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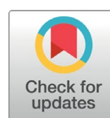

Homelessness, crack use, and length of stay as predictors of planned discharge of night care embracement in Psychosocial Care Center.

Situação de rua, uso de crack e tempo de permanência como preditores de alta planejada do acolhimento noturno em Centro de Atenção Psicossocial

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KEYWORDS

Crisis intervention
Embracement
Homeless persons
Patient discharge
Patient participation
Substance-related disorders

ABSTRACT

Objective: identify predictors of planned discharge to night care embracement in a Psychosocial Care Center Alcohol and Drugs (CAPS AD III).
Methods: Quantitative, retrospective, and documentary study of 560 medical records of people with problems resulting from the use of alcohol and other drugs who were admitted to the hospital at night in a CAPS AD III in São Paulo, over five years. As a dependent variable, the type of discharge was used (planned or not). As independent variables, the profile of the subjects related to substance use and time in hospital.
Results: 1,097 admissions were identified with 50.4% of unplanned discharge associated with homelessness ($p = 0.007$), problematic use *crack* ($p = 0.015$), length of reception proposed by the team ($p = 0.029$) and length of stay of the user ($p < 0.001$).
Conclusion: Being homeless, problematic use of *crack*, and lack of user participation on the decisions regarding length of stay in CAPS AD III were associated with unplanned discharge.

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PALAVRAS-CHAVE

Alta do paciente
Intervenção na crise
Acolhimento
Participação do paciente
Pessoas em situação de rua
Transtornos relacionados ao uso de substâncias

RESUMO

Objetivo: Identificar os preditores de alta planejada do acolhimento noturno em um Centro de Atenção Psicossocial Álcool e Drogas (CAPS AD III).
Métodos: Estudo quantitativo, retrospectivo e documental de 560 prontuários de pessoas com problemas decorrentes do uso de álcool e outras drogas que foram admitidas em acolhimento noturno em um CAPS AD III de São Paulo, no período de cinco anos. Como variável dependente, no modelo logístico múltiplo, utilizou-se o tipo de alta (planejada ou não) e como variáveis independentes, o perfil dos sujeitos relacionadas ao consumo de substâncias e ao tempo em acolhimento.
Resultados: Identificou-se 1.097 admissões com 50,4% de altas sem planejamento associadas à situação de rua ($p = 0,007$), uso problemático de *crack* ($p = 0,015$), à duração do acolhimento - tempo proposto pela equipe ($p = 0,029$) e tempo final do usuário ($p < 0,001$).
Conclusão: Estar em situação de rua, em uso problemático de *crack* e a não participação do usuário sobre a sua permanência em acolhimento noturno no CAPS AD III, associam-se à alta não planejada.

INTRODUCTION

One of the main challenges in extra-hospital care for people who make problematic use of alcohol and other drugs is crisis care[1]. The crisis is understood as sometimes urgent situations and is associated with a break in the subject's existence in his / her family, social and individual issues[2]. The crises are not limited to acute physical or psychic symptoms and may be accompanied by psychoactive substances. The crisis is a critical and growing moment that requires immediate interventions by the team and generally demands more intensive support, which can be promoted by night care embracement at Psychosocial Care Centers for Alcohol and Other Drugs 24 h (CAPS AD III)[4].

CAPS AD III is a public, community, and specialized treatment service for people with problems resulting from alcohol and other drugs in the Psychosocial Care Network (RAPS). It consists of primary health care, specialized psychosocial care (CAPS), urgent and emergency care, residential care, hospital care, deinstitutionalization strategies, and psychosocial rehabilitation to promote comprehensive care for people with mental health problems and those resulting from the use of alcohol and other drugs. It offers a comprehensive care by a multi-professional team to meet users' needs in the biopsychosocial dimensions, in the perspective of harm reduction, having in mode III 24 h the use of beds to avoid hospital admissions and ensure care for the crisis in the territory itself. Access to night care embracement is evaluated by the staff considering the user's Singular therapeutic project (PTS), built in conjunction with the user "based on clinical criteria, in particular, detoxification, or psychosocial criteria, such as the need for observation, rest and protection, conflict management, among others"[5]. The upper bound limit is 14 days in the month, which can be reassessed according to the needs of each case[5].

Night care embracement at CAPS AD III is considered by professionals, family members, and users a resource essential in RAPS6. However, studies point to the need to rethink its dynamics, mainly by reproducing biomedical and asylum practices the teams face in crises, which contradict the principles of psychosocial care and reinforce-fragmented care and institutionalized[7-9]. A typical result reflecting these practices is the early abandonment of care at night care embracement, with difficulty planning discharge between staff and users. Surveys show rates ranging from 15.3% to 36.2% of discharges without reception planning at the CAPS AD III, before the scheduled time, named discharges on request or evasion[11,12]. Additionally, current public policies do not value this model of care and disregard the necessary investments that must be made to improve and qualify this response, such as the training of teams and the expansion of resources[10].

No conclusive evidence was found on how to deal with the abandonment of night care embracement or more planned discharge, nor the variables related to this problem[1,10]. We understand that unplanned discharge may indicate that something needs to be adjusted to the PTS of each user to improve the results of crisis management in psychosocial care. In this perspective, this study intends to identify the factors predictive of the planned discharge from night care embracement at a CAPS AD III.

METHODS

Type of study

We used a longitudinal, retrospective, documentary, and quantitative approach to characterize and identify predictors related to planned discharge users with acompanhament[13] all the care process, from the night care embracement in CAPS AD III to its planned discharge.

Scenario

We studied a CAPS AD III in a region of the municipality of São Paulo, which gathers 11,048 homeless people and has the most extensive public spaces for substance use[14]. The mental health network of the territory consists of two CAPS AD III references to care for alcohol and other drugs. One of them is the CAPS AD III of this study[15]. At the time of the survey, it had nine beds for night care embracement in operation and a monthly occupancy rate of 87%—100% (service data).

Sample and data

We collected data from the medical records of people with problems resulting from alcohol and other drugs, admitted to night care embracement between June 2010 to June 2015, and was conducted from October 2016 to February 2017. The collection period was determined by the year of implementation of the night care embracement at CAPS AD III (2010) until the moment that maintained the operation dynamics (2015), year of management change.

Five hundred sixty-five medical records of 18 years or older people, who stayed for at least 24 h in night care embracement, were included. Five were excluded due to illegible or incomplete information for most variables, totaling 560 records. The data were extracted from two documents produced by CAPS AD III: the user's admission form to the service, that is, the first registration, and the night care embracement form, which corresponds to the entry into the night reception of each user.

We developed the data collection forms using an online tool. Forms questions were socioeconomic data, questions related to the consumption of alcohol and other drugs, and, above all, about the night embracement period at CAPS AD III. Data were collected from the first to the seventh reception (for those who had), as only 15 users had more than seven admissions. The instrument was previously tested on eight selected medical records in the sample randomly. Since the instrument did not change, these eight records made up the final sample.

Data analysis

Our dependent/response variable was the type of discharge defined by CAPS AD III staff. The discharge can be classified as "planned with a team" that performed jointly between user and team (initial goal of all PTS), or "unplanned discharge," those that occurred before the time initially agreed or contraindicated by the team, classified in the medical records as discharge on request or evasion. In this study, we will use the term "leaving without the team's knowledge" because the evasion refers to an idea of escape, which does not match the voluntary stay in the night care embracement CAPS AD III and, consequently, a psychosocial care model.

As independent/explanatory variables, those recognized by clinical practice and scientific literature were used[1,3,4,7,9,11] as factors that may interfere with the type of discharge: homelessness (yes or no), the substance used (alcohol, *crack*, cocaine and marijuana), the pattern of use (none, occasional, weekly or daily), medical and nursing evaluation for admission (yes or no), going to bed for detoxification (yes or no), length of stay proposed by the team and length of stay (numerical), need for hospital support during the night care embracement (yes or no), and hospitalization previous psychiatric (yes or no). It is worth mentioning that all these terms and criteria were reproduced following the template from paper records and patient documentation used in the CAPS.

The quantitative analysis of the data was made using the statistical package R v.3.5.1 (*R Foundation for Statistical Computing*, Vienna, Austria). We performed a descriptive analysis of the data (frequencies and distribution). In inferential analysis, we opted for a generalized mixed-effects model for binomial distribution and measured the chance of the planned discharge occurring, which is suitable for longitudinal databases. We calculated *odds ratios for* the planned discharge. For numerical variables, we calculated the regression (beta) for associating variables. For categorical variables, we calculated the planned discharge odds ratio for users who had or did not have the respective categories (being on the street or not, for example). We used 95% confidence intervals and a p-value less than or equal to 0.05 as a reference to indicate an association between variables.

Ethical aspects

This study was approved by the Ethics and Research Committees of the School of Nursing at the University of São Paulo and the Municipal Health Secretariat of São Paulo under opinion numbers 1,622,202/2016 and 1,645,121/2016, respectively.

RESULTS

One thousand ninety-seven admissions (1097) were identified in night care embracement, the CAPS AD III corresponding to 560 users with a predominant male profile (434/77.5%), single (362/71.1%) average age of 40 years. Regarding race/color, 279 records did not contain this information, representing almost 30% of the sample, which made the description of this variable inconclusive. In 763 (69.6%) of the reception, it was people on the street, in daily use of substances (882/82.4%) and who had alcohol as their substance of choice (277/50.8%) and *crack* (241/44.3%). The other variables related to the use of night care embracement are described in Table 1.

The time of night care embracement initially proposed by the team was an average of 14 days, both for users who had planned discharge or not. The final length of stay for users who were not discharged was on average four days, and for those who were discharged, nine days, when not planned with the team, was Hospital discharge related to discharge on request (318/29.3%) and leaving without the team's knowledge (230/21.1%). Table 2 shows the effect size (OR - odds ratio) of the association of each explanatory variable in the "planned discharge" response variable.

The pattern of use was identified as predictive factors associated with unplanned discharges (the more frequent use reduced the chance of discharge by 51.9%), use *crack* (45.3% less chance of discharged discharges), being on the street (40% less chance of planned discharge than those who were not on the street), and each day more than the team proposed for the user to be at the reception (3.6% reduction in the chance of planned discharge). When the user chose to spend more days in the night care embracement, this chance increased by 21.4% and was associated with the planned discharge.

Having previous psychiatric hospitalization,

consuming marijuana, alcohol, and cocaine, undergoing nursing and medical evaluation to be admitted, being welcomed with the primary objective of detoxification, and requiring hospital support during the period reception, were not associated with the chance of planned discharge. These variables played the role of control in the multiple models.

Table 1 — Characteristics of night care at a Psychosocial Care Center for Alcohol and Drugs. São Paulo/SP, Brazil, 2017.

Variables	n	%
Substance use pattern at the time of night care embracement		
None	9	0,8
Occasional	86	8,0
Weekly	93	8,6
Diary	882	82,4
Missing	27	2,4
Night care embracement with the primary purpose of detoxification		
No	264	24,2
Yes	825	75,7
Missing	8	0,7
Need for hospital support during the night care embracement		
No	1.006	91,8
Yes	89	7,9
Missing	2	0,1
Planned discharge from night care embracement		
No	548	50,4
Yes	538	49,5
Missing	11	1,0
New night care embracement		
No	775	70,7
Yes	321	29,9
Missing	1	0,1
Total	1.097	100%

Table 2 — Logistic regression with effects and odds ratios of the variables correlated with the planned discharge of night care embracement at a Psychosocial Care Center for Alcohol and Drugs. São Paulo/SP, Brazil, 2017.

Variables	OR*	95% Confidence interval		p-value
Hospitalization previous psychiatric	1,010	0,907	1,124	0,856
Homelessness	0,599†	0,414	0,867	0,007
Alcohol use	1,548	0,968	2,476	0,068
Cannabis use	1,392	0,630	3,078	0,414
Cocaine use	1,152	0,665	1,993	0,614
Crack use	0,547†	0,337	0,888	0,015
Nurse evaluation	1,008	0,622	1,634	0,973
Medical evaluation	0,992	0,535	1,840	0,980
Night care embracement for detoxification	1,238	0,835	1,836	0,288
Length of stay propose by team	0,964†	0,932	0,996	0,029
Length of stay	1,214	1,169	1,260	< 0,001
Pattern of use	0,482†	0,269	0,864	0,014
Need for hospital support during the night care embracement				0,136
No	2,567	1,048	6,291	0,039
Yes, physical support	3,886	1,369	11,032	0,011
Yes, severe withdrawal	2,008	0,529	7,625	0,306
Yes, psychiatric support	0,497	0,083	2,988	0,445

*OR, odds ratio. †, OR values with p-valor < 0,05.

DISCUSSION

The findings predictive of unplanned hospital discharge at CAPS AD III were homelessness, use *of crack*, and the pattern of frequent use. As for the length of stay, this factor influenced both planned and unplanned discharge. These data reflect the complexity of early abandonment of night care embracement as something more complex than non-adherence of the user to treatment, as suggested by other studies[4,7].

It is worth mentioning that the concept of adherence to treatment defined by the World Health

Organization (WHO) as "the extent to which a person's behavior corresponds to the recommendations of a health professional" does not consider the involvement and participation of users in their treatment and reinforce the biomedical model. Therefore, in the context of mental health, this issue should be deeply discussed[15].

It is worth mentioning that the concept of treatment adherence is defined by the World Health Organization (WHO) as "the extent to which the behavior of a person corresponding to the recommendations of a health professional." This concept does not consider the involvement and participation of users in their treatment and reinforcing the biomedical model; therefore, in the mental health context, this issue should be discussed in a comprehensive and differentiated way[15]. As for the predictor homelessness, it is known that its relationship with more severe problems resulting from the use of alcohol and other drugs and health network's difficulties in meeting the specificity of this population and adapting the functioning of services to meet their needs[17-18]. A study investigating the priorities of this population group found that the immediate demands were to have the basic needs met (food, sleep, hygiene), permanent housing, followed by work fixed, and, finally, dedicate to treatment15. The patient also tends to seek health services urgently, only in crisis or clinical health changes, and likewise, immediately requests discharge when these demands are resolved[17].

Research on the homeless population of the state of São Paulo showed that the main reasons for people to be in this condition were family conflicts (40.3%), unemployment (23.1%), and dependence on illegal substances (19%), of which 23.9% used *crack* (an average of 13 stones per day) and 75.7% of other substances14. In the literature, it is found that the use of *crack* is related to living on the street and to the consumption of an abusive pattern[17,19]; however, as in the multiple models, both the use of *crack* and the street situation affects realizes these are two predictors that have an association with unplanned discharge, mutually independent.

There are frequent reports about the non-effective connection of users *crack* in treatments in mental health services, in its various models, due to stigma, the difficulty of access, lack of harm reduction approaches, and the fact that the user evaluates the treatment as inefficient[6,8,18], which denotes the still prescriptive, biomedical and prohibitionist characteristic of care.

The social construction about becoming a user *crack*, which is also being assumed by themselves individuals, is pointed out by the researchers as a factor that limits the perspectives and possibilities of psychosocial rehabilitation and restoring life in other scenarios, that is, this chooses to return to the scene of use where he belongs and usually resumes consumption[6].

In this sense, it is necessary to consider that, in the context of a CAPS AD III that welcomes around 70% of people on the street and in daily use of *crack*, the basic needs and social issues can be just as urgent (or even more urgent) than the problems arising from consumption. This may have impacted the brevity of the night care embracement length. We also emphasize that the condition of abstinence (except tobacco) to be accepted and the consequent detoxification, even if this is not the main objective of the user's PTS, can influence the results relevant to future research. This requirement of abstinence is symptomatic of care that is not centered on harm reduction.

Recent studies show that the problematic use of substances and the severity of the problems experienced an impact on the abandonment of care[3,17], which concludes that the more frequent the consumption pattern, more problems, losses, and suffering may have the user, demanding more intensive care, a qualified team with good crisis management, which conducts the PTS in a common, integral, human and inclusive way.

Among the unplanned discharges, the departure without the team's knowledge stands out in 21.1% of the cases, which calls attention to the absence or difficulty of communication between users and professionals, difficulty in handling the user's motivation - who is faced with the lack of desire to continue in the night care embracement, and even the lack of appropriation of the psychosocial model, as already highlighted by other studies[7,9,19].

It is necessary to strengthen the relationships of trust between users and professionals, first align the function of night care embracement at a given moment and then, to ensure communication and the construction of community care with meaning for all involved[9].

Multi-professional teams assessed daily users in this study. During the night shift and on holidays/weekends, they were monitored mainly by the nursing team and, in 87.7% of admissions, the nurse conducted the initial assessment. Nursing is powerful to play a therapeutic role and approach the subject in its entirety, as it has different strategies to deal with the crisis in the psychosocial model[9].

Some phenomena related to the conduct of night care embracement emerged in the daily practice of services - they were not foreseen during their planning, organization, and operation[9,11]. The length of stay is one of them. This is relative, depending on the reality of each territory. However, the ordinance that guides the operation of CAPS AD III emphasizes that people who need night care embracement for a period longer than 14 days in the month should be referred to the Reception Units (AU) and, only in extreme cases, the team can propose the extension of this period[5].

The best outcomes occurred when the user stayed longer on night care embracement, with an increase of five days than those not discharged. Therefore, it is necessary for the team and users to jointly build the possible objectives for the period host, guaranteeing the user's right to choose whether to remain or not and opening a question for future studies - how to measure whether there is an association between this possibility of choice and the planned discharge.

A study that analyzed the degree of accountability and participation of users in treatment at a CAPS AD concluded that they are not unique and empowered by their care. The conclusion is that the health team conducts several standard indications and prescriptions without elaborating strategies to achieve the goals listed. They also demonstrated a discord

between users and staff regarding treatment goals 20, a possible explanation for our findings.

Involving people in their care and discharging processes is described as a challenge in mental health services because it requires a transition from tutelary health systems (professional control, fear of lack of assistance) to ideals of democratization (joint care) and not prescriptive)[21,22]. The professional needs clarity of this relationship of power/control and how this reflects on treatment delivery. This awareness may allow the staff to work differently, focusing on the individual needs, activities, responsibility, autonomy, and merging treatment purpose[21].

Even if no association effect is proven in multiple models, a significant result was the lack of hospital support of those admitted in 91.8% of admissions, suggesting a practical function of crisis management in CAPS AD III, aligned to strategies deinstitutionalization. Comprehensive assistance to users of alcohol and other drugs in vulnerable territories is challenging, but it must be based on harm reduction strategies with accessible and adequate care for those in need, often on the street and not within the services[17,19].

We recognize the impossibility of generalizing the data as a limitation due to the local context of the research. However, the predictors of planned discharge of the night care embracement can serve as hypotheses for future studies and practices in similar territories. Another limitation was that the source of data collection was the treatment records, which limited the description of the population and the identification of other variables that could influence the discharge from the CAPS AD III to night care embracement. Longitudinal studies using self-report information from users are suggested, measuring data such as quality of life, symptoms and problems experienced, comorbidities, issues related to the axes of psychosocial rehabilitation, and verifying factors associated with improving outcomes night care embracement.

CONCLUSION

There was an association between unplanned discharge from the CAPS AD III night care embracement and being homeless, the frequent use pattern of *crack*, and the vertical proposal fixed by the team for the length of stay, without the user's participation. The only factor associated with the planned discharge was the most prolonged embracement stay, with the participation of the user in this decision, which demonstrates the power of the joint construction of care, the essence of the PTS.

The discharge from night care embracement needs to be understood as a clinical bet that considers the agreement negotiated between professional and user, aiming at the co-responsibility of care and the production of autonomy. For this, the real needs of admission and length of stay in night care embracement should be understood and reassessed daily.

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