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The Intervening Factors on the Treatment Adherence of Drug Users Assisted By a *Caps-Ad*

Fatores Intervenientes na Adesão ao Tratamento de Usuários de Drogas Atendidos no Caps-Ad

Factores Intervenientes en la Adhesión al Tratamiento de Usuarios de Droga Atendidos en el Caps-Ad

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ABSTRACT

Objective: The study's purpose has been to recognize the interfering factors on the ambulatory treatment adherence by drug users. **Methods:** It is a descriptive study with a qualitative approach. Data were collected over the period from August to December 2015 through an interview process with seven users and following taken to thematic content analysis. **Results:** The first contact with drugs usually occurs by friends influence, while the search for treatment in the Psychosocial Care Center for Alcohol and other Drugs [*Centros de Atenção Psicossocial Álcool e outras Drogas* (CAPS-AD)] occurs by own person's will, considering that the family interferes positively in the initiation and also in the continuity of the treatment. The factors favoring adherence to treatment were as follows: the availability of health professionals to provide the care, which goes against the difficulty in accessing the service. **Conclusion:** The following was perceived as necessary in order to maintain the adherence to ambulatory treatment: the user's desire to stop using drugs, family support, personal bonds with the professionals, and easy access to the service in regard to the geography, financial and structural parameters.

Descriptors: Alcoholism, Illicit Drugs, Motivation, Mental Healthcare Services, Family.

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RESUMO

Objetivo: Conhecer os fatores que interferem na adesão de usuários de drogas ao tratamento ambulatorial. **Métodos:** Estudo descritivo, de natureza qualitativa, cujos dados foram coletados entre agosto e dezembro de 2015 por meio de entrevista com sete usuários e submetidos à análise de conteúdo temática. **Resultados:** O primeiro contato com as drogas normalmente ocorre por influência de amigos, enquanto a busca por tratamento no CAPS-ad ocorre por vontade própria, sendo que a família interfere positivamente no início e também na continuidade do tratamento. Os fatores que favorecem a adesão ao tratamento foram: disponibilidade dos profissionais de saúde no atendimento aos pacientes, o que se contrapõe à dificuldade de acesso ao serviço. **Conclusão:** Para manter a adesão ao tratamento no âmbito ambulatorial se faz necessário: desejo do usuário em parar de usar drogas, apoio familiar, vínculo com os profissionais e facilidade de acesso ao serviço, em termos geográfico, financeiro e estrutural.

Descritores: Alcoolismo, Drogas Ilícitas, Motivação, Serviços de Saúde Mental, Família.

RESUMEN

Objetivo: Conocer los factores que interfieren en la adhesión de usuarios de drogas al tratamiento ambulatorial. **Métodos:** Estudio descriptivo, de naturaleza cualitativa, cuyos datos fueron recolectados entre agosto y diciembre de 2015 por medio de una entrevista con siete usuarios y sometidos al análisis de contenido temático. **Resultados:** El primer contacto con las drogas normalmente ocurre por influencia de amigos, mientras que la búsqueda por tratamiento en el CAPS-ad ocurre por voluntad propia, siendo que la familia interfiere positivamente al inicio y también en la continuidad del tratamiento. Los factores que favorecen la adhesión al tratamiento fueron: disponibilidad de los profesionales de salud en la atención a los pacientes, lo que se contrapone a la dificultad de acceso al servicio. **Conclusión:** Para mantener la adhesión al tratamiento en el ámbito ambulatorio se hace necesario: deseo del usuario en dejar de usar drogas, apoyo familiar, vínculo con los profesionales y facilidad de acceso al servicio, en términos geográfico, financiero y estructural.

Descriptores: Alcoholismo, Drogas Ilícitas, Motivación, Servicios de Salud Mental, Familia.

INTRODUCTION

The abusive use of alcohol and other drugs is a present and worrisome phenomenon throughout the world. Approximately 10% of the world's population are drug abusers and 3.2% of the total deaths are due to alcohol use.[1] A United Nations report on Drugs and Crimes indicates that 68.7% of the adult population consumed alcohol at some time in their lives, and 11.2% had drug addiction.[1]

Drug legislation in Brazil has undergone major changes in the last 20 years. The National Anti-Drug System was created in 1998, in 2002 the National Anti-Drug Policy and in 2003 through the Policy of Integral Attention to Users of Alcohol and Other Drugs, therefore, the Ministry of Health linked the service of drug users to mental health, valuing the care in out-of-hospital networks, having as caregivers the *Centros de Atenção Psicossocial Álcool e outras Drogas* (CAPS-AD) [Psychosocial Care Center for Alcohol and other Drugs].[2]

The CAPS-AD initiative triggered a major change in the scenario of care for patients dependent on alcohol and other drugs, who were previously treated almost exclusively in psychiatric hospitals.[2] Thus, the Brazilian government has adopted several strategies aimed at combating the advance of alcohol abuse and other drugs through the integration of services.

The Psychosocial Care Network (PSCN), established in 2011, whose purpose is to create, expand and articulate points of health care for people suffering from mental disorders and suffering from alcohol and other drug use within the *Sistema Único de Saúde (SUS)* [Unified Health System], proposes the strengthening of extra-hospital services, such as the Psychosocial Care Centers, Therapeutic Residential Services, Conviviality Centers, Psychiatric Units in General Hospitals, generational income workshops, including the implementation of public policies and actions in mental health carried out in primary care, redirecting the mental healthcare model.[3]

Nevertheless, despite the Ministry of Health effort in this regard, there is still a large number of patients who discontinue treatment before its end. Such occurrence is highly detrimental to policies directed at alcohol and other drug users, since the efficacy of any treatment depends largely on patient compliance.[4]

Therefore, it is necessary to consider the multiple factors that interfere in adherence to the treatment of chemical addiction. Among the factors considered to be intrinsic are the individual motivation for behavioral change and treatment, the illusory idea that only drugs cause rehabilitation and the type of psychoactive substance of dependence. Among the extrinsic factors, family support and participation in treatment is considered; the influence of the social environment and the financial and labor conditions, and finally the influence of the service itself, which involves reception, infrastructure, training and the link between users and health professionals.[5]

Hence, it is important that the services provide appropriate approaches and that aim to improve the adherence of this clientele due to the gap between the motivations that lead the user to want to stop the use of drugs and the effective search for treatment.[6] Bearing in mind the aforementioned and recognizing the importance of this theme, the present study aims to know the interfering factors on the ambulatory treatment adherence by drug users.

METHODS

It is a descriptive study with a qualitative approach, which was carried out at the *CAPS-AD* in the city of *Maringá/Paraná* State. In this service, the activities carried out include: therapeutic workshops, and various groups, such as reception, family orientation, health education and psychopedagogical. Furthermore, the multiprofessional

team is responsible weekly for the elaboration, presentation, and discussion of the Singular Therapeutic Project (STP), taking into account the individual needs of each user, allowing greater autonomy, and especially, the psychosocial reinsertion of the individual in his/her sociocultural context.[7]

In order to select the participants, the inclusion criteria were as follows: being 18 years old or older, had been attending the service for at least three months, and was participating in one of the active health education groups. These groups are coordinated by nurses and participation/attendance is a prerequisite for the user to receive the other services (group or individual). The meetings (nine) are fortnightly, developed in the form of open group and offered in the three work shifts. About 15 users have participated. The topics covered include hypertension, diabetes, HIV/AIDS, STDs, use of alcoholic beverages, use of marijuana, liver cirrhosis/hepatitis, smoking, and tuberculosis. The users referred to the judicial service were excluded from the study.

The data were collected from August to December 2015 through an open interview with the following guiding question: What motivated you to attend the services offered by the *CAPS-AD*? The number of respondents was not determined a priori, since in the qualitative research the data collection must occur until the moment the information begins to repeat itself and the objectives of the study have been reached.

The interviews were conducted at the study location, which has several rooms for individual care, which allowed privacy during them. They had an average duration of 50 minutes, were performed by the first author and recorded in digital media after the consent of the participants.

The first contact was made in the presence of the nurse responsible for the group, at which time the objectives of the study were presented and the type of participation desired was explained. After a positive manifestation, a maximum of two individual interviews per day were scheduled, and these were performed after the end of the health education activities, so as not to interfere with the routine of the service.

The interviews were transcribed in full and later taken to content analysis, thematic modality,[8] following the steps established by the referential that included pre-analysis, material exploration, and data handling. In the pre-analysis the organization, transcription, and separation of the data set took place. Then the free reading of the empirical material with initial identification of relevant aspects from the objective of the study was done. In the exploration of the material, the classification and aggregation of the data were done through a thorough reading process, with the identification of the common and specific aspects, giving rise to the previous categories. Ultimately, in the data treatment, the categories were deepened by articulating the empirical findings with the theoretical material, constantly considering the research objectives and the emerging themes of the analytical process.

The development of the study followed the procedures established by the Resolution No. 466/2012 from the National Health Council, which are: authorization of the Municipal Secretary of Health and approval by the Research Ethics Committee involving Human Beings of the *Universidade Estadual de Maringá* (Legal Opinion No. 1.349.731). All participants signed the Informed Consent Form (ICF) in two ways and to ensure anonymity were identified by the letter P (participant) and sequential numbers indicative of the interview order.

RESULTS AND DISCUSSION

The seven participants were within the age group from 27 to 42 years old, being four males. Three were abusing alcohol, three were users of illicit drugs and one used alcohol and other drugs. Four of them were undergoing treatment for social reinsertion and cessation of chemical use for the first time and the others had already performed other types of outpatient treatment. The analyzed data were grouped into two categories, which will be presented next.

How it all begins: the trajectory into the world of drugs and the desire for change

Four interviewees revealed that adolescence was a troubled and propitious phase for the initiation of the use of illegal or illicit drugs, constituting a debilitating factor to the use of drugs.

> *(...) since the age of 15, by the influence of friends, curiosity, and when you see you are all on it (P2).*

> *(...) well, I started adolescence to drink beer, even with my friends... but then my father died, [...] then I think it was from there that I started with alcohol also, I drink to escape from the problems [...], then came the crack also [...] (P5).*

After the initiation period, it is observed that the maintenance of addiction is related to the experience of unpleasant moments, and these situations are known by them, remembered and related to compulsive use, without control, with detrimental consequences in the individual or collective scope, being the family more affected due to the nearer conviviality.

> *He wanted to stop because it harmed him, the more he earned, the more he spent on marijuana and cigarettes. There is also the loss of memory, because sometimes I put this (I took a pen) somewhere, hence I'm looking for it and I realize, it's in the same place where I put it (P1).*

When she drank and smoked, she used to get agitated, sometimes hot-tempered, you know. That was the danger, can you imagine my children, then? (P5).

Nonetheless, the fear of losing control of the situation, with consequent addiction on these substances, led participants to seek healthcare services.

I came by my own will, wanted to quit smoking and then I told my mother to do it for me, she went to the clinic and made the appointment for me. Then I went to talk to the psychologist and then she sent me here (CAPS-AD) (P1).

Well, I looked for the CAPS-AD service of my own free will, because of the alcoholism that made me very aggressive, many family conflicts, friends, service, everything [...] (P2).

It is emphasized that the family incentive was one of the factors that, either directly or indirectly, most influenced the demand for treatment. In these cases, the main objective was to improve the family and social relationship.

I already did several treatments in the alcoholic anonymous, but it got to a point that I came here because of my mother advices, my wife insisted, then I came (P3).

In addition to acting as an incentive to start addiction treatment, family members are also important in maintaining and preventing future relapses.

[...] Oh yes, they support, the whole family supported. When they see that I am stressed, nervous, already say "have you taken the medication today?" (P2).

It is noteworthy that in comparing previous experiences of treatment in psychiatric institutions or therapeutic communities, users referred to a preference for the CAPS-AD due to the fact that in this service there is no lack of freedom.

Well, I came here because I'm afraid of being hospitalized in the insane asylum (P5).

I came because I've been looking for help in those places that help people who use drugs, you know. I spent a few months there, I think about 6 or 7 months, then I left, and I did not drink anymore. But when I felt like it again, I came to look for help here, the people there had already told me about it, I came to see how it is, I did not know it (P6).

Intervening factors towards the treatment adherence

As a potential of care in the *CAPS-AD*, it is observed that the assistance is based on the needs of each user, through the preparation of the unique therapeutic project elaborated by the multiprofessional team.

Nowadays, I come every Monday, in the group of 11 a.m. and then there is the 1 p.m. in the afternoon (...) The health education is over, there were 9 topics. I know what cigarettes and marijuana mean, I have been smoking marijuana about 11 years and about 12 years the cigarette (P1).

Moreover, the group activities were mentioned by the interviewees as a motivating factor for the permanence in the service and continuity to the treatment.

I think that here is the best for us, to know more things, other diseases, other capacities of ourselves (P7).

Here, I like the groups, to know that there are more people in the same situation, you know. Sometimes it even makes me think about stopping, getting better. Things are not easy for anyone, except that in the one group it supports the other, like those groups of alcoholics that we see in the movies [...] (P4).

The personal relationships that users construct in the service, both with health professionals and with other users, make them feel free to express opinions, anguish, and feelings. This strengthens the personal bond with the professionals and, as a consequence, makes the patients develop confidence in the professionals and feel valued by the service.

[...] one thing that happened to me when I came here at the CAPS, was that I liked the consultations with the psychologist, I did not miss too, but when I needed to, she would call me asking what had happened. We realize that they mind us (P3).

The staff here do listen to you, whatever time you call here, they will listen (P2).

On the other hand, the inconveniency of access was cited as a factor hindering the maintenance of treatment. This difficulty arises from the fact that there is only one *CAPS-AD* in the municipality, and it is located far from the center of the city.

I live in Floriano city, so it's hard to keep coming, I come in the ambulance of the city (P5).

It was difficult when the CAPS came here, at first, I did not know where it was, so I ended up missing a group day, but then I discovered that and I came here. It's kind of a long way from home, but I have to, so I have to come anyway (P6).

Another weakness pointed out is the delay for individual care with different professionals, as well as the lack of medication to maintain treatment.

What I do not like here is that it takes too long, we have to wait a very long time. I spend the whole afternoon here (P4).

Well, today I struggled to get the medicine, I went to my city and they did not have it, I did not have it either; But I got lucky because after I left here, I found the medication in the pharmacy close to my home (P7).

Adolescence is a time when one tries to reach the limit and discover the unknown. And in this search, drugs are the ideal decoy for the mobilization and escape of anguish experienced by the changes that are occurring in the body and in relationships with the other.[9] In this sense, it has been evidenced that the beginning of drug use in adolescence, is related to easy social or economic access, to excessive work and study burden, to stress and lack of knowledge about the possibility of chemical dependence, influence of friends and relatives, and these also influence the search for treatment.[10]

This abusive behavior causes socioeconomic, psychological and cultural damages, among others, causing the reduction of conditions and quality of life for the user and family, loss of professional opportunities, interference in family and social relations.[11-2] However, when the user is seen at the bottom of the well, identifying and relating the compulsive use of drugs with the unpleasant facts and situations that experience, there is a behavioral change, which encompasses the search for help. Motivations such as fragile health, the experience of violence in their daily lives and the desire for change, as well as expectations related to their willingness to abandon drug use and to (re)build relationships with family and work, tend to stimulate demand for help.[6,13]

It is understood that the family and its relationships act as potential factors for adherence to treatment by the user. This fact is due to the family participation in the process of growth and emotional maturation of these individuals.[6] For the same reason, a broken family context can be the trigger for drug use, and domestic violence and the use of alcohol or drugs at home has been perceived as a weakening factor to the family structure.[14]

Nowadays, the treatment aimed at the social reinsertion of alcohol and drug users is carried out by the *CAPS-AD* service, focusing on individualized therapeutic planning, in which both family support and family care are valued.[15] In this context, the health services should prioritize light technology as an instrument to achieve the integrality and humanization of care, both for family members and for users seeking care.

This practice can be based on reception, dialogue, bonding, co-responsibility, and active listening. This is because completeness is present in the meeting, in the conversation, in the attitude of the professional who wisely seeks to recognize, beyond explicit demands, the needs of citizens with regard to their health.[16]

Herein, the potentialities mentioned by the users in relation to the service refer to the established link with the professionals, the reception, listening and the existence of a STP. Similar results were found in a *CAPS-AD* in the interior of *São Paulo*, demonstrating the satisfaction of the users regarding the competence and understanding of the team about their problems, help received and the welcoming coming from the team and the physical conditions and comfort of the *CAPS-AD* service.[17]

Hospitalization is a key tool to increase the link between professional and user, moreover, it makes possible a better understanding of the disease and stimulates self-care.[18] In this same line, the integral care stands out, which is understood as a set of actions that aims to encompass the individual in a full way, by means of welcoming attitudes on the part of the professionals of the area and responsibility of the individuals in front of their problems, appearing as one of the challenges of the practice in health.[19]

In relation to STP, the psychosocial care model recommends that its elaboration, be adequate for the characteristics of each patient, with the purpose of providing social reintegration activities, then enhancing the link with the service, social interactions, and the users' self-esteem.[20]

A study performed in a *CAPS-AD* from *Cuiabá* city/*Mato Grosso* State showed that STP resulted in family awareness and clarification of doubts about the psychic suffering of the user, favored the joint elaboration of the care plan and, consequently, the strengthening of the bond, since the user and family were present throughout the process, resulting in the construction of their autonomy. Thus, this device can be considered as indicative of the quality of the care process, as well as of the level of relationship between the professionals of the team.[21]

In addition to STP, the development of therapeutic workshops allows the projection of internal/external conflicts through artistic activities, in addition to strengthening self-esteem and self-confidence.[18] In this same direction, the therapeutic workshops were identified by several professionals working in the *CAPS* of *Pelotas* city/*Rio Grande do Sul* State, as important for the expression of the patients' subjectivity, allowing the participants to participate actively in their process of psychological and social rehabilitation.[22]

In relation to the weaknesses of the service, users made reference to the difficulty of access to it. It should be noted that according to the ordinance that regulates the functioning of the PSCN, one of its guidelines mentions the guarantee of access and quality of services, offering comprehensive care and multiprofessional assistance, under the interdisciplinary logic.[3] term access is a complex concept, which should not be understood just as the act of entering or joining, should be broadened to the understanding of accessibility. So, it can be understood as an intrinsic relation between service provision and its impact on the population's capacity to use it.[23]

The difficulty of access has been demonstrated in some studies,[23-4] suggesting that the coordination of integral care is a challenge for *SUS*, since both geographical and organizational access include peculiarities that favor or prevent people from receiving the care they need. In this sense, there

is an urgent need for greater integration between mental health teams and the Family Health Strategy, incorporation of mental health into the daily life of the reference team, diversification of therapeutic proposals and expansion of the clinic and reduction strategy of damages.[23]

It is worth mentioning that in Brazil, harm reduction policies related to drug use have been widely discussed. However, as public policy, its weaknesses are evident, since they rarely contemplate the monitoring and evaluation of projects and programs effectively implemented. Other issues to be addressed include validation of procedures, adherence and clinical follow-up of users, and epidemiological monitoring.[25]

Through this study, one can understand the factors that motivate the users in the search and maintenance of the treatment. Although, it was limited by the fact that some interviewees were performing their first treatment while others had already performed some kind of outpatient treatment. Therefore, it is not possible to infer that the perceptions described here are the same or similar to those of other people being treated in *CAPS-AD* in other regions of the country.

Conclusively, the importance of studies in this area is emphasized so that users' perceptions can be taken into account in the various places where they are inserted, as well as in the planning of attention strategies and the evaluation of public policies that meet the needs of this population.

CONCLUSIONS

The results of the study show some factors that weaken the use of drugs, such as initial contact with alcohol and/or other drugs from the influence of friends, attempted escape of personal, family and professional issues, and even out of curiosity, especially in adolescence. In turn, the initiation of the treatment of dependence is favored by the family support or by their own initiative before the awareness of the financial losses, in the health and quality of life itself and also of his family.

It should also be pointed out that in relation to the service, the performance of the multiprofessional team was cited as a positive factor in maintaining the purpose of maintaining adherence to treatment. In this sense, they emphasized the reception, singular therapeutic project, activities in group and the availability of the professionals to meet the demand of patients, being always willing to listen and to advise. On the other hand, the distance between home and the service was pointed out as a negative factor and as such may impair adherence to the proposed treatment.

It is important to underline the need for larger incorporation of mental healthcare into the daily life of all professionals working at the points of the mental healthcare network, so that the user can be welcomed in a comprehensive way, with greater accessibility, diversification of therapeutic proposals and expansion of the clinic at any point in PSCN in an integral and continuous manner.

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