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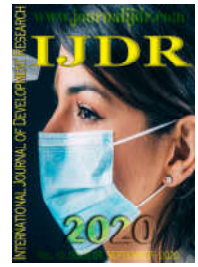
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## NOTHING ABOUT US WITHOUT US: CARE IN THE PERCEPTION OF USERS OF A CENTER OF PSYCHOSOCIAL ATTENTION

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### ABSTRACT

**Objective:** to understand the psychosocial care of users of psychoactive substances in a Center of Psychosocial Attention of Alcohol and Other Drugs through their perception and voice. **Method:** This is a qualitative approach study with exploratory character. The field of this study was the Center of Psychosocial Attention of Alcohol and Other Drugs of the city of Sant' Ana do Livramento- Rio Grande do Sul. The data was collected through the Narrative Focal Group technique, performed with 9 users, and the audio was recorded and transcribed in its entirety. The data were analyzed in the light of critical hermeneutics. **Results and Discussion:** Stigma was present in the posture of professionals and establishes a relationship of care that is often weakened and moralizing with users of psychoactive substances. The positive experiences of welcoming, bring CAPS as a space of care, treatment and listening. Through the strengthening of the professional-user relationship and the building of bonds they feel represented by mental health professionals in the management, intersectoral network and in the Psychosocial Care Network itself. **Conclusion:** The perceptions of care that Center of Psychosocial Attention of Alcohol and Other Drugs users bring, deal with the completeness of care and the light technologies, which meet the precepts of the Brazilian Psychiatric Reform, which currently suffers several attacks, dismantling erodes.

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### INTRODUCTION

The movement for Psychiatric Reform emerged in the 1970s as a critique of the model based on the logic of manicomial, which institutionalized individuals in mental suffering under precarious and inhuman conditions, in a scenario of neglect and violence. The Brazilian Psychiatric Reform (RPB) gains strength in a political period of redemocratization in conjunction with the struggle for human rights for victims of psychiatric violence (AMARANTE; NUNES, 2018). In 2001, a new model of mental health assistance was consolidated with the enactment of Law No. 10.216, which provides for the protection and rights of people with mental disorders and redirects the model of mental health assistance, guaranteeing

the rights of users, better treatment, insertion in the community, information about their treatment and right to full care (BRAZIL, 2001). Strengthening the ideals of RPB, the National Policy on Mental Health, alcohol and other drugs provides the strategies and guidelines adopted to organize assistance to people in need of specific treatment and care in Mental Health, the Network of Psychosocial Attention (RAPS) emerges that seeks to promote greater social integration, strengthening the autonomy, protagonism and social participation of the individual (BRAZIL, 2011). In agreement, the production of care needs a combination between the necessary technologies and humanization, being the user approached in his singular needs and subjectivities, in an integral way (CASTRO, 2007; CECÍLIO; MERHY, 2003).

Therefore, the dimension of completeness of care must permeate health practices and cannot be restricted only to technical skills and tasks, since reception, links of intersubjectivity and listening to the subjects compose the elements inherent to their constitution (PINHEIRO, 2009).

Thus, care is said to be the combination of a complex network of technologies: hard - instruments, medicines, equipment (dead work); light-hard-structured technical knowledge; and mild or relational (live work in action) - welcoming, bonding, listening, expanded clinical (CECÍLIO; MERHY, 2003; SLOMP JUNIOR et al., 2015a). Thereby, it comprises procedures, services, flows, routines and knowledge, which complement each other and compete with a certain awareness and negotiation, in the articulation of health workers' practices. This is received/lived by the user, fitting to his/her needs (CECÍLIO; MERHY, 2003). Care needs to respond to the real needs of the users and thus get closer to them, who in turn are unique subjects that differ from each other, in addition to promoting autonomy and encouraging the protagonism of these subjects. Therefore, workers need to prioritize the use of light, relational technologies, which give "life" proper to the work in health, is "the living work" that happens in act, producers (or not) of the care (MERHY, 2004; SLOMP JUNIOR et al., 2015a). The use of these technologies takes place in the professional user meeting, covering the context, the cultural universe, the specific ways of feeling and living, the affective and power relations (CASTRO, 2007; SLOMP JUNIOR et al., 2015b).

Faced with the field of mental health, these technologies enable the inclusion and stimulation of the user's autonomy in taking care of himself/herself, enabling the recovery of the subjects' citizenship, improvement of political achievements and construction of new practices, causing cultural changes in society, thus contributing to the strengthening of the RPB in progress and to the exclusion imposed for years on madness (CARDOSO et al., 2016). In view of this problem, dialoguing about the care of users of psychoactive substances (SPA) based on their discourse, highlights the potential of describing a real context, which reveals what is desirable and what is expected, is pertinent because it allows the identification of exploring and intervening in the practices and actions carried out. Through the knowledge of the users' perceptions of care, it allows them to understand and evaluate in some way the quality of the assistance being provided, because for them, and about them, mental health services are organized, and therefore, listening to them when approaching their own care is essential. The term "Nothing About Us Without Us" was based on the motto "Nothing About Us Without Us" of the disability movement, on an understanding that people with disabilities should actively participate in the decision-making processes regarding programs and policies on issues related to them (AMARANTE; LIMA, 2009). Hence, in the same understanding, users of mental health should have their right to have an opinion, discuss and decide on the care that is offered to them.

It is worth mentioning that the term psychoactive substance was used instead of drug, because although the latter is more commonly used on a daily basis, it has been used inadvertently, contributing to stigmatizing and mystified views, associated with value and moral judgments, about the use and users of SPA (BRITES, 2016). In contrast, the term psychoactive is more appropriate when referring to substances

that act preferentially in the Central Nervous System (CNS), as well as even some classes of psychotropic drugs through stimulation, depressing or altering their functions, producing tolerance, abstinence or dependence. From this perspective and believing that care should be centered on the needs of the user, concerns are raised about: "How does a psychoactive substance user understand the care they receive in Center of Psychosocial Attention of Alcohol and Other Drugs (CAPS ad)?" with the objective of understanding the psychosocial care for users of psychoactive substances in a CAPS ad, through the perception and voice of these users.

The construction of the article was based on the following topics:

- I) Introduction;
- II) Method;
- III) Results and Discussion;
- IV) Conclusion;
- V) Acknowledgements.

## MATERIALS AND METHODS

This study is a qualitative approach with an exploratory character. The qualitative research uses the universe of meanings, aspirations, beliefs, values, attitudes and culture, because it is understood that this set of human phenomena is part of social reality (MINAYO, 2014). The field of this study was the CAPS ad in the city of Sant'Ana do Livramento -RS, founded in 2014 and belonging to the 10th Regional Health Coordination of Rio Grande do Sul (10th CRS/RS). The selection of participants was made intentionally to ensure homogeneity of the group and the following inclusion requirements were used: to have been a CAPS user for at least 6 uninterrupted months, except in cases of hospitalization; to be in follow-up in the service for issues related to the use of psychoactive substances; to have a minimum attendance of 2 times a week; to be over 18 years old, or to have been legally emancipated; to accept to participate in the study and to sign the Informed Consent Term (TCLE). As exclusion criteria for the users were used, to present impediments of understanding and communication to answer the questions of the study; to present impediments of being present during the meeting of data collection of the study (focus group users); and/or to refuse to participate of the study. The data were collected in September 2018 through the Narrative Focus Group (GFN) technique, and the audio was recorded and transcribed in its entirety. The GFN technique was adopted because it understood the potentiality of knowing the opinions and understanding of participants on a theme, especially if this theme can mobilize diverse opinions, since the understanding that is built as researchers occurs in the interaction of the group, in the agreement or disagreement in the relationships that they establish among themselves. The data were collected in September 2018 through the GFN technique, and the audio was recorded and transcribed in its entirety. The GFN technique was adopted because it understood the potentiality of knowing the opinions and understanding of participants on a theme, especially if this theme can mobilize diverse opinions, since the understanding that is built as researchers occurs in the interaction of the group, in the agreement or disagreement in the relationships that they establish among themselves. The GFN was held in a room provided by CAPS of Sant'ana do Livramento and lasted approximately one and a half hours, being conducted by a moderator and a supporter, members of

the research team. They were guided by a guiding research script for the debate with users, which included, in addition to open questions, reading and discussion on the charter of rights to health users. The focus group was conducted with 9 users of the service. To perform the data analysis, the content was transformed into group narrative, validated by two researchers. This type of method was chosen because it allows a debate while being stimulated by moderators to explore collective perceptions about the object, since individual understandings are a part of the context to be analyzed (MUNARETTO et al., 2013). The GFN was held in a room provided by CAPS ad de Sant'ana do Livramento and lasted approximately one and a half hours, being conducted by a moderator and a supporter, members of the research team. They were guided by a guiding research script for the debate with the users, which contained, besides open questions, reading and discussion about the charter of rights for mental health users.

The questions that were part of the focus group's itinerary were: *"How do you realize that you are received/treated by the team at CAPS? And when you arrive under the effect of a SPA? What?"; "How was your participation (will) in the elaboration of the PTS?"; "How do you perceive the team's reaction when: Do you not agree with the PTS? Do you change your mind about the PTS? Do you decide to do, or do, something different from what was agreed in the PTS? For any reason do you intensify the use of SPA, or do you return to the old pattern of the consumption? Have you noticed it happening with someone here? And what do you feel about it? Let's talk about it: How are therapeutic activities planned and developed at the CAPS? In which space? Do you feel you have space/freedom to express your opinions about?"; "Regarding your rights: Do you know the users' rights charter? Have you been advised about your rights? Where? By whom? (Reading and discussion of the users' rights of the users' rights charter)"; "What do you understand by: Success in treatment at CAPS? Harm reduction? Abstinence? Hospitalization?"; "What is your opinion regarding the treatment offered by CAPS? Would you like to change anything?"*

The data were analyzed in the light of critical hermeneutics in a commitment to the truth, understanding that reality is not, but becomes as constructed by people at a given historical time. This method consists in opening oneself to the encounter, enabling the other right and not pretending to have the last word. It means a "practical truth", a continuous process that remains in unlimited resignification as long as the possibility of interaction remains open (AYRES, 2011). This study is a section of the research entitled: "The clinic in the context of psychoactive substances use: the perception of users, workers and managers about mental health care", registered in the Research, Teaching and Extension Project Information System (SIPPEE) under registration number 20170526125153. Approved by the Research Ethics Committee (Zip Code) of the Federal University of Pampa-UNIPAMPA, through opinion No. 2281711, on September 18, 2007. We highlight that all participants signed the TCLE in accordance with the Resolution 466/2012 concerning research involving human beings.

## RESULTS AND DISCUSSION

In this segment will be presented, through the narrative fragments, the users' perception of the care offered to them. As for the profile and characteristics of the nine users who

participated in the survey, 77.8% were male; ages varied from 19 to 69 with an average of 41, 22 years; the level of schooling was 33.3% Elementary School (EF) incomplete; 11.1% EF complete; 33.3% High School (MS) incomplete; 11.1% Complete MS and 11.1% Higher Education; 55.6% had no occupation; as for the family home arrangement 22.2% lived with friend, 22.2% lived with brother; 22.2% lived alone; 22.2% lived with partner; 11.1% lived in a hostel; and 100% made use of medication. Through their lines it was possible to organize the results in large groups, which will be presented below, together with the discussion, and which are directly related to the production of care: Stigma, Welcoming, Qualified Listening, Professional-User Relationship, Relationship, Co-responsibility of Care/Autonomy and Humanization. Health care envisions treating, respecting, welcoming, listening, understanding the suffering subject and his life history, seeking resolution. It occurs in act, among those who practice care, together with those for whom care is intended, who not only suffer the action, but is co-responsible in the process of making decisions about their health, requiring the recognition and inclusion in the care process of their desires, aspirations and peculiarities (PINHEIRO, 2009). However, something that can interfere negatively under the care provided, are the prejudices and stigmas existing to users of mental health. Stigma is configured as a negative characteristic, mark or sign in which the subject who possesses such attributes is identified as undesirable by a group of individuals, making them less valued than others and incapacitating them for complete social acceptance (GARRIDO et al., 2007; RONZANI; FURTADO, 2010; DA SILVEIRA et al., 2011).

The presence of stigmatizing relationships between CAPS health professionals and users and the discredit given to their lines can be observed in the following narrative fragment:

*"Sometimes the chemical dependent is generalized, they (the professionals) have this thing that dependent is all the same, all are the same thing. Dependent is a liar, dependent is manipulative, sometimes you are not. We already have the reputation of being aggressive, nay, because of the chemical dependence, so the person treats you badly and forces you to be verbally aggressive. And then we're the losers, because the guy is a drug addict, he's crazy, he's violent, he's bad, he's adulterated. You have to have a certain game of waist and she already wants to give medicine to the guy. She makes the guy nervous, she'll give medicine to your children, she's sick, and she's filling me up with medicine, leaving me even crazier!"*

In the fragment presented we can see that the stigma given to the individual in abusive use of SPA generalizes them, removing their individualities and subjectivities, and also puts him in a discredited position, thus removing his recognition, making his speech impossible and silencing his voice. Thus, he is inserted in a position of a "madman" or "junkie", incapable of possessing a critical judgment about his health and his choices, and, therefore, there is a need to be medicated and controlled, denying his feelings and reactions, and reaffirming a normatization of behavior, in which drugs take this power and control. This stigmatizing vision to SPA users, which is sometimes based on normative discourses, is also perceived in a study conducted in Primary Care, directly influencing the professional-user relationship and the production of autonomy, the power of decision on their own care. The authors also affirm that the loss of the feeling of control over the life of the

other awakens a feeling of frustration and anger in the professionals, leading to the exclusion of these individuals and the cessation of health actions to them (MALVEZZI, NASCIMENTO, 2018). People with similar stigma characteristics tend to approach and develop social relationships with each other, since the person who has a particular stigma is prone to have similar experiences to other individuals who have the same stigma as them. This can lead to a shared understanding of what selfhood and socialization or learning processes are like in a group of individuals who share the same stigma (GOFFMAN, 1981). This can be verified among CAPS ad users by identifying and relying on the collective:

*"The assembly that we see all the activities during the month, which serves everyone and everyone agrees the same thing. Then it is voted which one everyone agrees to do, it is done as a group, it is as in school, everyone participates and nobody is left out. The occupational therapist is the one who defines the activities. But we are consulted because everything is prioritized by the people, what is most prioritized by each one of us here is what is going to be done".*

In addition to the process of sociability and closeness of thoughts, in this way their "individual voice" and their desires that were once unrecognized, present themselves and strengthen themselves in the collective. Moreover, the very understanding of the self, of individual identity, takes place in contact and group interaction, and from others, with whom relationships are developed, that builds self-understanding as a subject. It is in the group that they bring the affirmation of their choices and the apprehension by their team, in the situation exposed, in defining the activities that are offered in the therapeutic workshops for their treatment and care. On the other hand, despite this identification and recognition in their peers, in those who share similar types of suffering, the stigmatized individual may present a tendency to stratify and differentiate from other stigmatized, depending on the degree of visibility and imposition of their stigma. Thus, he may assume a posture towards those who are more evidently stigmatized than him, the attitudes that the so-called normal ones take towards him, in a kind of reproduction of stigma in the other (GOFFMAN, 1981). This statement could be identified in statements from the group of users in treatment through the use of SPA in relation to those with more evident mental disorders, classified as "crazy", and not recognizing themselves in a mental health treatment:

*"This is a disease that doesn't become crazy, you understand? Suddenly the treatment is like an entrance to the insane asylum, but this is not mental health, it is chemical dependent".*

*"The welcome to the person who arrives numb could be better, with more respect, less indifference, we don't like to be destroyed, they (the professionals) need to understand that we came here to treat us and not to listen to stupidity. We think that the professionals lack qualification to receive us, because sometimes we will arrive "crazy" here".*

By considering the user from a single perspective and identity, that of stigma, believing that they are the only ones responsible for their health condition, the health professional demonstrates to the user a difficulty in welcoming him/her when under the effect of SPA use. Such attitude restricts the possibilities of

reception and access, and may constitute a barrier, negatively affecting the quality of care provided. However, the collective of users also brings positive and successful experiences, in which they were welcomed and listened to in some way, considering the place as a reference of space for care and affection, seeking for help, treatment, listening, and even to access basic activities of a human being, such as personal hygiene and food. Comparing CAPS ad as your family, your home, place of rest and refuge:

*"In this place the treatment helps a lot, we are welcomed, we receive psychological support, there is a social worker and what we need at some point, because sometimes we don't have a place to stay, nor someone to talk to, and here at CAPS we have this, CAPS ends up being our family sometimes, at least we are not on the street".*

The welcome, which is often understood in a limited way only as the moment when the user appears for the first time to the unit seeking treatment, can be understood as a posture adopted by the professional and principle of reorientation of health services (CASTRO, 2007). To receive is to recognize what the subject brings as a legitimate and singular health need, supporting the relationship between teams/services and users/populations, by building relationships of trust, commitment and bond (BRAZIL, 2015). The practice of welcoming promotes a closer professional-user relationship and a greater bond, allowing a welcoming space for listening, dialogue and a greater understanding of the user's health needs, considering his/her subjectivities and singularities. Besides the recognition of the protagonism and autonomy of the user in the face of his/her health-disease process, providing co-responsibility in the care, and sharing of knowledge and experiences, in the search for resolutivity.

Beyond the biological care, for the "disease" presented by the "subject to be cared for", the one that the "caring subject" brings his technique and scientific knowledge, he seeks to be accepted in his demands and needs that go beyond the physical body, which involves other aspects of his experience and way of organizing himself in the world, in which he influences and suffers this influence. This can also be seen in the study by Machado et al. (2020), in which users who also participated in a GFN brought needs and expectations that went beyond the desire to interrupt or reduce the use of SPA, but also sought in mental health services the construction of social bonds, health care in their psychic and/or organic commitments, access to basic conditions of human dignity and autonomy. Because of this, the relevance of listening to the users is stressed, considering that "each case is a case", therefore, they present approximations, but also distances and differences, because this is about apprehending the singularities of the subjects. In this respect, there is a need to understand the place that SPA occupies in the life of the user, but also his/her life stories, not reducing his/her whole trajectory and biography to use:

*"The situation is delicate, sometimes you "are" without using any shit there, discussion with someone that you "like" a lot or that you don't like very much, understand? And that's not the reason, the reason is that you "want" to use, and really at the time I almost hit on him, but he was right, no reason is a reason for you to use, the reason you "want" to use, becomes instinctive, the instinct of the person. It leads to use. Before I didn't argue with anyone everything was happiness, it was like going to a party I had to use, going to the movies I had to use,*

*looking at a movie I had to use even in the best parts, moments of my life I used, then the person became adept".*

In these circumstances, in order to improve the welcome and strengthen relationships, listening to the user is necessary, and this is another perception brought by the collective. Qualified listening and availability to listen to users and their needs require from the professional a reflection on the user, as a subject who has an individuality, for whom the health services are intended, through an interaction that is attentive to the reality lived by those permeated by desires, beliefs, fears and hopes that involve them (SILVA JUNIOR et al., 2005). The importance of listening also appears in the voice of the collective users:

*"We are often forbidden to talk about drugs here at CAPS, but those who work here need to understand that this space, even if in one shift, is when we stay away from drugs. We could be listened to more so that we could get an occupation beyond being here, some had a life outside of here, I have conditions to work, I don't want to retire because "I am" taking the place of another".*

In the fragments presented above, users emphasize the importance of listening in their treatment and care process. They also bring another very important element, rehabilitation or social reinsertion, which is one of the objectives of CAPS ad, in line with the precepts of Psychiatric Reform. Addressing the aspect of work, they emphasize the need to insert themselves in society, concomitantly with their treatment of chemical dependency. Despite the difficulty the mental health team often has in listening to and understanding their real needs, users also assume their importance as their representatives so that their voices can be heard in other spaces, beyond the field and mental health services:

*"The Secretariat itself has to have the disposition in the case, it has to help, but with us it never talked. Because if I go to the Secretariat to take care of my treatment, there is no one there for me, now if I go with someone, with a social worker, with a doctor... But they won't depend only on the team, and I don't have a father or a mother, there's no one to come here, my direct association of people is CAPS, direct to the team, which has conditions to speak for me, understand? At CAPS they know what we need, they take the first step and then the others come with us".*

In this way, as exemplified, the professionals of the mental health unit become their voice in front of other services, whether in the management spaces, in the intersectoral network services, and even those that make up the Psychosocial Care Network

This also reflects in a lack of knowledge on the part of the users of speech spaces and representativeness, such as the association of family members and the Municipal Health Conference, and when they are aware of them, they do not recognize this place as one of representation. Would they have a place of speech?

*"We are always invited, we are not summoned"*

The relationship established between professional and user, in which the one being cared for sees in the other representation, has to do with the bond built between them, and involves

dimensions and meanings that are born with contact and deepen with the bond. This light technology of care comprises affectivity, the therapeutic relationship and the continuity of care, configuring itself as a relationship of reference and trust, continuous in time, personal and subjective, producing autonomy (SILVA JUNIOR; MASCARENHAS, 2004; CECÍLIO, 2001). As for this, the users affirm in the following fragment:

*"We like to talk, each one has a person who likes it more, identifies himself more, we talk about the problems, whether we use drugs or not, but we miss the preparation of the professionals to listen to us, many don't even have a word to give you, they are not the right person to listen to things at that moment, they also need to understand that the focus here is us and not them".*

Although they emphasize the construction of links with some professionals and the recognition of CAPS ad as a space for listening and treatment, very well defined when they say *"we are the focus"*, they also emphasize sometimes obstacles in the process of listening, and perhaps, precisely for this reason, professionals present this difficulty in dealing with users, perceived by them as unpreparedness or lack of qualification. Corroborating this, studies show that the lack of experience and the absence of specific training to work in mental health generate a distance between team and users (RIBEIRO, 2015). Finally, this concept of health care includes humanized care, based on welcoming, bonding, listening, in the social reality, guaranteeing the user as co-responsible for his/her own care, thus stimulating his/her autonomy (CASTRO, 2007). Autonomy is based on the guarantee and access to information, the purpose of freedom of choice and decision, among others. In the subject's legal sphere, the will is seen as freedom, enjoyment and exercise of subjective rights, of power and of the fulfillment of duties towards other subjects, that is, it also has to do with citizenship, while information enables the individual to make his choices in the context of a balanced coexistence in society (MARCHI; SZTAJN, 1998). In this respect, users are unaware of important information about their own care and guaranteed rights, when asked if they knew the Mental Health Users' Bill of Rights and if they had access to their files:

*"I've never heard of it, the first time I'm listening, it was omitted, they hid it from us. Is the chart the "business" of hospitalization? And I heard here from CAPS that I wouldn't have this right, me to read my briefcase, understand? But they also released me to read it, only if the nurse opens it, only if you take the folder, bring it here and show it to us, you read it to us, we don't give it to you".*

Concerning the access to information about your treatment, it should be noted that the mental health user according to Law 10.216 has the right to "receive the greatest number of information regarding your illness and treatment" (BRAZIL, 2001). The possibility of opining and deciding about their treatment is a fundamental part of exercising their autonomy and citizenship, and also in the process of deinstitutionalization as a denial of the asylum logic in an attempt to approach the humanization of care. The concept of humanization is related to that of deinstitutionalization, insofar as it contributes to breaking with the psychiatric devices, the manicomial culture, the logic and dynamics that govern the routines of attention services and the relationships between

professionals, users and family members. In relation to this, there are discussions in the literature alerting about the institutionalization process and the manicomial culture present in CAPS, called by Amarante (2003) as the "CAPSização do modeloassistencial" or the term "enCAPSulando", by Martinhago and Oliveira (2015). The humanization of care is also brought as an important tool in mental health care by users and as the lack of this impact on their perceptions:

*"We as chemical dependents understand manipulation, and we see that many times they want to manipulate us, they need to realize that we are human, sometimes they put us down, they "drop their paws", they think that we have no feeling, they have nothing, they don't know what we go through, what we feel, they don't know anything, who doesn't use doesn't know. The way of talking counts a lot, if they explain us carefully it's easier. At the moment that we need to intern, we lose access to everything, family, telephone, and the team can do that, but sometimes it doesn't".*

On the other hand, the presence of humanized care contributes to the recovery of citizenship and dignity of users, strengthening the professional-user relationship in the construction of bonds, producing autonomy and co-responsibility for care, deconstructing prejudices and stigma that surround the use and abuse of psychoactive substances:

*"Sometimes we leave here and they go after us, they know that we suffer from needs like feeding, bathing and other things, they worry, they don't judge us by our choices".*

In the fragment presented it is possible to verify that the user seeks to be accepted in his/her singular and subjective demands and needs, besides his/her illness and mental suffering. One of the sets of integrality is identified there, in which the practices of health professionals must be guided according to the health needs of the user, in an integral way, which goes beyond the biological reductionism allowing the individual to be seen as a whole, in his/her subjectivity, "to be able to produce more satisfactory approaches to the singular processes of production of singular and collective existences (because that is what life is all about)" (MERHY et al., 2010).

## Conclusion

The purpose of this study was achieved, being possible to understand the care of SPA users through their perception. The findings demonstrate the importance of listening, welcoming and building a bond for the care closest to the user, a care that values the autonomy and co-responsibility of the subject in the process decided. We conclude that for the users it is important that professionals understand and apprehend the subjectivities and singularities of each subject, considering their weaknesses and weaknesses and potentialities, as well as their life stories, which include the use and relationship that the subjects have with the psychoactive substances, but more than that their trajectory and biography. Humanizing care. Overall, the perceptions of care that CAPS ad users report, deal with the completeness of care and the light, relational technologies, which meet the precepts of the Brazilian Psychiatric Reform which currently undergoes several attacks, disassembly and setbacks. Thus, considering the perceptions and affections of those who suffer, a more resolute care can be offered, which covers the needs of the user, becoming less institutionalizing and manicomial. As a suggestion for future research, it would

be the evaluation of the quality of health care provided to the users, which would contribute to the improvement of the care provided and better satisfaction. One of the ways would be to establish criteria of quality indicators in health, which could be based on the seven concepts or pillars of quality, proposed by Donabedian, effectiveness, efficiency, optimization, acceptability, legitimacy and equity (PORTELA, 2000).

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