Mission and effectiveness of Outdoor Clinics (Consultórios na Rua): an experience of consensus production

Missão e efetividade dos Consultórios na Rua: uma experiência de produção de consenso

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ABSTRACT This is an experience report about a Workshop carried out by professionals working in Outdoor Clinics ('Consultórios na Rua') in Rio de Janeiro, including the presentation of day-to-day work, discussion about the effectiveness of the offered health care and construction of consensus through the Delphi Technic. The Workshop concluded that the Outdoor Clinic is a facilitator of the arrival of users in Primary Care, that use of harm reduction is a standard practice in all services of this kind, and that there is a certain degree of integration of the Outdoor Clinics with health, mental health and the intersector, and this integration, even problematic, is essential to the work.

KEYWORDS Homeless persons. Drug users. Mental health. Primary Health Care.

RESUMO *Este é um relato da experiência de uma Oficina realizada com profissionais de Consultórios na Rua do estado do Rio de Janeiro, que inclui a apresentação do cotidiano do trabalho, discussão acerca da efetividade do cuidado oferecido e construção de consenso por meio da Técnica Delphi. A Oficina concluiu que o Consultório na Rua é um facilitador da chegada dos usuários à Atenção Básica, que o uso da redução de danos é comum a todos os serviços desse tipo, e que há algum grau de integração dos Consultórios na Rua com a saúde, a saúde mental e o intersetor, sendo essa integração, mesmo problemática, fundamental para o trabalho.*

PALAVRAS-CHAVE *Pessoas em situação de rua. Usuários de drogas. Saúde mental. Atenção Primária à Saúde.*

Introduction

The abuse of psychoactive substances, which, according to the World Health Organization (WHO), affects about 10% of the population in urban centers around the world, with serious health and social damages (BRASIL, 2004), is still more severe in Brazil due to the limitations of the assistance to the users and the situation of social vulnerability observed in some urban contexts. This assistance loss is due to the fact that, over many years, the issue of abuse and/or dependence was approached from a predominantly moral, judicial and institutionalizing perspective, which did not consider its social, psychological, economic and political determinants.

When the Ministry of Health (MH), following the recommendations of the III National Conference on Mental Health, published, in 2004, the Policy of the Ministry of Health for the Integral Care of Users of Alcohol and Other Drugs, the abusive use of psychoactive substances began to formally become a public health problem. With the purpose of dealing with the progressive increase in the use of crack among vulnerable and street populations, public policy established a commitment to face this situation through social integration, production of autonomy of the user and construction of new qualified care networks. For this purpose, among other acts, in 2009-2010, it published the Emergency Plan for Expansion of Access to Treatment and Prevention in Alcohol and Other Drugs (Pead) in the Unified Health System (SUS) and the Integrated Plan to Combat Crack and Other Drugs (Piec). These two plans of action began to intervene in the causes and effects of harmful consumption, considering the social vulnerability of this population, together with deficiencies in the field of health, education and public safety (BRASIL, 2009).

Pead and Piec had the challenge of proposing practices that would advance care for a deprived population of health care

and suffering the effects of the exclusion that the use of crack can cause. The Street Office (SO) was initially proposed and implemented as a strategy by Pead, inspired by a pilot project developed by the Federal University of Bahia, in Salvador, and continued as a proposal in Piec. Its objective was to expand access to health services, improve and qualify the service provided by the SUS to people who use alcohol and other drugs, especially the most vulnerable segments and crack users, always through street actions.

The choice of occupying the streets for the assistance of these users comes, according to Oliveira (2009), from the perception that, with the arrival of crack in the 1990s, drug use in this space has taken on an even more serious dimension, with an increase in exclusion social and health care, requiring managers to create alternatives for this population. The Brazilian Center of Information on Psychotropic Drugs (Cebrid) has indicated an increase in drug use among children and adolescents in a street situation greater than that observed in children and adolescents who attend school (NOTO ET AL., 2003). A study organized by the Oswaldo Cruz Foundation (Fiocruz) found that an expressive share of crack users found in scenes of use in urban centers is in a street situation (about 40%). They are groups that live in unfavorable socioeconomic contexts and in poor health conditions (BASTOS; BERTONI, 2014), which reaffirms the importance of a policy for this specific population. Therefore, the OC, based on the recognition of the social determinants of vulnerability, risk and consumption patterns of this population, proposes that the health professional should go to the user wherever he/she is, leading to the ultimate consequences of the principles of universality, completeness and equity, through the actions of harm reduction and intersectoriality.

In the continuity of the discussion about the promotion of health for the population living on the street, the MH recognized the argument that there are other needs besides attention to alcohol and other drugs abuse,

and proposed, in 2011, the joining between the SO program (itinerant team with a focus on mental health) and the Family Health Strategy of the Homeless Family (FHS with specific teams for integral health care for the homeless population). Thus, SO teams were disconnected from the comprehensive care network on alcohol and other drugs, and the Outdoor Clinic (OC) was integrated with Primary Care (PC) teams as an action for specific populations, described in the Decree nº 2.488, of October 21, 2011. With this change, Primary Health Care started to count on a flexible team adaptable to the reality of those who live on the street and use alcohol and other drugs (TEIXEIRA; FONSECA, 2015), with the objective to include these users in the Basic Health Units (BHU) or units of the Family Health Strategy (FHS), the main entry point of the system, which has the attribution of being resolutive in the face of diverse demands (BRASIL, 2011).

Because it is a new device, but with great potential to access a population that was previously marginalized and excluded from public policies, it was observed a great interest among managers and health professionals in their implementation and functioning. However, there are still few academic productions that systematize a knowledge about the OC, and there are few studies that verify its effectiveness, including with regard to the assistance to alcohol users and other drugs that live in this situation, characterizing an important production gap of knowledge in the field of psychosocial care (DELGADO, 2015). The fact that this device is part of the National Policy of Primary Care since 2011 was celebrated by health managers, social movements of the street population and by professionals, as a way for this population to cease to be invisible in the eyes of health, but the effects of this change have not yet been verified.

Therefore, an exploratory Workshop for the knowledge of the OCs of the Rio de Janeiro state was proposed by a research group on public mental health policies of a public university in Rio de Janeiro. It was also the objective of this Workshop the construction of a consensus on the role/mission of this device, the use of harm reduction as a work strategy and the connections/partnerships developed with PC itself, mental health and intersectoral resources.

Configured in the Experience Reporting mode, this article aims to present and analyze this Workshop, as well as to explain the main discussions and referrals from it. This is an exploratory study of qualitative methodology that gave subsidy to a research project submitted and approved by the Ethics and Research Committee, under the opinion 1.287.934. The main characteristics of some OCs and thematic approaches will be highlighted, as presented by the professionals that compose them, and the results of the consensus achieved through the Delphi Technique about some previously chosen themes.

Methodology

The consensus Workshop was held in November 2014, and, for it, the thirteen OCs in operation in that period were invited to eight municipalities in the state of Rio de Janeiro. Divided into two parts, it had the experience report of three OCs, followed by a debate whose triggering question was: *"Are the Outdoor Clinics effective in monitoring the users of alcohol and other drugs?"*. The discussion proceeded freely, without any interference, dealing with various subjects. The participants, despite having accumulated experience with people in a situation of use, expressed their opinions, but also questioned the meaning of what they do and what would be the most powerful strategies of care. This first part was open to the public, counting on the presence of professionals from eight OCs, students and municipal and state managers. Through the analysis of the material content, according to Bardin (2011),

the researchers identified four themes that included the main issues discussed, which will be presented in the results.

In the second part, restricted only to the professionals of the OC, there was a consensus Workshop with application of the Delphi Technique – a Nominal Group Technique (NGT), which allows synthesizing information to obtain consensus among specialists on criteria, training programs and improvement (DESLANDES; LEMOS, 2008), constituting a quanti-qualitative method in order to obtain a collective and qualified opinion on complex issues. The group selected to treat them is considered to have expertise in the subject, be it academic or practical (PIOLA; VIANNA; VIVAS-CONSUELO, 2002).

Participants were explained that a Consensus Technique would be used in order to verify common characteristics in their work experiences. All of them signed the Term of Free and Informed Consent, and, then, were presented, one at a time, three questions that should be answered individually. There was a back-up team that consolidated the answers, put together the ones that were similar, systematized the rest, and returned them to the group so that it could work again on them, reaching consensus on more general aspects of the device.

The questions were previously chosen with the intention of obtaining a primary description of the OC from indicators that expressed its mission, existing resources and organizational conditions of the team. The first one was: what, in your opinion, are the five main functions of the Outdoor Clinic? For this question, 70 individual responses were initially collected that, after agglutinated and discussed by the group, were transformed into 16.

The second question was: in your opinion, does your Outdoor Clinic use the harm reduction strategy? If yes, give two examples of harm reduction actions you have taken. The last question investigated the relationships and partnerships established for the work by means of a question subdivided into three: 3.1) Your Outdoor Clinic is articulated or develops a work in partnership with other PC devices (Family Clinic, Basic Health Unit (BHU), Municipal Health Center, Support Center for Family Health)? If yes, how do you evaluate this work together? I) Weak, II) Regular, III) Good, IV) Excellent; 3.2) Does your Outdoor Clinic articulate or develop a work in partnership with mental health devices (Caps – Psychosocial Care Center, Mental Health Clinic, Coexistence Center, Reception Unit)? If yes, how do you evaluate this work together? I) Weak, II) Regular, III) Good, IV) Excellent; 3.3) Does your Outdoor clinic articulate or develop a work in partnership with other devices of the intersector (Social Assistance, Education, Culture, Sports and Justice)? If yes, how do you evaluate this work together? I) Weak, II) Regular, III) Good, IV) Excellent.

Results

Experience reports

The three Clinics invited to share their experiences presented common characteristics, such as the fact that they started operating as SO, linked to a Psychosocial Alcohol and Drug Attention Center (Caps AD) and counting on damage reducers in their teams. By the time they were integrated into PC, they became OCs and had social agents instead of harm reduction agents. Their working conditions were improved, they had more resources and a car for the displacement of the team. Two of these offices became type III, that is, with at least six professionals and a doctor, and they started to have their headquarters in a BHU and in a Family Clinic. The third one was type II, also with six professionals, but without the presence of the doctor in the team, with its own headquarters. As common points among them all, were registered: the work with the population found

on the street in a situation of vulnerability, with sex workers and transvestites, as well as with people sheltered in social assistance devices, carrying out the activities at different times and different places, according to the displacement of the assisted clientele, and the fact that all professionals, except for the administrative officer, go to the field. In addition, the three clinics distributed different inputs according to the reality and the work performed in each municipality.

The intersectorial articulation was considered fundamental by professionals. All of them carried out cultural and recreational activities in the territory, used as a facilitator for bonding, especially with children. When in the field, they performed, also, sputum collection, bacilloscopy, and were attentive to the most prevalent infectious and contagious diseases in vulnerable populations. In addition, they shared the difficulty of the continuity of follow-up, since the population in question is mobile, with great circulation and little adherence, making the locomotion and the interventions of the teams need to be constantly discussed.

As a challenge, they presented the work with the Mobile Emergency Medical Services (Samu), regarding the removal of users, the articulation with the intersector and difficulties in the day to day with Primary Health Care (PHC).

The debate

MISSION AND FUNCTION OF THE OUTDOOR CLINIC

The professionals considered the OC a facilitator of the arrival of the vulnerable users to the services of the PHC, at the same time that they identified a failure in this function, inasmuch as these services have made difficult the access of this population. The question arose of the training of teams as a way to make work feasible, but also the fact that there is no specialized training to welcome

vulnerable populations, but rather an expertise that is acquired on a day-to-day basis. One solution, therefore, would be the intensification of the partnership work.

The OC was evaluated as an advance in terms of public health policies because it has reduced the invisibility of the population in a situation of vulnerability, increasing the care offered to it. On the other hand, the OC has also been affirmed as a 'subSUS' for those who cannot access the public health services, possibly representing, thus, a setback in politics. Regarding this, it was discussed the need to work on the autonomy of users to circulate through health devices, avoiding tutelary practices, and the need for services to create vacancies for this population that does not have a fixed document or housing.

Finally, the managers present affirmed that the OC is a controversial device, still under construction, supported by the National Movement of Population in Street Situation, but which can be dispensed with 'when SUS is, in fact, universal'.

WORK STRATEGIES

The professionals emphasized matrix-based strategy, psychosocial attention and harm reduction as strategies that guide the work in team, the relation with the health and intersectorial network and the way of approach of the users, indicating that some OCs choose one of these strategies as a priority.

The matrix-based strategy was defined as a sensitization of the territory to the problems of the one that circulates in the meetings with the services, seeking to implicate other professionals in the care, since the OC cannot be responsible for all the demands of the street population. Psychosocial care was associated with a way to follow the users from case discussions with the services, building joint care strategies. Harm reduction was related to work in loco, with the approach and treatment performed on the street, including health and drug abuse issues.

THE SCENES OF USE

The professionals raised questions about ways of caring in these spaces and about the people who inhabit them. They defended that care actions should consider the socio-political and cultural context of each territory, and the perception of the users of where they live and their use of it.

WORKING WITH CHILDREN AND ADOLESCENTS

It was emphasized that the original project of the SO included children and adolescents, who are now rarely assisted because of the difficulty of accessing them in the territory. At the same time, questions were raised about the type of work and harm reduction that was most appropriate for this clientele, pointing to the ludic and sportive activities as possible strategies.

Finally, it was registered that the invisibility of work with children and adolescents favors the compulsory collection actions, developed by social assistance. However, although this is a complex issue, requiring an in-depth discussion of the health sector, it was not taken as the privileged object of debate by the participants.

The Workshop with the Delphi Technique

In the first question presented, and after discussion, 16 answers were consolidated that were not listed in order of importance. The result about the mission/function of the OC was mostly based on the rights, resocialization, stigma and visibility of the population served, and responses that related to access to care, either in the services or in the street, including promotion, prevention and reduction of damage to health.

Chart 1. The main functions of the Outdoor Clinic according to the participants of the Workshop

1 – Redeem citizenship and guarantee the rights of the population in a street situation

2 – Re-socialize the population in a street situation

3 – Understand the dynamics of life of the population in a street situation

4 – Ensure the access of the population in a street situation to SUS

5 – Empower users

6 – Perform a specific and non-specialized job

7 – Promote care for the population in a street situation from equity

8 – Be a gateway to health

9 – Work from the harm reduction policy

10 – Treat on the street those who cannot reach the health unities

11 – Promote local health actions for those who do not reach the services

12 – Establish respectful bonds with users from listening and receiving

13 – Promotion and prevention of health

14 – Provide clinical and mental health care

15 – Make articulations with the intersector

16 – Give visibility to the street population by reducing their stigma

Source: Own elaboration.

Regarding the second question, it was concluded that all services there represented carried out harm reduction actions and discussed more closely an example of replacing crack with marijuana in case of tuberculosis and a request from the team so that local commerce would not sell thinner to users.

Chart 2. The use of harm reduction according to the participants of the Workshop

Does your OC use the harm reduction strategy?		
Yes	No	Did not inform
13	0	1

If yes, give two examples of harm reduction actions you have taken.

- distribution of inputs such as condoms and lip protectors

- guidance on the use of substances

- vaccination

- caloric food supplementation

- elaboration and execution of activities in group with orientation for the population in a street situation

- pipe distribution (performed by only one participant)

Source: Own elaboration.

In the discussion of the third question it was highlighted, unanimously, the need for some degree of integration between health, mental health and the intersector, for the development of work. It was also highlighted, in relation to BC, the fact that the OC is one of its devices and, even so, the joint work is not guaranteed, and the hypothesis that if PC worked well with this population there would be no function or place for the OC. It was argued, without reaching a consensus, whether the function of the OC would be to build such an effective articulation with the PC that the OC itself could in the future dispense with its existence.

About mental health, the perception was of a consistent articulation with the OC, a fact associated to the history of this device that, in the origin, was linked to the Caps.

In addition, one professional emphasized that mental health has always dealt with a 'marginal' population, users in diverse situations of vulnerability and outside the pre-established patterns of sociability.

As for the articulation with the intersectors, the 'weak' evaluation was significant, pointing to an apparent contradiction: intersectoriality was considered fundamental for the work, but not executed. However, the social assistance sector was detached from the others because, even with divergences in the direction of work, as in the case of compulsory collection, it indicated openness to the discussion. With regard to justice, the enormous difficulty of articulation was affirmed; and with Education, the lack of dialogue. With regard to Culture, the record was that of 'no receptivity'.

Chart 3. The relation with Primary Health Care, mental health and the intersector according to the participants of the Workshop

3.1) Does your Outdoor Clinic articulate or develop a work in partnership with other primary care devices (Family Clinic, Basic Health Unit, Municipal Health Center, Family Health Support Center)?

Yes	No
14	0

If yes, how do you evaluate this work together?

Weak	Regular	Good	Excellent
3	3	8	0

3.2) Does your Outdoor Clinic articulate or develop a work in partnership with the mental health devices (Caps - Psychosocial Care Center, Mental Health Ambulatory, Coexistence Center, Reception Unit)?

Yes	No
14	0

If yes, how do you evaluate this work together?

Weak	Regular	Good	Excellent
0	4	8	2

3.3) Does your Outdoor Clinic articulate or develop a work in partnership with other devices of the intersector (Social Assistance, Education, Culture, Sport and Justice)?

Yes	No
14	0

If yes, how do you evaluate this work together?

Weak	Regular	Good	Excellent
7	4	3	0

Source: Own elaboration.

Discussion and final considerations

It is known that the Policy of the Ministry of Health for the Integral Care of Users of Alcohol and Other Drugs (BRASIL, 2004) was formulated from an increasingly diverse and community-based model of mental health care. This policy adopted Caps AD as a fundamental health equipment for the treatment of drug users because, in addition to being flexible and open, they are articulators of other community resources and promoters of intersectoral actions, enabling the user to better integrate into their environment. It also indicated the model of harm reduction "as a clinical-political method of territorial action inserted in the perspective of the expanded clinic" (BRASIL, 2004, P. 24).

However, vulnerabilities associated with crack use, such as physical and psychological degradation, violence, marginalization and disruption of affective bonds make access to health services difficult (RAMIRO; PADOVANI; TUCCI, 2014; RODRIGUES ET AL., 2012). Similarly, the lack of family structure, schooling, and occupation also decrease adherence to the treatment (ARAÚJO ET AL., 2012; HORTA ET AL., 2011; MONTEIRO ET AL., 2011; PEIXOTO ET AL., 2010). The data obtained by Noto e*t al*. (2003) revealed that most young people on the street who sought help for the harm of drug abuse made it into a specific care institution for this population, with only 0.7% seeking a health unit. Similarly,

Horta e*t al.* (2011) verified that the serious users with greater social commitment do not access or remain in the SUS services, but in the community support networks.

On the other hand, Conte (2004) and Lancetti (2006) point to positive experiences, carried out in Brazil in the places where the users live, which show a greater adherence to the preventive guidelines and have as an effect the establishment of bonds between the harm reducers and the users. Within this perspective, the SO was deployed for active participation in the street population, meeting their needs and respecting their social context.

Workshop participants described the OC as a breakthrough in public health policy for a previously invisible and marginalized population. They referred to the work from local health actions that include health promotion and prevention practices, based on the very dynamics of street users. However, they also questioned the pertinence of this device, since SUS is for everyone. Barriers to access to services – such as the need for documents, being adequately cleaned and dressed – and the unwillingness of the professionals to serve this population were discussed. These obstacles were taken as something to be overcome with the help of the OC, becoming one of the functions of this device, in addition to its responsibility in building and strengthening the link of users with different services. For this, the matrix-based strategy was chosen as fundamental tool.

Trino, Machado and Rodrigues (2015) affirm that the OC, because it works with the concept of vulnerability and with the concept of network care, can better manage the complexity of problems presented by those who are in a street situation. Therefore, it seems important to maintain the discussion about the mission of the OC and effective street work, so that the vulnerability of a particular population, which, among other things, hampers its arrival in formal health services, is not lost on the discussion of what is or is not pertinent to be addressed in these units.

The use of harm reduction was highlighted by professionals as an important and widely described practice, including the distribution of inputs, the contact with the user in the place where he/she lives, health prevention and education actions and the discussion with others actors of the user's territory. The workers appeared to be sensitive to the fact that the clinical orientation of work is something to be built up in the encounter and in the bond that merges with the other, so it is not a process in which a priori goals are defined. The choice of harm reduction as a method and guideline for this clientele offers a promising path for professionals, since it recognizes the users in their singularities, tracing strategies for the defense of their life through diverse and non-exclusive paths. This possibility of common construction implies increasing the degree of freedom of the user and making him/her co-responsible for the decisions made in his/her treatment. Thus, by using inputs and actions of prevention and health education, the technicians bet that those subjects could, even in unfavorable conditions, be protagonists of their choices.

When it came to the relation of the OCs with health itself, it was evident that, even though they are part of the National Policy of Primary Care (BRASIL, 2011), professionals feel they work in isolation from this sector and solitary in their units. They attribute this problem to the difficulties of interlocution, to the prejudice that health workers still have with this population and to the fact that they do not feel qualified or able to attend to it, since they consider that this is an own or exclusive expertise of the OC professionals. This problem is pointed out by Ramiro, Padovani and Tucci (2014), who indicate that the marginalized condition widely disseminated in the media makes the phenomenon of drug consumption have an even greater impact, increasing the stigma and the difficulty of these users to access health services.

Silva, Cruz and Vargas (2015) also draw attention to the fact that the work of linking health services with the street population carried out by the OCs is compromised by the own work organization of the PC, which, unlike which is advocated, still offers, many times, care focused on medical practice and prescriptive procedures. On the other hand, the OCs participants in the Workshop say that they insist on changing this reality by sharing work from matrix-based strategies and persisting with the effort to include this population in unskilled assistance. After all, it is only in the daily contact between the OC technicians and those of the BHU, and between these and the users, that the stigmas of the professionals can be overcome, offering a more adequate assistance. As a solution to this issue, the workshop participants presented a concrete proposal: the reservation of places in the services for consultations and examinations of this population.

In this respect, it is worth remembering that, in affirming that the street population is the responsibility of every SUS professional, but especially AB, the National Policy of Primary Care (BRASIL, 2011) aims to increase access of those who are on the street to the health network, using a specific team for this. This has the function of registering these users, describing their problems and producing the necessary care, in order to include them in the BHU, the main entry point of the system. However, it is necessary to emphasize that this is a complex work, which cannot be confused with the act of transporting the user to a health unit, although this is, sometimes necessary. This connection happens in the daily work of network construction, establishment of partnerships, case discussion, sensitization of professionals, in shared services, in the arrivals of users to the units and in the going of the professionals that compose other teams, other than OC, to the territory. The meetings provided by the sharing of daily work and the possibilities of analyzing them together are powerful resources for overcoming some stigmas.

The network construction with mental health, in turn, was consensually considered satisfactory and justified by the professionals by the history of this device, which originated in Caps AD. In addition, it is believed that the fact that mental health work with vulnerable populations favors the arrival of these users in their services. On the other hand, the relationship with the intersector is considered fundamental, but weak, and still needs to be built.

It should be concluded, therefore, that a continuing discussion about the assistance of vulnerable populations is important, with an emphasis on the potency and effectiveness of the work of the OCs, considering the natural difficulty of these users to reach the health units and also the professionals of these units to receive them. In addition, it could be inferred from the discussions carried out in this Workshop, that the transition from mental health to PC has produced significant changes in the functioning of this device, even if not all of them are intended. The transition from SO to OC did not reduce access barriers faced in health, as might be expected, and took care of alcohol and other drug users out of focus, losing the specificity of care for them.

Collaborators

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