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An experience with the Gaining Autonomy and Medication Management approach for users of drugs: creating autonomy

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Abstract:

Gaining Autonomy and Medication Management (GAM) is a strategy in the mental health field that seeks to foster co-responsibility in health care between users, workers, and family members, encouraging user autonomy in regard to medication treatments as well as the ability to negotiate with the health care team. More recently, GAM methodology has been used as a harm reduction strategy in the health field in cases of use of alcohol and other drugs, focusing on the relationship with psychoactive substances. In this text, we present an experience with GAM methodology at a Center for Psychosocial Care for users of alcohol and other drugs in an area of social vulnerability in the city of São Paulo (Brazil), where we followed users and professionals in training support. The experience, ongoing since May 2017, has taken place across two moments: the training process of the professionals on the team by means of workshops for a collective production of knowledge, and a discussion group with workers, users, and researchers focusing on experiences of drug use and medication, besides demands for mental health care and quality of life, led by the use of GAM guides for both user and moderator. The consequent effects are: an increase in commitment, autonomy, and actions of reduced use by users; creation of a space where professional scan consider conducts and evaluate processes; more openness, empathy, and proximity in the professional-user relationship; changes in the forms of expression, of attention, and of introspection of participants, as well as appreciation of the group.

Introduction

The rise in use of psychotropic medications, together with a growth in diagnoses of the so-called "mental illnesses" within the context of a strategy for medicating life[1] has been the focus of researchers all over the world, concerned about the production of the population's health. The World Health Organization (WHO), in its guidelines for mental health and human rights[2] recommends the empowerment and protagonism of people suffering from mental issues in regard to their treatment, a key aspect for producing health and care. This perspective, along with evidence of the importance of sharing treatment decisions with the user, has led to improvements in health indicators[3].

Gaining Autonomy and Medication Management (GAM) is a strategy in the mental health field that seeks to foster co-responsibility in health care between users, workers, and family members, encouraging autonomy of the user in relation to medication treatments as well as the ability to negotiate with the health care team. The clinical-political aim of this strategy is to encourage co-management of psychiatric medication, by means of the access and sharing of experiences with medication use, emphasizing the connection between health and human rights.

The methodology applies the Gaining Autonomy and Medication Management (GAM) Guide, developed in the 1990s in Canada by associations of users of psychotropic medication, containing small texts and questions about user experience. With the GAM approach, the guide is read and discussed collectively, seeking to encourage a sharing of experiences and the appreciation of points of view from different members of the group. In sum, the aim is to create spaces for debate and contemplation between users and health services, using tools for co-management and autonomy[4].

In Brazil, the GAM approach has been carried out with basis on a multicentric study, part of an international partnership between Brazil and Canada (ARUC — Research Alliance between University and Community — IDRS/SHS). The goal is to promote research and the training of researchers in Mental Health, besides consolidating the experience among communities and health services in different Brazilian regions[5]. In order to begin this partnership, given the regional and political specificities of each area, it was necessary to create a Brazil-

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ian Guide to Gaining Autonomy and Medication Management (Guia GAM-BR), based on the translation and adaptation of the Canadian guide that originated in Quebec[3].

More recently, GAM methodology has been used as a strategy for harm reduction in the field of health care, in cases of use of alcohol and other drugs, aiming at discussing relationships with psychoactive substances and the substitution for psychotropic (or composition) drugs as part of treatment. The experience reported here takes place in a Center for Psychosocial Care for Alcohol and Other Drugs (Centro de Atenção Psicossocial Álcool e Outras Drogas —CAPSAD) located in a highly vulnerable area of the city of São Paulo, occurring within a group composed of users, managers, health care workers, and researchers. But first, we must examine a few elements relating to normative Brazilian mental health policies and to the location of this research.

Territory and community based public health and mental health care in Brazil

The Brazilian Unified Health System(SUS) was created in 1988 by means of the Brazilian National Constitution, after social movements from different sectors mobilized in order to devise a free and high quality health network for the country's population, ensuring universal access to health services at all levels of care, according to the needs of each user, and with a new concept of the health-sickness process that took into account social inequalities in order to organize and execute actions through the notion of equity (more for those who need more; different for those who need different)[6]. By emphasizing the planning, organization, and execution of health action sat a local level (municipality), the notion of territory became strategic and central both for planning health policies and for care practices. In other words: with this type of direction, it became possible to construct interventions based on territorial health indicators, allowing for an evaluation of the impact of services upon the health levels of this population, by permitting health teams to work closely with users in their everyday lives, allowing for connections to be forged between user-worker-service.

In a similar manner, the Brazilian psychiatric reform gained strength as a social movement in the mid 1970s, positioning itself against the asylum model of the psychiatric hospitals, due to innumerable reports of ill-treatment, violence, and terrible work conditions[7]. Law 10.216[8], which deals with the integral care of people with mental issues, with dignity and at liberty, required a new assistential reconfiguration in order to incorporate territorial links between health care network services and clinical-political practices, which include the construction of social, community, and family connections, and place the person, with its own singularity, history, and daily relationships, at the center of attention.

The Centers for Psychosocial Care(CAPS), along with other care mechanisms such as Residential Therapeutic Services (Serviços Residenciais Terapêuticos SRT) and the Social and Cooperative Centers (Centros de Convivênciae Cooperativa CECCO) implemented in the city of São Paulo, were models created to substitute asylums, prioritizing that individuals with mental health assistance demands could be cared for within their own communities[8,9].

Currently, the Brazilian Unified Health System (SUS) faces neoliberal government practices that operate under the logic of Minimum State: a reduction of investments in social policies and the maximization of privatization programs. In the field of Mental Health there has also been regression: in 2017, key changes in legislation were approved affecting care for those suffering from mental afflictions. As a result, psychiatric hospitals once again became central to the care network[10]. Regarding the care network for those who make heavy use of alcohol and other drugs, the political scenario is no different: since 2015, the allocation of public resources for private institutions has been observed, benefitting organizations of clinical internment called "therapeutic communities", which operate by a logic of user hospitalization and social isolation. In addition, and especially in the case of the care network for users of alcohol and other drugs, tension between models that are based on the defense of dignity and social rights and their counterpart, based on assimilation of social control functions, such as a "medical police"[11], have left a mark on the policies created in Brazil in the last decades. Within this context, maintaining the experiences of the GAM approach at a CAPS-AD in the city of São Paulo seems relevant to us.

Contextualizing the GAM experience at the CAPS-AD

The sanitary territory covered by the CAPS-AD of the experience in discussion covers a population of approximately 400 thousand inhabitants and is characterized by the occupation of watershed areas and overpopulation in almost all of its terrain. The people who live in the area are, for the most part, considered "low income", with a monthly household per capita income of up to half a minimum wage (equivalent to R$477.00 or USD 146.64 per person, per month). Another important aspect of this territory is that its population is predominantly black, making this the region with the highest absolute number of black inhabitants in the city of São Paulo almost 51% of the population declares itself as black or mixed race[12].

This territory is representative of suburban poverty in large urban centers and is among those with the worst social inequality index in the world[13]. Historically, the land is marked by social struggles for the guarantee of a right to health, and currently all the equipment advocated by the Psychosocial Care Network(Rede de Atenção Psicossocial RAPS) for mental health care has been implemented[14].

This territorial panorama has been key to establishing a partnership between the health care administration for the area and the Pontifical Catholic University of São Paulo (Pontifícia Universidade Católica PUC/SP), by means of the programs PET-Saúde (Program for Education for Work in Health) and Pró-Saúde (Program for Reorientation of Health Professional Training)[15]. The partnership between teaching and service, by means of the University's commitment to actions of research extension within this particular territory, is a crucial step toward strengthening the collective struggle in defense of a public and high quality health care.

Through these exchanges of knowledge, and the joint elaboration of health care demands for the region, such as in cases of excessive use of medication combined with low user autonomy, a proposal emerged for applying the GAM approach at different health units: the primary care center (Unidade Básica de Saúde UBS), the adult CAPS and the youth CAPS, besides the CAPS – AD, aimed at people who make use of alcohol and other drugs, which is the experience reported here.

It is important to point out that, in its essence, GAM focuses on the debate on use of medication and the impact of treatment in the lives of users, aspects that, although also a demand of people suffering due to heavy alcohol and drug use, at some moments becomes secondary due to the need for a discussion on use of substances, both legal and illicit.

Despite this, the experience of setting up a GAM approach in a mental health institution attending a public that makes use of alcohol and other drugs has produced shifts that indicate powerful paths for the production of new conducts in this field. This process, which has been taking place since May2017, has been divided into two important moments: a) setting up a training process for the team's professionals by means of workshops for a collective production of knowledge and b) forming a group with workers, users, and researchers that creates a discussion space to talk about experiences of drug use and medication, besides demands for mental health care and quality of life, led by the use of GAM guides for both user and moderator. The experience is made up of different theoretical-methodological

elements, such as co-management, the production of groupality, and the care of self[16] in regard to the field of collective health; the production of autonomy[17] and the support role[18] will be presented as discussion vectors for the experience.

Strengths and challenges of the experience

The creation of a space for actions and debate on autonomy and substance use mobilizes participation in GAM meetings, first of all because participants are dealing with a common experience of loss of autonomy, which, in this sense, constitutes a space for care of self, for converting self-gaze. At an individual level, this suffering is felt as a loss of control of the mind, of desire, and of the body. Both users and professionals have a tendency to place upon the individual the responsibility for behavior choice and control. However, in the experiences reported, it is clear that the collective level is always mentioned, either by encouraging use, or as a protector against use of the substance, so that carrying out own conducts, or the government of self, varies according to group relationships and connections. The collective, as a relational sphere that generates individuation and means, is the reference for considering notions of autonomy, co-management, groupality, and support.

From this perspective, it is not an issue of individual management of use of medication and, in this case, alcohol and other drugs, but of a practice of co-management where health professionals, users, and researchers conduct a group process of investigation, of situated knowledge a process that allows, by means of its connections, new possibilities for experiencing subjectivity in a context of support. It is worth mentioning that this is a process of care of self where the dimensions of power, knowledge, and affection overlap.

Co-management runs throughout the entire approach. This is particularly important in conducting meetings with users where the participants are asked to take charge of the space, the duration, the number of participants, the agenda, and debate management, the ethics constructed during the meeting, use of the GAM guide, the goal, and the meaning of the meeting. But the approach includes other connections with the institution's team: reservation of meeting space and time, printing of guides, participation by service management, the agenda of the professionals involved, who they are and how many, what they must put aside in order to work with GAM, how they take turns, and how the approach fits in with the institutional plan of the service. The process of worker training pharmacists, psychologist, occupational therapist, nurse, pharmacy technician, harm reduction agent includes regular meetings with support researchers, and is part of the approach as an exercise of co-management practices, of involvement, and of engagement with a process for creating something new. Training is based on: participation in building the approach; communication of different points of view within the group's heterogeneity; valuing knowledge gained from work experience; a gaze upon own conducts and relationship standards making way for new forms of seeing and talking about service routines. Within this formative process, workers contemplate relationships of judgment and confrontation with users, noting their expectations and frustrations, by means of which they place upon them the fault for addiction, relapses, and consequences of drug use. In this manner, the training process creates a space for exercising co-management, producing changes in the professional-user relationship, so that professionals can feel more openness, empathy, proximity, and lightness.

The invitation for users to participate in GAM is an invitation to co-management. In this experience, we are faced with a method which has been created and tested in another environment, unrelated to addiction to the use of alcohol and other drugs, which brings up the need, in the present case, to test, adapt, and evaluate the themes, the sequence of steps, and the issues that make up the Guide for Users and Moderators, besides creating another name for the approach. The invitation, however, includes working to construct the method along with the users. This constructivist perspective guides the group's conducts, always allowing for questioning, in actions for knowing, thinking, and producing collectively whatever may be the theme under discussion, so that this is not about applying a method to reach a goal harm reduction, abstinence, autonomy but is instead a process where the aim is to create, construct, and practice the method.

As mentioned, this practice of co-management operates on a plane of heterogeneity and of communication of different points of view, which, with Guattari[19], we call a plane of transversality. It is at this plane that the new emerges. By communicating differences, new possibilities for experiencing subjectivity surface. This dimension must be cared for, as this approach is vigorously traversed, either by verticality, which tends to standardize conducts with basis on established models, such as, for example, the GAM guides themselves, standardized instruments for conducting groups, or by horizontality, which tends to homogenize points of view through identity traits, for example, of users of alcohol and other drugs. The plane of transversality is always under tension: with no final answers and nosettling for stereotypes, which are always present since they are sense stabilizers, representing a common sense and generating known expectations. Among the most frequent stereotypes are: positioning as dependent, whether of drugs, medication, or treatment; relapse as a personal weakness and moral failing; substance use as an escape from reality; addiction seen as disease; places that imprison the user, and that justify repetition and blame the individual. As dialogue circulates at meetings, space opens up on the plane of transversality so that voices can emerge and produce other narratives, creating a crisis of stereotypes and expectations, and making way for other possibilities of subjective experience and for the construction of new values.

Groupality is an issue that surfaces vehemently during meetings. The experiences narrated tell tales of use motivators that are situated within the relationships with others and within the group. When participants look at themselves, at their process and participation in GAM meetings, they place value upon this participation which leads to improvement. During meetings, participants modify their forms of expression, attention, introspection, and they value the group as a protective space. They talk about their own experiences of growth in autonomy and gestures of use reduction since they began to frequent the group. These reports embody a force of contraction of this groupality where an ethic of respect to the person and their experience is constructed, favoring responsibility and a higher level of collective commitment.

This experience in constructing a GAM approach with basis on service worker training to moderate user groups needs to be looked at. For the approach to be instated, a support process is necessary where a support researcher takes part in regular meetings with the team. This support strategy demands permanent visibility for the process of care of self, and in managing the relationships that are established between power, knowledge, and affection, present throughout the experience. It also insists on the subjective dimension of this work, dismantling the idea of training as technical qualification and as a transmitter of knowledge, working against an administrative, protocol-based, and vertical rationality. Within this support strategy, the processing of work experiences places the instituted forms of health practices under analysis and opens up the possibility of instituting new processes.

This support then establishes a creative dynamic that is circular and a multiplier: the workers who take part in this support are supported, and become, in turn, supporters. The support strategy sets in motion an ethical-political positioning that encourages connections between management and care, clinic and policy; without this, the processes analyzed above would not be possible.

The main challenges of this experience can be observed in the overload of worker activities, limiting regular participation in the groups, and in the need for communication with other

CAPS professionals about the GAM approach, avoiding referrals that do not respect the desire of users to participate in the group, a key aspect in our eyes: autonomy.

Conflict of Interest: We acknowledge that there is no conflict of interest at this paper.

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