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The meanings constructed in the attention to a crisis in the territory: the Psychosocial Care Center as a protagonist*

OS SENTIDOS CONSTRUÍDOS NA ATENÇÃO À CRISE NO TERRITÓRIO: O CENTRO DE ATENÇÃO PSICOSSOCIAL COMO PROTAGONISTA

LOS SENTIDOS CONSTRUIDOS EN LA ATENCIÓN DE LAS CRISIS EN CAMPO: EL CENTRO DE ATENCIÓN PSICOSOCIAL COMO PROTAGONISTA

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ABSTRACT

The attention to a crisis is a strategic point in the process of paradigm changes proposed by the Brazilian psychiatric reform, requiring changes in alternative services and in the professionals that must use new technologies of care. This study aimed to identify the actions of attention to a crisis in the territory and the meanings as they evolved, beginning from the discursive practices of the professionals. It was a qualitative study that used the theoretical perspective of social constructionism. From the database of the research, Evaluation of the Psychosocial Care Centers in Southern Brazil (CAPSUL), 27 interviews were analyzed from the professionals of Psychosocial Care Center for Alegrete, along with field diaries with 390 hours of observation. Results showed patient engagement/welcoming and accountability for care. We concluded that freedom, reciprocity, contractuality and responsibility for care were the new meanings needed for the alternative care services to overcome the asylum and sense of exclusion and dangerousness.

DESCRIPTORS

Mental disorders
Crisis intervention
Mental Health Services
Psychiatric nursing

RESUMO

A atenção à crise é um ponto estratégico no processo de mudanças paradigmáticas propostas pela Reforma Psiquiátrica brasileira, exigindo que serviços substitutivos e profissionais utilizem novas tecnologias de cuidado. Este estudo objetiva identificar as ações de atenção à crise no território e os sentidos que as envolvem, partindo das práticas discursivas dos profissionais. Trata-se de um estudo qualitativo que utiliza a perspectiva teórica do Construcionismo Social. No banco de dados da pesquisa Avaliação dos Centros de Atenção Psicossocial da Região Sul do Brasil (CAPSUL), foram analisados 27 entrevistas realizadas com profissionais do Centro de Atenção Psicossocial de Alegrete e três diários de campo com registro de 390 horas de observação. Os resultados evidenciaram o acolhimento e a responsabilização pelo cuidado. Conclui-se que liberdade, reciprocidade, contratualidade e responsabilização pelo cuidado são os novos sentidos necessários aos serviços substitutivos para superação do manicômio e dos sentidos de exclusão e periculosidade.

DESCRITORES

Transtornos mentais
Intervenção na crise
Serviços de Saúde Mental
Enfermagem psiquiátrica

RESUMEN

La atención de crisis es un ítem estratégico en el proceso de cambios paradigmáticos propuestos por la Reforma Psiquiátrica Brasileña, imponiendo que se utilicen nuevas tecnologías de cuidado. Se objetiva identificar acciones de atención de crisis en campo y los sentidos que las involucran, partiendo de las prácticas discursivas de profesionales. Estudio cualitativo utilizando la perspectiva teórica del Construccionismo Social. En los datos de la investigación Evaluación de Centros de Atención Psicosocial de la Región Sur de Brasil (CAPSUL) se analizaron 27 entrevistas realizadas con profesionales del Centro de Atención Psicosocial de Alegrete y tres diarios de campo con registro de 390 horas de observación. Los resultados demuestran la acogida y la responsabilización por el cuidado. Se concluye en que libertad, reciprocidad, contractualidad y responsabilización por el cuidado son los nuevos sentidos necesarios en los servicios sustitutivos para la superación del manicomio y de los sentidos de exclusión y peligrosidad.

DESCRIPTORES

Trastornos mentales
Intervención en la crisis
Servicios de Salud Mental
Enfermería psiquiátrica

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INTRODUCTION

Meanings of madness and its social representations have been socially constructed since antiquity. Knowing and understanding the response given by society to this phenomenon supports rebuilding and reframing knowledge and practices around a *new* meaning and a *new* place for the insane.

The understanding of reactions and the meanings aroused by insanity in a social context, and their relationships with the construction of practices of violence and exclusion that have marked the course of the insane in the area of Psychiatry has been instigated in some social subjects, as the desire to initiate a process of deconstruction of the knowledge and practices of the asylums.

This movement started the Psychiatric Reform in Brazil, which elected the community as a privileged space for care that respects the rights and dignity of individuals in psychological distress.

A network of mental health care consisting of multiple services existing in the territory was established: Psychosocial Care Centers (CAPS), Psychosocial Nuclei of Care (NAPS), Community Centers for Alcohol and Drugs, Care Centers for Childhood and Adolescence, Basic Health Units, Family Health Strategy (FHS), Mental Health Units in General Hospital, Day Hospital and Therapeutic Residences, which together, meet the complexity of demands[1].

Attention to the crisis is one of the demands that generates more difficulties in this context of paradigmatic changes, considered one of the most difficult and strategic aspects in the process of psychiatric reform[2]. It is still very present in our society that the individual in crisis should be guarded or excluded. This is a meaning whose roots can be found in the history of psychiatry, which established the treatment, based on intolerance to different behaviors of insanity, tending toward the exclusion of individuals as an option to ward off the different and *to protect* society[3].

For many years, psychiatry has played an important role in controlling deviant subjects and eventually in marginalizing and excluding them from society, removing their autonomy and independence[4]. In this model, the crisis is understood as a situation in which there is a severe dysfunction that occurs exclusively as a result of the disease[2]. In virtue of this conception, the response to the crisis is based on containing aggression and lack of discipline, maintaining the relations of power and submission that underpin the day to day life in the asylum.

In the context of Mental Health, an expression of an existential, social and family crisis that involves the subjective ability of the subject to respond to triggering situations is conceived[5]. Therefore, it is considered a social situation, more than biological or psychological, requiring from psychosocial care services an *accountability* in front of people who are receiving care, by means of the welcoming/patient engagement and the construction of emotional and professional bonds[2].

So that the actions of attention to the crisis include the complexity of the needs of the subjects, it is necessary that the professionals take hold of new care technologies. One of these is the attention to the person in his context of life, that is, within his territory, that can be understood as the space that results *from the inseparability between systems of objects and systems of actions*[6]. The work in the territory does not mean the establishment of a psychiatric or mental health plan for the community. It presupposes, in fact, taking care of the crisis in a context in which the premise is freedom, with emphasis on the expression of conflicts and subjectivities.

Taking as its starting point the Psychosocial Care Center, which is the articulator of the demand for Mental Health in the territory, it is possible to demonstrate the change that has been established in the country in order to take care of the crisis in freedom, that is, away the walls of the psychiatric hospitals.

Thus, the importance of studying the attention to the crisis within the context of network services established by the Psychiatric Reform and the new meanings that are constructed from new care practices. Taking as its starting point the Psychosocial Care Center, which is the articulator of the demand for Mental Health in the territory, it is possible to demonstrate the change that has been established in the country in order to take care of the crisis in freedom, that is, away the walls of the psychiatric hospitals.

This study sought to answer the following question: *Which meanings of attention to serious mental crisis are present in the discursive practices of the professionals of Psychosocial Care Centers*?

METHOD

The opposition to asylum discourse, constituted for centuries, takes place through the construction of new meanings and, consequently, new ways of dealing with and relating to the subject in psychological distress. The knowledge and a new culture in the field of mental health requires a dialogue with theoretical perspectives that helps us to understand the time in which we live.

The social constructionism was chosen as a theoretical perspective for understanding the meanings that are being constructed in the daily life of the new practices of care for the crisis in the territory. It has as basic assumptions the construction of meaning on the part of the subjects involved in the phenomena to be studied, or that is, the meaning that is constructed in the social interaction, beginning with the discursive practices located in a specific time and space[7].

The data used were part of the research database, Evaluation of the Psychosocial Care Centers in Southern

Brazil (CAPSUL), which was divided into two studies, one quantitative and the other qualitative. The qualitative evaluation was developed as a case study with the participation of users, families and professionals, and the evaluation of the fourth generation[8-9] guided the theoretical-methodological process.

Data collection occurred from July to December of 2006, and field observations and a semi-structured interview were used, initially composed of three guiding questions, whereas new questions were incorporated by means of the utilization of the hermeneutic dialectic circle, in a concurrent process of analysis and data collection[8].

This project was submitted and approved by the Committee on Ethics and Research of the Medical School of the *Universidade Federal de Pelotas* (Of. 074/05). All interviewed patients agreed to participate in the research by means of signing the Terms of Free and Informed Consent Form.

The interviews of 27 professionals from CAPS of Alegrete were analysed. After reading the interviews, the *interpretative repertoires*[10] were identified, which were the units of construction of discursive practices[11], to determine the most relevant issues and empirical categories related to the proposed objective. Following this, *maps of association of ideas*[10] were constructed, which are instruments for visualization that aim to assist the systematization of the process of analysis of discursive practices, seeking formal aspects of linguistic construction, of the used repertoires and the implicit dialogue in the production of meaning.

RESULTS

The following fragments of speech of the service professionals were found that related to the actions of attention to the crisis in the territory :

Accountability for the care of the crisis in the territory

1.1 We are always trying to ask our colleagues from the front, when they pick up the phone, to ask if it is urgent or not. If it is a case that the patient is attacking the family or something we have to leave everything that we are doing to go attend (A2).

1.2 I think that there is no way that we are not very vulnerable. There's no way to separate. It is difficult. But usually when we need to, we have the support of someone. But there are cases that you have to put yourself out there. That you have to go. You have to see. But we're really vulnerable, sometimes is a little complicated (A7).

1.3 If you see that the mental state is at a break, that he attacked, broke, that it cannot wait for another day, he is taken to the emergency room in the city, where he will be medicated, often until released to home. If it's a case that can wait for another day we combine with the patient, with the family, to come here and schedule, get an appointment with the psychiatrist who will refer him to a psychologist, or if applicable he starts attending, being of the CAPS (A2).

User monitoring in crisis during hospitalization in the General Hospital

2.1 Then in another (break) that he had, about a year and a half ago, and then he dropped and the complaint was that he did not improve, and then I started going to the hospital. I said: - It's not possible. We are going to have to take this user from here because this creature does not improve, is always with those delusions...*Then, I started going to the hospital to see what was happening. Then, one day I did go and met the psychiatrist who said*: – *That boy, medication is like water for him. We give it, give the medication and nothing happens*. Then, I went in there and said – *What is happening? He has already taken the medication?* – *No, he did not take the medication*. I said: – *Why didn't he take the medication?* – *Ah! Because we give medication at 10 am, and in that time he is not here anymore, he has his breakfast and leaves*. I said: – *And at night, what happens?* – *Ah! He never takes the medication, because he always arrives after eight and the medication is scheduled for 8pm*. So really the medication was water, but he was not taking the medication. And then after that day I said: – *People, you are treating a person who leaves the hospital, he has to take it, at breakfast, you have to go there, to give the medication to him.* Then I talked with the sector chief. Then, his treatment was remodeled throughout and within a month he was perfect, and until today he has had no more breaks (A3).

2.2 (...) *If you can stay, if you have to stay in the emergency room you stay, or are hospitalized in the hospital, stay that week. The outbreak is gone, it improves, two or three days and we start, we bring him back here. Then, when... he begins to improve, we bring him to spend the day here. He spends the day, gets fed, goes to his workshop, we take care of him, we talk. He is not stuck in the hospital* (A11).

CAPS as a space to construct a reciprocal relationship between user and professional

3.1 I think we have to be careful that when a person is in crisis, to always have someone who can be intensively closer (A4).

3.2 Then sometimes it happens (crisis), as has happened with user X and then we assume the patient care. A change of therapist and we will make another approach. So that, I think, is really cool in our team. It's a very humanistic thing (A11).

3.3 We are going to disarm, we will not go... if the person is angry, violent, I'm not going there to provoke his violence. On the contrary, I want him to support me, to see if he can defuse the violence that is inside his head. That's how I proceed in these matters. (...) then he comes: – *Ah, flying saucer, I do not know what...* I will not say that there is no flying saucer... I enter into his madness, I flirt with his madness to try to build a bit of health, to construct. At first, there is no way to go against it. (...) There are things that you will not be able to manage, you must have, be together with others. You have to hold on, have to sit down, have to calm down (A6).

Prevention of crisis situations and their aggravation.

4.1 The strategy I always think and I always talk about to the group is a strategy of prevention. If I know that a user is

going into crisis and I know why he's here all day long with us, since the reception to here. If I know that a user has a more serious problem, I have to anticipate that (...) If he starts having problems we have to intervene (...) Then, we have to be constantly looking to prevent the outbreak. (...) The vision that we try to have and discuss at staff meetings is: let's prevent. (...) So, I think that prevention, if he came here in bad situation attend him soon. If you need to take him to the emergency room, do it, because we do not have a psychiatrist 24 hours, only eight hours a day, here. Then, there are certain things we do not want to do. Will we have to call the psychiatrist?... then take him to the emergency room that is there, the car is here. If not, there is an ambulance. You take an attitude to avoid it (A3).

DISCUSSION

In virtue of the new model of mental health care focusing on deinstitutionalization, we propose a discussion about the actions of attention to the crisis in the territory developed by CAPS of Alegrete.

The crisis, as a moment of conflict, creates a lot of anxiety for both the subject who experiences it and for the people that are around it, such as family and friends. The welcoming/patient engagement in a crisis can be a rich moment in the production of bonds and accountability, turning the service into a reference in these situations. One of the techniques incorporated into psychosocial care is the welcoming/patient engagement, that is presented as a reorganizing of the health service; it aims to ensure universal access and improve quality of care, promoting the relationship between the user and the worker, increasing intervention in search of resolution and humanization of care[12-13].

In statement 1.1. it was clear that professionals have constructed a sense of responsibility for caring for the crisis in the territory and that the community recognizes this, as it resorts to the service when those situations occur.

What is sought in health practices is the production of clinical and health accountability and resolute intervention[12]. Beyond resolute, it needs to be immediate, because in a crisis you cannot ask the subject to come in another time. Thus, the ready welcoming/patient engagement is the main tool and technique to overcome the barriers that often prevent the access and the inclusion of individuals in psychological distress[14-15].

In excerpt 1.2 it can be seen that, although the professionals recognize they are vulnerable in some situations, they demonstrate commitment and willingness to welcome/engage with the crisis situations that occur in the territory, highlighting the sense of accountability.

In many cases, the mere availability of *to go to meet* the subject in crisis can prevent traumatic impact, making the professional presence immediately reassuring for relatives, neighbors and community. This contributes to *dedramatizing the contents of the crisis, distressing for the patient and for everybody who is near*[16]. So, the fact of being available to welcome/engage the crisis is extremely important for the development of bonds with the subject, their families and the community, who begin to identify the service as a support place, a point of reference to seek real help.

The offer for listening and concrete help, that may occur within the service or in other spaces of the territory, enables the construction of a relationship of trust among the professional and the user and the beginning of *taking responsibility*. This concept is the willingness to learn the various forms and moments of suffering, *which relates to the responsibility of the service about mental health of the entire territorial area of reference, assuming an active role in its promotion*[16].

In CAPS Alegrete, there is a *taking of responsibility* for crisis care and some resources are used in the territory for that, such as the Emergency Room, as reported in statement 1.3. This is a guideline used to replace the logic of private services, structured to respond to spontaneous demand, by the logic of public services, which have as axes the coverage of domiciliary and reference care[15].

In Alegrete, CAPS is responsible for organizing the mental health demand and, in the case of crisis situations, the service is responsible for welcoming/patient engagement and resolute care, even if it is necessary to refer the subject to other resources existing in the territory. As can be seen in the presented statements, the service team takes care of the crisis wherever it happens: at home, when the professionals go to the house to assess the situation where it is occuring, and in the emergency room, since professionals monitor the crisis situations and await the referrals that may arise from this care.

Crisis situations often are determined to require hospitalization[14], but this need does not seek more isolation and submission to institutional rules or a medicalized approach, but a new logic aiming to deinstitutionalize chronic or acute situations (crises).

In Alegrete, crisis is no longer being used as an indication of admission to mental institutions because, when required, hospitalization occurs in a bed at the General Hospital. This fact meets the current mental health policy, in which psychiatric hospitalization *became more judicious, with shorter hospitalization, favoring the consolidation of a model of mental health care that is more integrated, dynamic, open and community-based*[3].

In the city, the service works with partial hospitalization, which is an important strategy so that there is no disruption of the social and emotional bonds of the users. Thus, the user spends the night of crisis at the General Hospital and during the day goes to the CAPS.

In statement 2.1, the situation of a user in crisis is discussed, that, after being hospitalized at the General Hospital, he showed no improvement in his situation, so

they had a CAPS professional talk with hospital staff to monitor the care that was being offered. This monitoring shows the importance of dialogue between the different services that compose the alternative network to the asylum, because it is necessary to know what happens at different moments of care, so it does not become segmented and meaningless.

In Alegrete, due to the monitoring conducted by the CAPS professionals, hospitalization in general hospital proved to be an opportunity to maintain the bond with the user and provide moments of complicity and trust, overcoming the idea of *feeling alone* in confronting the crisis.

The acceptance of the demands of the territory reflects the expansion of the concept of accessibility to mental health services. In contrast to the proposed hierarchy recommended by the SUS for care in the basic network and hospitals, the network concept has been developed in mental health policy. A network of services integrates and focuses on care at any time and in different dimensions of the subject's life in psychological distress (family, community and other services).

We found this reality in CAPS of Alegrete, which is co-responsible for caring for the crisis in the General Hospital – the professionals follow the course of caring that is provided there at night, and during the day, the subject in crisis goes to the CAPS and participates in activities, maintaining the social and emotional bonds he has been developing with professionals and other users. This user participation in service activities, even in time of crisis, is discussed in the statement 2.2.

This fact demonstrates that even in crisis, the subject is free to move within the territory. This practice is consistent with the Basagliano thinking[5] that considers freedom as one of the most important therapeutic resources in mental health care. Freedom to relate to each others, to express subjectivity, even if it is supervised. It is understood the word *supervise* is not meant as restriction, but in the sense of *caring*, *watch out for* the other, as to defend the freedom but not proposing that the subject is left *so* free as to be ignored. The subjects in crisis need professional care that is ready to *be together*, to understand the context of the crisis and be a point of support, one emotional bond that helps them in this conflictual moment.

It advocates the need for commitment to construct the care practices accountable to citizens' lives, because *the production of the caregiver act is immediately being accountable for an intervention, which has a strong dimension of guardian, but it can and should be involved with effective gains of user autonomy*[17].

From the discursive practices of professionals it is recognized that in the city of Alegrete, the care actions for the crisis have their axis in CAPS. Although they use other resources and therapeutic spaces, the service is the focus of care and their actions are part of a reciprocal relationship between user and professional. It is observed that there is respect for subjective expression of the subject, even if it is in aggressive way, and the recognition that in moment of crisis there is need for support and intensive care, with responsibility and humanity.

The reciprocal relationship between professionals and users, in which there is a correlation between the bargaining power, is shown to be a possibility for approaching and constructing a therapeutic relationship[18].

A technique of mental health care needs to be developed from the ethical commitment to welcoming/patient engagement, to care and construct with the subjects in psychological distress therapeutic alliances based on responsibility and solidarity. Therefore, constructing a relationship of reciprocity and contractuality is critical, especially because it breaks the relationship that the asylum has traditionally produced: power and submission. The ethical approach is proposed to break the institutional rigidity and chronicity, so that they can create devices for the anguish of subjects, offering attention to suffering, as opposed to simply eliminating the symptoms[15].

Thus, the work of the psychiatric nurse gains new perspectives, because the changes recommended by the Psychiatric Reform, the notions of therapeutic listening, welcoming/patient engagement, individualized therapeutic plans and therapeutic practices aimed at the rehabilitation of the subject in psychological distress, rescue the work with collective characteristics which provide multidisciplinary interventions. Thus arises the need for *requalification and expansion of the professional nursing roles, in the provision of mental health care*[19], inserting it in a larger practice in which other resources are used in addition to the traditional ones, and that new knowledge and instruments for care are being developed.

The prevention of a worsening of the crisis situation from reviewing of the Individual Therapeutic Plan (ITP) is a strategy that demonstrates that the relationship between professionals and users in CAPS Alegrete is not static. It is performed in a constant manner, especially in the crisis, when conflicts and new needs emerge. The ITP is a type of contract used in alternative services that aims to overcome the vertical and authoritarian prescriptions of the traditional psychiatric model that nullifies the contractual power of the subject and that eventually submits him to their practices, as if this was the *sine qua non* for access to treatment[20].

To *look at* the subject as belonging to a territory, that is, beyond the symptom, indicates the availability to know him and understand his conflicts in a way that in a crisis there is the possibility of preventing a situation of extreme aggression.

Statement 4.1 brings important elements to the discussion of strategies for attention to the crisis: the prevention,

using the resources of the service, the review of the treatment plan, home visits for monitoring, recognizing the urgency of the crisis, acknowledging the importance of immediate care to prevent diseases that cause more suffering to the person, and the recognition of the limits that the service has, for not functioning for 24 hours and not having a psychiatrist during all eight hours of operation, which requires the professional knowledge of the territory and the resources it provides.

Currently CAPS follows the Ministerial Decree number 336/02, which defines new parameters for the outpatient area, expanding the breadth of alternative services in the daily attention in order of increasing size/complexity - CAPS I, CAPS II and CAPS III, based on population criteria[21]. However, we would like to highlight here the organizational differences between CAPS II, the model of service we are studying in this work, and CAPS III. The intention is not to draw a comparison, but capture an aspect of uniqueness and specificities of each of these, maintaining a strict relationship with care during a crisis, the subject of this study.

In addition to the population coverage, the main feature that distinguishes CAPS III is that it must offer continuous care, 24 hours a day, every day, including holidays and weekends, while CAPS II works in two shifts (8 am to 6 pm), five days a week, and can comprise a third shift (up to 9 pm). This is reflected in assistance provided, since the CAPS III is responsible for the night, holidays and weekend welcoming/patient engagement, with a maximum of five beds for rest and/or observation.

Therefore, this calls attention to the importance of a territorial network of mental health services in towns which only have CAPS II, since this cannot replace the asylum. We also noticed, primarily, the need for dialogue between services. In this aspect, CAPS is strategically considered a system, because it is responsible for regulating the demand for mental health in the territory. In crisis situations, it needs to draw on other resources existing in the territory, which requires the availability of professionals to provide care of the crisis in the various spaces in which the subject moves.

It is necessary to take the initiative and assume responsibility for the individual in face of situations with which he is confronted, because mental health care needs to be a project open to singularities and specificities of various forms of expression of the human condition in the contexts of life[22]. Therefore, it is essential to have an open door, which not only means freedom to enter and permission to remain, but also the welcoming/patient engagement. It is the welcoming/patient engagement during the psychic suffering without pretexts for refusing or imposing conditions of hospitality, which in turn triggers the bond and accountability for care.

CONCLUSION

The experience of attention to the crisis developed at the Center for Psychosocial Care (CAPS) in Alegrete, learned from this study, showed that between the actions of attention to the crisis, there is the *welcoming/patient engagement* in the emergency situations, conducted in the service and at the home (with home visits); the *prevention* of crisis situations and their aggravation by reviewing of the ITP and use of territory resources; the *monitoring* of users in crisis during their stay in the emergency Room and General Hospital, demonstrating accountability for these cases, which contributes to the formation of the bond and transforms CAPS into a space for the construction of *reciprocal relationships*.

These actions contribute to the construction of a look that respects the individuality and values the subjectivity. The availability of meeting crisis situations wherever they occur demonstrates that there is already a *taking responsibility for the territory*, that is, there is a sense of accountability for crisis situations that occur in the city. CAPS proved to be a territorialized place, opened and able to meet emergencies and welcome/engage users in crisis.

In the field of mental health, we experienced a process of construction and reconstruction of meaning, of constant confrontation, negotiation, legitimization and transformation of care practices, that we learned, based on the narratives of those involved. The discursive practices of the professionals demonstrated the new meanings that are being constructed with respect to attention to the crisis.

Freedom, reciprocity, contractuality and accountability for care, demonstrated by the availability of welcoming/patient engagement during crisis, using the devices of the territory, are the new directions needed for the alternative services in order to overcome the mental hospital and sense of exclusion and danger it represents.

We hope that this study contributes to the reflection about the crisis care practices and the meanings and attitudes that are constructed daily, because the meanings of the asylum are always surrounding what we do. And in the context of nursing work in mental health, historically marked by disciplinary model, it is expected that this work could demonstrate the power of teamwork for the construction of new meanings in relation to madness and mental crisis that, like other situations of suffering, require a multidisciplinary and interdisciplinary approach.

We need to constantly evaluate our practices; deconstructing old ways of doing things, and constructing others that are more sympathetic and that respond to and have respect for the rights of the people. This study showed that psychiatric reform is an ongoing process and not something that is completed, which brings the need to know the reality of each user and each territory and, from this knowledge, to invent new ways to do things differently and to make a difference.

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