that PCC AD is one of the most powerful services in the crack user service network, working with many of the demands of users and family that seek daily care. There are innovative strategies highlighted by interest groups, such as the user-centered mode of communication based on the link and the host, as well as the open door, which guarantees universal access and is committed to the needs of the people.

However, the PCC must not (nor was it born to) absorb all the demands of mental health. This is where the interest groups emphasize the need to invest in a network composition that goes beyond the walls of specialized services. Thus, it is necessary to incorporate the relevance of constituting extended access to the weekends and at night, precisely when the user of the drug is more susceptible to its effects.

The evaluation research developed here has brought to the debate on the phenomenon of the use of crack, a tendency that demarcates the priority aspect in the hospitalization, typical strategy of the asylum model. On the contrary, it has strengthened not only the participation of the actors in the process of daily constitution of the network, but also led us to reflect on the reforming capacity of the services and the various elements that are part of this process.

REFERENCES

1. Pinho LB, Kantorski LP. Psychiatric care in the Brazilian context. Ciên. Saúde Colet 2011 [acesso em: 16 jul 2014];16(4):2107-14. Disponível em: http://dx.doi.org/10.1590/S1413-81232011000400010
2. Sampaio JJC, Guimarães JMX, Carneiro C, Filho CG. O trabalho em serviços de saúde mental no contexto da reforma psiquiátrica: um desafio técnico, político e ético. Ciênc. Saúde Colet. 2011 [acesso em: 16 jul 2014];16(12):4685-94. Disponível em: http://dx.doi.org/10.1590/S1413-81232011001300017
3. Laranjeira R. Legalização de drogas e a saúde pública. Ciên. Saúde Colet. 2010 [acesso em: 16 jul 2014];15(3):621-31. Disponível em: http://dx.doi.org/10.1590/S1413-81232010000300002
4. Brasil. Ministério da Saúde. Decreto nº 7.179, de 20 de maio de 2010. Institui o Plano Integrado de Enfrentamento ao Crack e Outras Drogas, cria seu Comitê Gestor, e dá outras providências. Brasília: Ministério da Saúde; 2010.
5. Moura FG, Santos JE. O cuidado aos usuários de um centro de atenção psicossocial álcool e drogas: uma visão do sujeito coletivo. SMAD, Rev. Eletrônica Saúde Mental Álcool Drog 2011 [acesso em: 20 abr 2014];7(3):126-32. Disponível em: http://www.revistas.usp.br/smad/article/view/49585/53660
6. Guba EG, Lincoln YS. Avaliação de quarta geração. Campinas: Unicamp; 2011.
7. Kolb SM. Grounded theory and the constant comparative method: valid research strategies for educators. JETERAPS 2012;3(1):83-6.
8. Lacchini AJB, Ribeiro DB, Soccol KLS, Terra MG, Silva RM. A enfermagem e a saúde mental após a reforma psiquiátrica. Rev. Contexto Saúde 2011 [acesso em: 22 out 2017];10(20):565-68. Disponível em: https://www.revistas.unijui.edu.br/index.php/contextoesaude/article/viewFile/1579/1334
9. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. Agir em saúde: um desafio para o público. 3. ed. São Paulo: Hucitec; 2007. p. 71-111.
10. Rocha G, Barcelos ICRR. A relação intersubjetiva no cuidar de enfermagem em saúde mental – competência para o cuidado em saúde mental. R. Pesq.: Cuid. Fundam. Online 2010 [acesso em: 20 abr 2014];2(ed. supl.):921-25. Disponível em: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1180/pdf_329
11. Ballarin MLG, Carvalho FB, Ferigato SH. Os diferentes sentidos do cuidado: considerações sobre a atenção em saúde mental. Mundo Saúde 2010 [acesso em: 16 jul 2014];34(4):444-50. Disponível em: http://www.saocamilo-sp.br/pdf/mundo_saude/67/218a224.pdf
12. Pinho LB. Análise crítico-discursiva da prática de trabalhadores de saúde mental no contexto social da reforma psiquiátrica. Tese [Doutorado] – Universidade de São Paulo; 2009.

13. Franco TB, Merhy EE. Cartografias do trabalho e cuidado em saúde. Tempus, Actas de Saúde Colet. 2012 [acesso em: 16 jul 2014]; 6(2):151-63. Disponível em: http://www.tempusactas.unb.br/index.php/tempus/article/view/1120/1034
14. Costa MS. Construções em torno da crise. Saberes e práticas na atenção em saúde mental e produção de subjetividades. Arq. Bras. Psicol 2007 [acesso em: 16 jul 2014];59(1):94-108. Disponível em: http://pepsic.bvsalud.org/pdf/arbp/v59n1/v59n1a10.pdf
15. Ferigato SH, Campos RTO, Ballarin MLGS. O atendimento à crise em saúde mental: ampliando conceitos. Rev. Psicol. Unesp 2007 [acesso em: 16 jul 2014];6(1):31-44. Disponível em: http://www2.assis.unesp.br/revpsico/index.php/revista/article/viewfile/44/84.html
16. Jardim K, Dimenstein, M. Risco e crise: pensando os pilares da urgência psiquiátrica. Psicol. Rev 2007 [acesso em: 16 jul 2014];13(1):169-90. Disponível em: http://www.pucminas.br/imagedb/documento/DOC_DSC_NOME_ARQUI20080521172535.pdf
17. Brasil. Ministério da Saúde. A política do Ministério da Saúde para a atenção integral a usuários de álcool e outras drogas. Brasília: Ministério da Saúde; 2004.
18. Amarante P. A clínica e a reforma psiquiátrica. In: Amarante, P, coordenador. Archivos de saúde mental e atenção psicossocial. Rio de Janeiro: Nau; 2003. p. 45-65.

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