



Fourth-generation evaluation in an Alcohol and Drugs Psychosocial Care Center^a

Avaliação de quarta geração em Centro de Atenção Psicossocial Álcool e Drogas
Evaluación de cuarta generación en Centro de Atención Psicossocial Alcohol y Drogas

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ABSTRACT

Objective: To qualitatively evaluate the actions provided by an Alcohol and Drugs Psychosocial Care Center from the perspective of family members and service users. **Method:** This is a qualitative case study developed using the fourth-generation evaluation method from September 2019 to March 2020. Data were collected through observation and individual open interviews and analyzed by the constant comparative method; nine family members and eight service users were informants. The ATLAS.ti 9.0.18 software was used to help organize and present the data. **Results:** Both focus groups highlighted positively the free treatment, reception, support, and information provided by the team through the groups, social reintegration, and providing medication. In addition, psychologists and social workers were cited as the professionals that the participants felt the closest to. Access to care was cited with ambiguity by the focus groups, and the weaknesses included the continuity of care by the points of the psychosocial network. **Final considerations and implications for practice:** This study recognizes the effectiveness of the service, although it requires improving the articulation of interprofessional and intersectoral actions among the other points of care and including the family in the treatment.

Keywords: Health Evaluation; Substance Abuse Treatment Centers; Family; Mental Health Services; Drug Users.

RESUMO

Objetivo: Avaliar qualitativamente as ações ofertadas por um Centro de Atenção Psicossocial Álcool e Drogas na perspectiva dos familiares e dos usuários do serviço. **Método:** Estudo qualitativo, do tipo estudo de caso, desenvolvido pelo método de avaliação de Quarta Geração, nos meses de setembro de 2019 a março de 2020. Os dados foram coletados por meio da observação e de entrevista aberta individual e analisados pelo Método Comparativo Constante. Os informantes foram nove familiares e oito usuários do serviço. Para auxiliar na organização e na apresentação dos dados, utilizou-se o *software ATLAS.ti 9.0.18*. **Resultados:** Ambos os grupos de interesse ressaltaram positivamente a gratuidade do tratamento, o acolhimento, o apoio, as informações ofertadas pela equipe por meio dos grupos, a reinserção social e a oferta de medicação. Além disso, psicólogos e assistentes sociais foram citados como profissionais de maior proximidade. O acesso foi citado com ambiguidade pelos grupos de interesse, e as fragilidades incluíram a continuidade do cuidado pelos pontos da rede psicossocial. **Considerações finais e implicações para a prática:** O estudo reconhece a eficácia do serviço, no entanto, necessita aprimoramento na articulação das ações interprofissionais e intersetoriais entre os demais pontos de atenção e a inclusão da família no tratamento.

Palavras-chave: Avaliação em Saúde; Centros de Tratamento de Abuso de Substâncias; Família; Serviços de Saúde Mental; Usuários de Drogas.

RESUMEN

Objetivo: Evaluar cualitativamente las acciones ofrecidas por un Centro de Atención Psicossocial Alcohol y Drogas en la perspectiva de los familiares y usuarios del servicio. **Método:** Estudio cualitativo, del tipo de estudio de caso, desarrollado por el método de evaluación de Cuarta Generación, entre los meses de septiembre de 2019 hasta marzo de 2020. Los datos se recogieron mediante la observación y la entrevista abierta individual y se analizaron mediante el Método Comparativo Constante. Los informantes fueron nueve familiares y ocho usuarios del servicio. Se utilizó el *software ATLAS.ti 9.0.18* para ayudar a organizar y presentar los datos. **Resultados:** Ambos grupos de interés destacaron positivamente la gratuidad del tratamiento, la acogida, el apoyo y la información ofrecida por el equipo a través de los grupos, la reinserción social y la oferta de medicación. Además, los psicólogos y los trabajadores sociales fueron mencionados como profesionales de mayor proximidad. El acceso fue aludido con ambigüedad por los grupos de interés, y entre los puntos débiles estaba la continuidad de la atención por parte de los puntos de la red psicossocial. **Consideraciones finales e implicaciones para la práctica:** El estudio reconoce la eficacia del servicio, sin embargo, necesita mejorar la articulación de las acciones interprofesionales e intersectoriales entre los demás puntos de atención y la inclusión de la familia en el tratamiento.

Palabras-clave: Evaluación de la salud; Centros de Tratamiento de Abuso de Sustancias; Familia; Servicios de Salud Mental; Usuarios de Drogas.

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INTRODUCTION

In 2017, there was the reorganization of some points of the Psychosocial Care Network (RAPS) with the return of psychiatric hospitals as members of the network, starting a process of dismantling what has been achieved throughout decades due to the Psychiatric Reform (PR)¹. This change, along with the others that occurred in mental health policy, represents a significant risk to community-based services, especially substance abuse treatment centers.

In 2019, changes in the guidelines of the National Drug Policy legitimized therapeutic communities as a treatment strategy for substance users, prioritizing abstinence over harm reduction and disregarding psychosocial care services as the principal places of care and treatment for this population².

Such changes imply losing rights that had been previously won in the context of the PR, consequently weakening the activities developed until then by the Alcohol and Drugs Psychosocial Care Centers (CAPS-AD). Hence, this context highlights the relevance of social participation for mental health care to prioritize psychiatry to the detriment of other fields of knowledge, the expanded clinic, and interdisciplinary teamwork³.

Despite the unfavorable scenario, CAPS-ADs prioritize care and assistance directed to drug users and their families as a specialized and territorial service in the RAPS; although it also requires care, the latter should be seen as a unique and participatory partner in this process⁴. Therefore, the participation of family members and users in building care favors the result and mobilizes the groups involved and makes the social reinsertion and autonomy of care possible, thereby valuing assistance to the user and family context contributing to constructing knowledge from the experiences lived^{5,6}.

The sharing of experiences among professionals, users, and family members can inspire the construction of new possibilities in psychosocial care through the collective building in the conviction of a care practice that considers the individual⁷. To this end, in-service evaluations are essential tools to seek answers and a central strategy to verify aspects of health care quality, which is fundamental for expanding and qualifying access and care to the population^{8,9}.

In this sense, there is a need to invest in a proposal guided by a participatory health evaluation model, giving voice to the groups involved, seeking systemic, dynamic, and interactive methods, providing the necessary protagonism to all institutional actors, and improving the service^{8,9}.

Hence, considering the importance of community/social participation for the construction of care in psychosocial care, especially concerning alcohol and drug consumption, this study aims to qualitatively evaluate the actions provided by a CAPS-AD from the perspective of the family members and users of the service.

METHODOLOGY

This study employs an evaluative and qualitative approach and is part of a dissertation project entitled "Fourth-Generation Evaluation in an Alcohol and Drugs Psychosocial Care Center" supported by the theoretical and methodological framework of the fourth-generation evaluation model¹⁰. This evaluation has a hermeneutic-dialectic, constructivist, and responsive approach.

This study was conducted at a CAPS-AD of a medium-sized municipality in southern Brazil; in this center, the activities performed include therapeutic workshops, psycho-pedagogical groups, health education groups, and family guidance. It is constituted by a multi-professional team that welcomes users and family members seeking the service by spontaneous demand or referred by other devices. It is open from Monday to Friday from 7 am to 9 pm.

Two focus groups participated in the study. The first group consisted of nine family members who were being followed up at the CAPS-AD, and the second group had eight users being treated at the center. The study included family members and users over 18 years of age who had been attended at least once at the center three months before the study.

Information was collected from September 2019 to March 2020 through observation and individual interviews established by the hermeneutic-dialectical circle (HDC). Field observations totaled 218 hours and were recorded in a field diary. The participants were individually invited to participate, and interviews were held at the end of the scheduled care in a private room. The HDC guided the interviews, and the researcher selected the initial respondent (R1) of each group based on the respondent with the highest attendance in the services during the observation period.

Initially, two guiding questions were asked: "How does the CAPS-AD that you attend work?" and "What are the strengths and weaknesses of the CAPS-AD?" After R1's statement, the claims, concerns, and questions (CCQs) were analyzed, leading to the initial construct (C1). For the next respondent (R2), who had been indicated by R1, the same guiding questions and the initial construct (C1) were introduced for them to comment on. This process was repeated until the circle was closed without new indications or constructions that presented no new data¹⁰.

The HDC was concluded when the CCQs did not lead to new data. Following this criterion, we decided to conclude the HDCs of family members by interviewing the ninth respondent (R9) and users by interviewing the eighth respondent (R8). The interviews were audio-recorded and transcribed completely and analyzed using the constant comparative method, which allows data to be analyzed concurrently with their collection¹⁰.

Afterward, the next step consisted of the negotiation session, which is when a set of questions can be consensually validated by the interviewees or modified by adding new information; nonetheless, this did not occur due to the COVID-19 pandemic and the restrictions imposed by it¹⁰. Thus, the data presented herein come from the interviews conducted using the HDC of both focus groups.

have problems, that we have difficulties, and they solve these issues (U5).

I went through all of these professionals, and it's such a vast team of professionals, and I was always very well supported and cared for (U4).

Look, in our case, we are a family; we went through this healthcare group (with a social worker) and psychological assistance. So, I see that it is even more help; in our case, it was more of psychological assistance (F5).

The access of users/family members to the service brought an ambiguous evaluation, being understood as positive for the availability of extended hours, which allows patients to be attended by those involved without jeopardizing their professional activities. Nevertheless, the geographic location of the service was negatively evaluated, considering that the CAPS-AD is in a neighborhood with high drug consumption and sales.

The schedule here is good; this time I come here, I leave work and come here; for me, it's a convenient schedule, which is not during my working hours (F6).

Our greatest difficulty is actually the distance because we live on the other side of town. We leave work and come straight here. And we have accompanied him too; we come together, it is a bit far (F5).

It seems that the movement of patients has dropped concerning where it used to be (old address), I don't know if it is the geographical issue of the place, because here we are in an area that apparently, in the past or even in the present, has many drug points (U3).

Family members reported weaknesses in the continuity of care by the other points of the RAPS and the lack of knowledge of the services that compose it. Added to this is the non-prioritization of these services in providing the care requested by the CAPS-AD, especially regarding psychological care to the family.

We know it exists, but... we were not informed on how the (mental health) network works (F5).

Sometimes there are situations where the child is violent; what do you do in this situation? Call the ambulance, call the police, call who knows what?! (F6).

She referred me to a psychologist, which has to be the treatment through the basic unit; she referred me one day and the next day I went, then it was scheduled that they would contact me, but this was on January 21, I went there on January 22, today, this is already in March, from January 21 until March 3 nobody has called me yet (F8).

The social worker referred me there to the health center, but it takes so long there that up to now, it hasn't been possible for me or my granddaughter (F2).

However, for users, there is a centralization of care in CAPS-AD services when they should have the participation of primary care in region-based care.

When there is a problem, like the one that came up (itchy hands), I go to the general practitioner (at the CAPS-AD). At a different time, she prescribed me a very good ointment. So, today when I go to the psychologist, I ask him to refer me to the general practitioner, who already knows my problem and follows up on me (U5).

2. CAPS-AD actions that affect treatment: the user's and family's perspective

Family members and users were unanimous in recognizing that the reception provided by the professionals, both on the first day of care and the following days, including home visits, is essential for treatment follow-up. From this perspective, the humanization arising from the reception by the professionals was positively evaluated by both groups.

Look, this support from the CAPS-AD, for me, has been very good; as I said, I was well received here, I have been well received. The social worker is very good; she always came to my house, she always referred them to come here (F7).

I feel very welcome. In this sense, they are very attentive and lovely; they are dedicated professionals in their respective areas (U4).

Every moment I came back, I was super well received, called by my name, all of my data was in the system, everything was written down, my medical records, they already knew me, they already knew my situation, and they welcomed me super well. It is, in that part, fantastic (U3).

The interviewees highlighted the guidance given by professionals in support groups or individual consultations due to the quality of the information received and the professionals' instructions.

I think the main guidelines are having patience and intelligence to deal with the child (F6).

They give me all the guidance and instruct me; I can see that it is not enough just to stop using drugs, but you have to begin treatment without a doubt (U3).

They were straightforward that the family had to participate and that they were coming, and sometimes I look back and say: "I could have come sooner" because it would be of great value; the biggest difficulty was the family relationship. Today, my relationship with my parents is impossible to describe, it changed from water to wine (U4).

In addition, the emotional support provided to family members and users was positively evaluated considering the difficulties of living with a person who uses alcohol and other drugs. The

actions that stimulate re-socialization and the return to the labor market were also cited as positive.

It gives me strength, a stronger structure because we can't do it alone. So, I have come here to the family meeting for over two years now, and it is here that I get stronger, that I tell her my problems, and she gives me guidance (F2).

They give transportation vouchers; they provide food, follow-up. If the person has difficulties at home, they refer them to the social worker's service to get food staples, to get food vouchers, all of this (U5).

For me, it was good because I was having trouble working, and today I no longer have difficulty. It helped at work, but I couldn't stop drinking (U8).

For the interviewed family members, the service provides clarifications, resources, and necessary actions for the user to continue their treatment, get involved, and be responsible for their self-care.

I think that if the person has the willpower and tries, doing everything correctly, taking the medicines right. Because there is a psychiatrist, there is a psychologist, there are medications, there is a social worker. So, I think that it is enough, you just have to want it (F2).

As these things are put aside, the normality, the human, the body begins to work again; then you have to have the will to continue because that's when the fight begins; with addiction, you are fighting yourself. And at this point, the CAPS-AD is essential because it has help (U1).

It has a physical structure and a group of professionals who work here, who are dedicated. Today, in this city, there is really no help unless the person wants it because here you have the possibility of a psychologist, psychiatrist, occupational therapy, and social worker, you have a pass that you get to come, to go, so, if you want it, it works (U3).

Among the actions provided in the treatment of alcohol and other drug use, interpersonal relationships, bonding, and emotional support between professionals and users/family members are positively evaluated as positively influencing treatment and the protagonism of the user for their effective rehabilitation.

DISCUSSION

Among the actions provided by the CAPS-AD are activities aimed at people who use alcohol and other drugs and their families, which are established under the logic of interdisciplinarity, re-socialization, and social participation by including family members in mental health care.

Among family members and users, it was a consensus that one of the potentialities of the CAPS-AD is providing medication as an indispensable tool for treating the user. It is noted that

medication is seen as the primary form of achieving well-being and the ability to live in society. In this sense, caution is necessary because when the subject is under medication, there is a tendency for the whole team to be unaccountable, assigning the physician as the only one responsible for the guidance on the subject¹¹. In addition, the primacy of the biomedical model for mental health care deserves to be rethought since it seems to contribute to the participants feeling hindered from a satisfactory social coexistence and reaffirming the centrality of drug therapy for the care of their substance use disorders¹².

It is known that multidisciplinary teams must be based on light technologies rooted on an interdisciplinary therapeutic intervention that stimulates the user's autonomy. Thus, as the bond between the professional and the user is established, the professional becomes co-responsible for the follow-up of this user, whether in the CAPS-AD or primary care¹³.

In the evaluation made by users and family members, two professional categories were mentioned the most frequently in the care: psychology and social work. In mental health, the term "roles" refers to the specific professional practices of each category and is governed by the laws of professional practice, class councils, and subject to rules, rights, and duties. Nonetheless, the term "functions" includes the social actions and the various processes conducted by professionals in order to reinsert the person with a mental disorder and the psychoactive substance user back into the family and society¹⁴.

Regarding the roles and functions of professionals in the psychosocial network, a study conducted in seven services of the RAPS in the city of Natal (northern Brazil) pointed out that the main activities performed by upper-level professionals were: observation, recording behaviors, and promoting user autonomy¹⁴. However, the care of family members and specialized training was inadequate among the team professionals, which may generate asylum behaviors and insecurity for the team to develop actions within the psychosocial model¹⁴.

Regarding the lack of representation of nurses in the interviewees' statements, it is plausible that due to the characteristics of their academic training, it is necessary to invest more in the actions of these professionals in mental health scenarios. Therefore, nursing courses must integrate with mental health services to collaborate in the daily activities so that undergraduate students can experience the practices presented in the field¹⁵.

Home visits were appointed by both groups as a means of welcoming and assisting the user and family. It is understood as a valuable tool for care, allowing the professional to observe the family's routine, monitor the user in the coverage area, in addition to activities to search for absentees in the service's activities. The knowledge of the context and local support network qualify the care provided by the service, making it possible to develop approaches consistent with the family's reality and seek to understand and assist the demands and needs of health and care⁹.

However, the home visit is an alternative that needs to be better explored by the services because it requires trained professionals and teams prepared for the continuous care of

the service for house calls. To achieve this comprehensive care as one of the dimensions of quality of care, it is necessary to establish a network of care capable of understanding the complexity of care and ensuring autonomy and citizenship to people in mental distress⁸.

As for the care of the families of users who attend the CAPS-AD, the extensive service hours of the evaluated center contribute to their access. A study carried out in another service of the same type, which operated for 10 hours a day, showed a more significant presence of family members and better care of crises¹⁶. Another study demonstrated that, for greater participation of family members, it is necessary to provide alternative hours for appointments as a way to facilitate access, stimulating insertion into the service and contributing to the user's therapeutic process^{5,9}.

As for the location of the CAPS-AD, it should be noted that its proximity to areas of drug use and selling, which the participants see as a weakness, can be understood as ease of access to users who frequent these places when seeking treatment. And this is precisely what is intended in the ordinance of implementation of CAPS-AD IV, which should be located near the areas where drug use occurs in order to welcome individuals seeking treatment spontaneously or by being referred¹.

Nevertheless, in addition to the geographical location of the service, other factors must be considered for the adherence of users and families to treatment, such as education, the effectiveness and support of the CAPS-AD, the division of care activities within the family, health problems, and feelings of burden on family members. Therefore, it is understood that the CAPS-AD plays a vital role in these people's lives, significantly influencing their quality of life¹⁷.

It is also emphasized the need to strengthen mental health actions in primary care and articulated in a network to strengthen user adherence and access to the service. The mental health care provided at this level of care can minimize stigma and discrimination and respect the human rights advocated by the PR. In this sense, it is emphasized that primary care favors the bond between the user and the health team, decentralizing medical knowledge and stimulating user participation, thereby generating positive results¹⁸.

A study conducted with reference teams of matrix support and managers in southeastern Brazil, shows that the matrix support in mental health is a crucial tool of transformation for CAPS-AD professionals because they approach the discussions about the area of coverage as well as for primary care professionals, who become familiar with the theme of mental health. Additionally, it highlights the reduction of fears, especially of primary healthcare unit (PHU) professionals, in dealing with people in mental distress and the approximation between PHU and CAPS-AD in a productive exchange of knowledge and practices¹⁹.

Another potentiality mentioned by the interviewees is related to the reception and humanization of the professionals during care. It is understood that the team's conduct is directly related to the effectiveness of treatment since the relationship of each professional with the user and family members must be unique

and allow possibilities of helping the subject to multiply. For this, the team's interpersonal relationships with users and family members must lead to welcoming, resolute, and humane care¹³.

One study evaluated users' adherence to mental health services and reported the bond established with professionals as a potentiality of the service, including the welcoming, listening, and uniqueness of the therapeutic project provided. It is understood that welcoming constitutes a primordial tool to increase the bond between professionals and users, enabling a better understanding of the disease and resulting in autonomy for care⁶.

Support groups directed to family members allow participants to share the experiences of chemical dependence, thus strengthening and helping in decision making. This fact can be corroborated by a study from Rio Grande do Sul State, in which family members recognized changes in their attitudes towards chemical dependence and in their understanding of the users' behavioral issues. In the sense of contributing to establishing an integrated and less fragmented family environment, the orientations received by professionals were considered positive⁵.

Besides the family support and the multi-professional team mentioned herein, the users' protagonism in recognizing the necessary changes for the effectiveness of their treatment is evident, identifying the compulsive use of drugs with the unpleasant factors experienced, for the awareness of the damage of life, either in their own quality of life as in that of their family⁶.

In addition, the study showed that it was a consensus among the interviewees that the user must take responsibility for their treatment. From this perspective, it is relevant to emphasize the link between mental health teams and the user to provide dialogue and access to all RAPS care points⁶. Although CAPS-AD are specific services for mental health care, they should ideally provide treatment for a transitional period and not for extended periods because their goal is to strengthen the care network, thus bolstering links with primary care and other points of care²⁰.

Therefore, the actions and practices of mental health care should be seen as an opportunity to reach the user's autonomy, social inclusion, and emotional support in the processes of life itself. Thus, such practices must focus on the context in which the user is inserted²⁰. In this logic, psychosocial rehabilitation should advocate spaces for exchange, valuing the subjectivity and the protagonism of the user²⁰.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study made it possible to evaluate the actions provided by the CAPS-AD based on the fourth-generation evaluation model, which allows us to consider the different perspectives of the interest groups composed in this study by family members and users of the service.

Thus, it is evident that the actions provided by the CAPS-AD under study are positively recognized by family members and users of the service, even in the face of the weaknesses identified by the participants, such as the geographic location

of the CAPS-AD and the fragmented flow of care in the RAPS, thus demonstrating the need for adjustments in the psychosocial care network.

The service was considered of fundamental importance by the focus groups because of the completeness and free treatment and supply of medications, as well as the multi-professional team service and extended hours of service without harming the professional activities of those involved. In addition, we highlighted the humanization, reception, emotional support, guidance, and information exchange provided by professionals for the understanding of chemical dependency as a disease and the emphasis on the co-responsibility of the user in their treatment.

With regard to the implications for nursing practice, this study made it possible to recognize the effectiveness of the CAPS-AD as a specialized service in caring for people who use alcohol and other drugs. Nonetheless, according to the assessment of family members and users, the importance of improving the articulation of interprofessional and intersectoral actions is clear between the CAPS-AD and the other points of care and the inclusion of the family as an ally for the continuity of treatment.

Evidently, the CAPS-AD consists of a specialized mental health service, territorially based, belonging to the RAPS, focusing on the social reinsertion of users in the community. Further studies are needed to investigate the different scenarios where mental health care is inserted to qualify the care for family members and alcohol and drug users. Hence, one limitation of this study is the absence of negotiation between the interest groups due to the COVID-19 pandemic, making it impossible to reach a consensus and acquire new information, which is understood as a stage of data validation by the research participants.

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