Motivation and expectations in treatment search for abusive use and addiction of crack, alcohol and other drugs*

Motivações e expectativas na busca de tratamento para o uso abusivo e dependência de crack, álcool e outras drogas

ORIGINAL ARTICLE

Rebeca Rodrigues Gomes[1], Mara Cristina Ribeiro[2], Ewerton Cardoso Matias[3], Mércia Zeviani Brêda[4], Elisabete Ferreira Mângia[5]

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ABSTRACT: This research was conducted in a Psychosocial Care Center for Alcohol and Drugs and intended to analyze under which circumstances users seek the service, as well as the motivations and expectations that are involved in this process, and foster compliance to the treatment. It is an exploratory, descriptive, and qualitative investigation that involved a bibliographical and documentary study and 10 interviews with users of the service, which were submitted to Content Analysis. The results point out that families have a strong influence on motivation, both in the search for the serviced and in the compliance with the treatment. Other motivations are fragile health, violence experienced in the daily lives of users, and a wish for change. The expectations are related to their desire to quit using drugs and to (re)build their ties with their families and work. Specialized services are concluded to be required to extend their strategies to insert families and the community in the care, aiming at strengthening the care process. Investments in their skills, autonomy, and protagonism should also be developed to meet the expectations of users to rebuild their life stories.

KEYWORDS: Mental health services; Drug users; Substance-related disorders; Alcoholism; Rehabilitation.

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RESUMO: Pesquisa realizada em um Centro de Atenção Psicossocial Álcool e Drogas que objetivou analisar sob que circunstâncias ocorre a procura ao serviço e as motivações e expectativas que envolvem este processo e impulsionam a adesão ao tratamento. Trata-se de investigação exploratória e descritiva de caráter qualitativo que desenvolveu estudo bibliográfico e documental e realizou 10 entrevistas com usuários do serviço submetidas à Análise de Conteúdo. Os resultados apontam que a família exerce forte influência na motivação, tanto na busca do serviço quanto na adesão ao tratamento, outras motivações são a saúde fragilizada, violência experienciada pelo usuário em seu cotidiano e o desejo de mudança. As expectativas estão relacionadas à vontade de abandonar o consumo de drogas e à (re)construção de vínculos com a família e o trabalho. Conclui-se que os serviços especializados devem ampliar suas estratégias de inserção da família e da comunidade na atenção objetivando o fortalecimento do processo de cuidado. Investimentos em suas habilidades, autonomia e protagonismo também devem ser desenvolvidos para responder às expectativas dos usuários de reconstrução de suas histórias de vida.

DESCRITORES: Serviços de saúde mental; Usuários de drogas; Transtornos relacionados ao uso de substâncias; Alcoolismo; Reabilitação.

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1. Occupational Therapist. Graduated from Alagoas State University of Health Sciences - UNCISAL, AL, Multi-Professional Resident in Collective Health with focus on management of Health Care Networks, from the University of Pernambuco – UPE, Arcoverde, PE, Brazil. E-mail: rebecaa_gomes@hotmail.com.
2. Occupational Therapist. Associate Professor in the Occupational Therapy Course of Alagoas State University of Health Sciences - UNCISAL, Maceió, Alagoas, AL, Brazil. E-mail: marauncisal@yahoo.com.br
3. Occupational Therapist, Assistant Professor in the Occupational Therapy Course of Alagoas State University of Health Sciences - UNCISAL. E-mail: ewerton_to@hotmail.com
4. Nurse. Associate Professor in the Nursing Course of the Nursing and Pharmacy School of Federal University of Alagoas - UFAL. E-mail: merciazb@gmail.com
5. Occupational Therapist. Associate Professor in the Occupational Therapy Course of the Faculty of Medicine of University of São Paulo. E-mail: mangeli@usp.br

Correspondence address: Mara Cristina Ribeiro. Alagoas State University of Health Sciences. Rua Jorge de Lima, 113. Trapiche da Barra, Maceió, AL, Brazil. CEP: 57010-379. E-mail: marauncisal@yahoo.com.br

INTRODUCTION

The use of psychoactive substances has been present in different cultures under singular characteristics throughout history. Nowadays, this issue has gained specific characteristics, and it has been understood as a multifactorial problem that requires actions from several sectors such as Health Care, Social Assistance, Education, Justice, among others. There is a concern with the abuse of alcohol and drugs and the problems that arise from such use; such situation can be discussed considering economic, social, and cultural transformations that are characterized by the weakening of social and professional bonds, especially in large urban centers[1].

In order to treat people suffering from or with problems resulting from mental disorders and/or consumption of alcohol, crack, and other drugs, the Brazilian Unified Health System (*Sistema Único de Saúde*) proposes the organization of an integrated, articulated, and effective Psychosocial Care Network (*Rede de Atenção Psicossocial – RAPS*) composed of several points of attention. This network considers local specificities and prioritizes community-based services based on the logic of care that is focused on people's needs. Thus, it defines as its main care components: Basic Health Care, Strategic Psychosocial Care, Emergency Care, Transitory Residential Care, Hospital Care, Deinstitutionalization Strategies, and Psychosocial Rehabilitation[2].

Regarding Strategic Psychosocial Care, there are Psychosocial Care Centers (*Centros de Atenção Psicossocial – CAPS*), services which, along with the basic health care actions, are responsible for organizing the network care.

CAPS, in their different modalities, comprise interprofessional teams that must conduct sectoral and intersectoral actions to treat people with severe and persistent mental disorders and people with needs resulting from the use of crack, alcohol, and other drugs. They develop works prioritizing collective spaces and acting in an articulated way with the health care network as well as with the remaining networks[2].

The Psychosocial Care Centers for Alcohol and Drugs (*Centros de Atenção Psicossocial álcool e drogas – CAPSad*) were created in the specific area of care to people with disorders that result from the use of and addiction to psychoactive substances. They are psychosocial care services[3] that must provide treatment that is specific for each patient, their family members, and the community around them, working under the logic of Harm Reduction (HR) and being supported by other community care practices[1].

Under this perspective, the implementation of CAPSad III has been intensified. They are destined to provide comprehensive and continuous care to people with needs regarding consumption of alcohol, crack, and other drugs. They have as an important characteristic being open 24 hours a day, seven days a week, including weekends and holidays. They are destined to work with open doors, on daytime and nighttime shifts[4].

They ensure access to effective care and accountability of cases through actions conducted by their interprofessional team that must provide: individual treatment for appointments in general, psychotherapeutic care and guidance; provision and management of medications; group psychotherapy care, operative group, and social support activities; therapeutic workshops; house visits and care; treatment to families, individuals, and groups; psychosocial rehabilitation activities aiming at stimulating the protagonism of service users and their family members, among other actions[4].

The search for and the compliance with care services to people with needs related to consumption of alcohol, crack, and other drugs have been increasingly shown to be a great challenge, for they involve objective and subjective factors. Such process includes questions inherent to the subjects, their perceptions concerning the use, and their relationships with the team treating them, their degree of engagement and participation in the development and decision of the therapeutic project, as well as the insurance of provision and qualification of the care rendered and the support received in and outside CAPS.

In this context, the study aimed to analyze under which circumstances users look for CAPSad service, and which motivations and expectations involved in such process are capable of contributing to the compliance with the provided treatment.

In this research, we adopted the term "compliance" regarding the decision of those who seek to follow a health treatment, comprising a relationship between users, professionals, and the service; and the term "motivation" as something that, in the perspective of users, influences the direction to do what is needed. It may have an external origin (pressures, coercive actions) or an internal one (something that comes from within individuals themselves)[5].

The research was submitted to the analysis of the Research Ethics Committee of Alagoas State University of Health Sciences and it was approved on September 4, 2013, under CAAE no. 16225613.0.0000.5011.

METHODOLOGY

The investigation, which was based on a qualitative approach, was characterized as exploratory and descriptive. A bibliographic and documentary analysis was conducted to develop the research, besides a semi-structured interview based on guiding questions that aimed to know the subjects and to enable them to describe which circumstances caused them to seek treatment and comply with it.

The interviews were conducted from September to October 2013 in a CAPSad III of Maceió municipality, capital of Alagoas state.

Participated in the study ten users (people connected to the service receiving some type of treatment) who met the inclusion criteria – having started their treatment in the service one month before or less, being able to understand the research purposes at the time of the interview, and accepting to be part of the study. The option of investigating users who had started treatment a month or less before is justified by the fact that we understand that the circumstances that led them to seek treatment are still clearly present, since the expectations and motivations for their compliance are probably being formed at this moment.

The number of subjects was determined through the saturation criterion[6] – such number had been included in the experiment design, but the decision to either include or not new respondents was made afterwards, considering that the general objective of the study was restricted and that there was significant homogeneity in the studied population; that is, since the respondents had sought and were attending one same service of specific care and for a similar period of time, the findings were found to repeat themselves, which justified interrupting the research for new interviews.

After subjects were introduced to the research and its objectives, they had access to the informed consent form, and all doubts regarding each item were solved. Following that, the subjects were individually interviewed in a private place to protect their anonymity. All of them were recorded after subjects authorized us to do it, which allowed speeches to be faithfully registered. The recorded material was transcribed and systematically reviewed for the composition of the analysis.

The obtained results were analyzed by the Content Analysis technique, in the theme analysis modality, which consists of finding out meaning cores composed in communication, considering significant presence and frequency of themes for the analyzed topic[7]. As a methodological procedure for the analysis, we followed the three recommended steps (pre-analysis, exploration of the material, and treatment of results – inference and interpretation), aiming to analyze and organize the contents of information obtained[8].

Central ideas were then identified and their meanings were interpreted. Then, they were grouped into empirical categories that were classified in more general themes, around which the topics were further analyzed.

STUDY SETTING

The CAPSad in which the study was developed was open in 2006, and it initially treated children and adolescents, being firstly classified as CAPSII. Throughout its early years, the service had its treatment profile changed – it started treating young adults only, and then extended it to the general public.

In 2013, the service started operating as a CAPSad III, thus having its care proposal extended and being the only municipal service in this modality so far. In average, eighty users seek the service per month, treating approximately 70 users per shift. It provides therapeutic groups, individual care, distribution of medications, and care to family members.

Also according to data from the service, most treated users report that the main drugs they use are, in this order, alcohol, crack, and marijuana – tobacco was not considered.

The information from this study was obtained in the administrative coordination of the service in the period through which the research data were collected.

RESULTS

Among the ten users interviewed, all are men, and their ages ranged from 18 to 47 years. Half of them reported being homeless. Most of them reported being currently unemployed and having been committed to therapeutic communities.

Table 1 shows information regarding age, marital status, whether they have children or not, and education level.

Table 2 shows the information regarding the current housing and working statuses of the users, whether they had already been committed to psychiatric hospitals (PH) or therapeutic communities (TC), and how long they have been treated at the CAPS in which the study was conducted.

The data produced by the interviews were organized for the analysis in theme categories, which were previously define, in order to reach the investigation objectives. They were:

1) Motivations to seek the service;
2) Motivations to remain in the service;
3) Expectations regarding the treatment.

Table 1 - Information about the users

Interview	Gender	Age	Education Level	Marital Status	Has Children
1	M	21	9th Grade	Married	Yes
2	M	29	5th Grade	Single	Yes
3	M	28	4th Grade	Single	Yes
4	M	47	Some High School	Single	Yes
5	M	27	5th Grade	Divorced	Yes
6	M	29	8th Grade	Single	No
7	M	27	6th Grade	Single	No
8	M	36	Some Elementary School	Single	Yes
9	M	22	9th Grade	Single	No
10	M	18	5th Grade	Divorced	No

Table 2 - Current housing and working statuses of the users

Interview	Current Housing Status	Current Working Status	Committed to a PH	Committed to a TC	Time at CAPS (days)
1	At home, with family	Unemployed	No	Yes	30
2	Homeless	Unemployed	No	Yes	28
3	Homeless	Unemployed joiner	No	Yes	28
4	Homeless	Unemployed	No	Yes	3
5	Homeless	Unemployed	Yes	Yes	5
6	At home, with grandmother	Unemployed	No	Yes	24
7	At home, with mother	Unemployed	No	Yes	8
8	At home, with mother	Civil Servant	Yes	No	30
9	At home, with sister	Unemployed baker	No	Yes	30
10	Homeless	Unemployed	No	Yes	25

Motivations to seek the service

The interviews showed that families have a strong influence in the decision to seek treatment: the isolation of users, coupled with the conflict that is generated by other behavior changes concerning family members, and their wish to recover or strengthen family bonds may be pointed out as great motivators.

> *[...] because I wanted to be home, and my mother didn't want me there the way I was [...], having all of that I have again helped me want to get treated at CAPS. (U1)*

> *Because I couldn't stand the suffering any longer. Crying, with no friends [...], because I couldn't see my daughters [...], now that I'm on the street, the access is even harder [...] I also wanted to come because I've already lost my marriage, I had isolated myself from friends, I took a leave of absence from work. And then my mother and my grandma encouraged me to come here. (U2).*

Involvement with drug trafficking, experiences of violence, risk of death, and police-related experiences also played a role in the decision to seek protection and in the wish for change.

> *[...] I had a brother who was a user, they killed him in front of me [...] I was also scared of dying. I wanted to quit this kind of life [...] I had already hit rock bottom. And they tried to kill me three times, but didn't manage to. (U1)*

> *Using drugs, getting into fights with criminals, with drug dealers, stealing drugs from them. And now there are many of them trying to get me. I couldn't stand it anymore. (U3)*

> *[...] Actually, I'm not afraid of drug dealers... None of them. I'm scared of the police. (U5)*

The search for medical care and the need for referral to other health care services were also pointed out as relevant factors in the motivation to seek treatment at CAPSad.

> *I have a health problem, and that is also why I'm here [...] it's not just because of alcohol and my son. I've already got three doctor's appointments scheduled. (U4)*

> *I came because I was using drugs too much. I even fainted once from using drugs way too much, without eating, without taking care of myself... That is when I saw I needed help... Then I came here by myself. I looked for it and eventually found it. (U5)*

When mentioning the negative consequences and the compulsive dynamics of their drug use, the subjects, despite not realizing or identifying HR in their daily lives, develop strategies to reduce harmful consequences based on their own life and use experiences.

> *I started smoking during the day and went the whole night smoking. When I woke up on the other day, it seemed like I'd been beaten up. [...] I smoke a joint because I crave for crack – as I don't want to use it, I keep to marijuana – if you hit the crack pipe once you can't stop, you spend your whole day trying to get more, and risk stealing, doing what you don't want to or can't, only to smoke (U2).*

The perception and awareness of their health statuses and social issues and the possible relationship between those factors and the use of psychoactive substances may serve to impel users to seek the service.

> *I came on my own because I feel weak, because chemical dependency is not easy. (U3)*

> *No one forced me. My mother helped me, she came with me... I have my daughters, my mom is already old, and I need a social life... I have also suffered too much financial loss. (U8)*

Motivations to remain in the service

Several factors were reported by the respondents as motivating them to continue with their treatment. The most important reference was attributed to their families. The motivation and the returned confidence from the mother figure, and the wish to get reacquainted with other family members, especially children, were highlighted.

> *My mother is the only thing that keeps me going. The support she gave me, even after all that I have done to her, she never abandoned me to get destroyed by drugs, and because now I want to regain her trust. (U6)*

> *The reason is my daughters. Actually, they are the reason I'm alive today, that I'm alive now, because if it were not for them, I would not even be in this situation. I would probably be dead by now. (U5)*

Another relevant factor for the subjects to be motivated to continue with their treatment was the different ways through which care was provided at CAPSad.

> *[...] I'm getting my documents now, they are helping me, I've already got my identity card, they took me to the Public Defender's office, they got the paperwork, they got my identity... (U9)*

> *I really like talking. You must have already noticed... And I've only been here a few days, but there are very good professionals here, and I get to talk, that's been very good for me. (U4)*

> *I always take part of the groups, I'm even really interested in the theater classes, I love them. That's been really motivating me here, I've been learning how to improve the way I express myself, my way of talking, and that may be silly for some people, but it's essential to me. (U5)*

The interviews also showed that the subjects were determined to overcome the challenges they were facing, thus reinforcing their motivation.

> *The difficulties I've been going through, I need to convince myself it's just another obstacle I need to overcome... (U2)*

> *I've already suffered too much and I can't stand it anymore. I'm still suffering, but now I've been closer and closer of being back on my feet with everybody that is helping me here. (U3)*

The subjects also mentioned other relevant factors which were capable of influencing them to stick to their treatment: the availability to deal with obstacles and the valuing of small victories.

Expectations regarding the treatment

The respondents mentioned their involvement in new life projects and plans they considered as concrete, such as:

definitively quitting drugs or their desire to remain being treated and keep using drugs in a more responsible way; their return to school and work; and their plans of being able to control their finances.

They mentioned some desires such as the one of leaving the streets or shelters and of being able to support themselves, to (re)build their family bonds, and to engage in the rehabilitation of other subjects.

In the reports, we observed that the expectations regarding the treatment, the wish for changes, and the feasibility of concrete projects are linked to new attitudes and quitting drugs.

> *I expect a lot, you know? I need to believe I will make it, that I will be fine, healthy. I need to have my family, but before that I need to have a different attitude regarding my actions. Because I've already done many wrong things, I've stolen because of drugs, I've made my mother suffer too much [...] Now I really want to change. In order to get what I want, to love myself more, to have the will to stop. (U6)*

The intention of the subjects of returning to their work or their wish to get qualified in order to get new jobs, besides their expectation of going back to school, are highlighted as paths towards their independence and autonomy.

> *I used to work as a joiner... But I wanted to get qualified to do something else. If I had a chance, I really wanted to go back to school and finish my studies, since I studied until I was in the fourth grade only. (U3)*

> *A man needs dignified work, and I also want to be able to get back to work. I've already worked a lot as a janitor, and I have a job there, I want to get well so I can come back. (U6)*

The contents refer to the subjects' expectation that, from the moment they are back in the labor market, they will focus on leaving the streets or shelters as their main priority; they also consider this strategy as a mean to (re)build family bonds and escape from their vulnerable condition on the streets.

> *I want to have money to buy my own house, to leave the streets... to have my daughters, a family. (U2)*

> *I need to quit drinking to be able to work, to have my own place, to be able to leave the shelter, and to help my son... I think about having my own house, not for myself, but for him, in the future. (U4)*

> *I want to have money to have a little room where I can sleep, so I do not have to be on the street... Because the streets are dangerous. (U5)*

The respondents expressed great expectations regarding (re)building their family bonds.

> *I hope it changes everything. Because human beings without their families are nothing [...] And this is the truth: the intention to get my daughters back together. And the truth is I'm getting old. I'm not a kid anymore, no, not a boy. I want to take care of my children like a man. (U2)*

> *It's something I really want, to build a family, to have my wife, my children. Because I even had a son, but the woman didn't want to, his grandmother didn't want me to add my name to his birth certificate. (U3)*

Another thing the respondents mentioned was that, after rehabilitated, they wished to get engaged in the rehabilitation of other subjects.

> *Whenever I am on the street and I see drug users I go up and talk to them, I tell them about CAPSad, I invite them to come and get recovered too [...] My life is wonderful here, and I intend to see the treatment through, bringing more and more brothers to get recovered here with me. (U1)*

> *I know that the best help to a drug addict, no matter how much the person has studied, the best help comes from a recovered addict. They can help, because they have been through the whole thing. Because we all go through the same thing, it is only loss, only destruction. [...] I will help my fellow man, my colleagues who are in this life... There are several of them, really. (U3)*

We observed that the subjects believe the treatment can promote significant changes in their lives, but all of them were associated with their first plan to quit the abusive use of drugs, considering their wish of completely quitting drugs. However, it should be noted that, all of those who have already experienced treatments focusing on full abstinence considered such approach as ineffective, and they believe in gradual rehabilitation.

DISCUSSION

Family bonds were found to be broken or damaged due to the use of alcohol and/or other drugs. However, the interviewees showed that, even with the trouble that was caused by the risks and problems related to using drugs and relapsing into the habit, their families remained as the main support for them and as a motivation to seek rehabilitation – mother and child figures were frequently mentioned. Thus, their seek for CAPSad is mentioned as an instrument to reconcile relationships, at the same time it is configured as a response from the subject to expectations and encouragement from family members.

Souza et al.[9] state that even the bonds that remain are permeated by ambiguities and stress, due to the troubled relationships and the loss of trust that comes from relapsing into drugs. Therefore, the services regarding the specific care to that population must focus their actions on stimulating the strengthening and improvement of the quality of these family bonds[10] – as we could observe, they are often the only ones that remain.

Another very important aspect to be considered is that drugs are represented in society at different times and in distinct contexts. The meanings are transitory and the use of substances generates discussions on their legality. Intolerance and criminalization have played a role in such a way that these subjects are perceived as unpunished, as outlaws, and drug addicts who need to be cured.

The consequences of this multifaceted scenario, which is polarized between care and violence, is materialized in the following manner: subjects who have been away from their families, who are victims of lack of support, who sleep in shelters or on the streets, and who are viewed as demons because of the use of drugs.

The study subjects expressed not only their fear of suffering violence from drug dealers and policemen, but also of being punished by the law, which contributes to the development of critical consciousness and a recognized need for change, motivating them to seek care.

It is important to point out that, in the professional practice, it has been common to hear accounts, which are sometimes desperate, from subjects or their family members regarding death threats arising from unpaid debts and involvement with drug traffic. Many of them run away or move to relatives' houses; other seek the service because they feel the need to be welcomed to an environment that is distant from the ones they live in[11,12].

The reports indicate that when they arrived in the service, many of them felt weakened, with distinct needs. They report having been welcomed, evaluated by a psychiatrist, medicated, and some of them remained in the nighttime shelter. When needed, they were sent to other care services to go through health exams, thus showing that they are aware that these services can actually be found. These factors influence the motivation to seek the service.

It was possible to detect, therefore, that in the context of testimonials, users reported conducting strategies to ease the social and health damage. Starting from the premises of humanized care and that seeking proper care, from the needs of each user, are also factors that determine the motivation to remain in the service, and HR is also a strategy that aims to minimize the problems regarding the several situations involving the use of psychoactive substances.

By analyzing the interviews, we notice that the motivations mentioned for seeking the service arise in the everyday life context. However, we may infer that they result in the perception of the need for changing and building new life projects, which generates internal motivation and personal mobilization for subjects to seek and comply with treatments.

Another relevant factor that can be inferred is that families do not only play a fundamental role for users to decide to seek the service, but are also pointed out as a relevant factor that motivates them to stick to it.

Thus, this study shows the importance of families taking part in the treatment, and it strengthens the idea that family relationships, even when troubled, must be in the focus of care, as they are one of the first steps to recover lost social relationships.

The interviews allow observing that CAPSad is recognized as a catalyst for several needs that transcend the clinical treatment. Souza et al.[9] state that, in contrast to the broken or weakened bonds of subjects, CAPSad is seen as the main health care service that is capable of favoring the strengthening and extension of socio-relational networks.

The provision of group spaces with varied themes promotes the refinement of the bond between users and the service, among the users themselves, and between the professionals and the users, and it is also a determining factor in the decision to remain in the service.

Figlie et al.[13] highlight the importance of including subjects in therapeutic groups. They consider that the therapeutic action of a group may be processed through the possibility of each person seeing herself and being reflected in other participants, thus being able to

recognize aspects they are denying. Groups allow sharing experiences, which facilitates the perception of a person's functioning through the interactions that take place in the group context.

Regarding the perspective for change and the feasibility of new projects, which are seen in the speeches, Rigotto and Gomes[14] state that often it is in the breach, in the perception of failure, in the comparison between what one wants and does not want that the comprehension of what is possible or feasible emerges. The determination for change is, actually, the combination between being aware of the problem and the will for change. They point out that it is not possible to start a project of change without that condition being met.

Alves et al.[15], upon describing the difficulties they found in the context of rehabilitation and reinsertion into the labor market, indicate that treatments must not only focus on people quitting substances, but also on the subjects' cognitive and social deficits, which are jeopardized due to their substance abuse.

In addition, it must be considered that unemployment and the difficulties faced are also consequences from the stigma they carry with themselves, thus making it difficult to get a job or even to keep one.

Some identified factors, such as the compulsive use of drugs – which is recognized by users as the biggest cause for their weakened bonds with their families and work –, besides the lack of qualification for work and low education level, refers us to the propositions that Castel[16] defines regarding vulnerability and social exclusion processes. In the context analysis of research subjects, it is possible to state that some are in the **vulnerability zone**, which is characterized for lack of a job, but with the presence – even the fragile ones – of relational support or, inversely, the presence of work and absence or frailty in the socio-relational network. Such dynamic situation may lead a subject to the **exclusion zone**, in case the breach of bonds with the labor market and socio-relational networks are simultaneously lost.

Figure 1 shows the variation zones of the social cohesion proposed by Castel[16]. In this perspective, the rehabilitation actions must be focused on the construction of ties to enable subjects to leave the exclusion zone, in which, as we could see, some are already in, and the strengthening of already existing ties, so that the vulnerability zone is a transition in this process, as these zones are understood to be dynamic; that is, their frontiers are mobile, and permanent changes from one to another are operated[16].

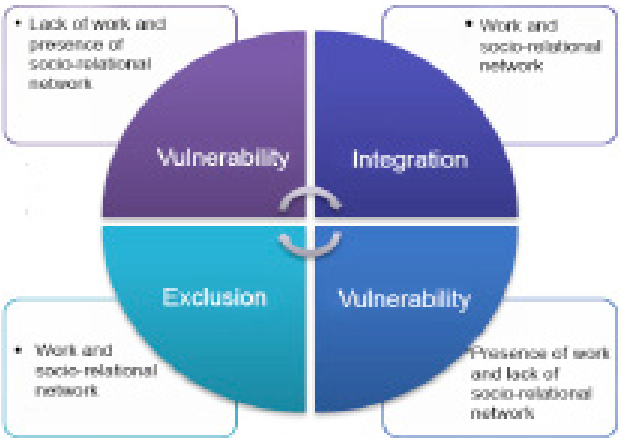

Figure 1 - Variation zones of social cohesion (Castel)[16]

Last but not least are the contributions from the respondents of the study regarding their wish of getting involved in the rehabilitation of other subjects who are in situations that are very similar to the ones they were in before using the services and complying with the treatment.

Jorge and Brêda[17], by bringing the experience of *Consultório de Rua* (Street Office), mentioned the possibility of former and current alcohol and drug users working with the HR strategy through their inclusion in the teams, thus becoming harm-reducing agents who are capable of contributing to the strengthening of this form of care. The current team of *Consultórios de Rua* still keeps these professionals, and they consider them extremely important in the care process.

We may state, therefore, that the engagement of CAPSad users in actions regarding the search for the service of new users, the promotion of health, the care in the surrounding community, among others, must be considered.

CONCLUSION

Considering that the speeches of the respondents point towards the importance of their families taking part both in the process of seeking and continuing the treatment and in their life projects, and that the activities CAPSad proposes, especially the therapeutic, theatrical, and sporting groups, have played a fundamental role in stimulating these users to continue with their rehabilitation processes, we notice a need for extending and articulating operation strategies of this services in these fields, in order to include families in the process of care to users' health, in such a way that these families may also receive care and realize

they are essential for the subjects to keep motivated and committed to being treated.

We must consider that the very vulnerability condition that is perceived in the speeches of the users may contribute to their relapsing and interrupting their treatment. Thus, both the involvement from families, whenever possible, and the extension and improvement of therapeutic and reinclusion activities that are offered may strengthen the users in their rehabilitation process.

Considering the users' expectation of rebuilding their interrupted or weakened family bonds and (re) building their bonds with work, it is important that CAPSad actions involve the community by providing information, clarifying misconceptions, and breaking paradigms. Furthermore, it is essential that integrated and interdisciplinary actions are proposed allowing subjects to be socially reinstated through discoveries and improvement of skills, ability to solve problems, being empowered, as well as by recovering their autonomy, self-esteem, and their roles in their families and communities, thus responding to the expectations of rebuilding their life stories.

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