Violence experienced by workers of a psychosocial care center on alcohol and other drugs

Violência vivenciada por trabalhadores de um centro de atenção psicossocial em álcool e outras drogas

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RESUMO

Objetivo: Descrever as situações de violência vivenciadas por trabalhadores de um Centro de Atenção Psicossocial em Álcool e Outras Drogas e as consequências dessa violência em seu cotidiano. **Método:** Trata-se de estudo quantitativo descritivo e exploratório aprovado pelos Comitês de Ética em Pesquisa (CAAE: 62471416.3.3001.0086 e 62471416.3.0000.5392) que foi realizado em um Centro de Atenção Psicossocial do município de São Paulo. Fez-se análise descritiva dos dados com o software R Studio Versão 3.4.3, pacote Rcmdr versão 2.4.4. **Resultados:** Mais de 96% dos entrevistados relatam ter sofrido alguma situação de violência enquanto trabalhavam no serviço em que a pesquisa foi realizada, a maioria em forma de agressão verbal. Suas reverberações foram divididas entre atitudes de fuga, busca de apoio e adoecimento. **Conclusão:** Revela-se crucial explorar essa temática para compreender fatores implicados nessa violência, formas de minimizá-la ou de minimizar seu impacto na vida dos trabalhadores de saúde.

Descritores: Psicologia; Violência no trabalho; Saúde do trabalhador; Saúde Mental; Centros de Atenção Psicossocial.

ABSTRACT

Objective: To describe the situations of violence experienced by workers of a Psychosocial Care Center on Alcohol and Other Drugs and the consequences of this violence in their daily lives. **Method:** This is a descriptive and exploratory quantitative study approved by the Research Ethics Committee (CAAE: 62471416.3.3001.0086 and 62471416.3.0000.5392) and conducted in a Psychosocial Care Center in the city of São Paulo. Descriptive data analysis was performed using R Studio Version 3.4.3 software, Rcmdr version 2.4.4 package. **Results:** More than 96% of respondents report having experienced some violence while working in the service in which the survey was conducted, mostly in the form of verbal aggression. Their reverberations were divided into flight, seeking support, and illness. **Conclusion:** It is crucial to explore this theme to understand factors implicated in this violence, ways to minimize it or minimize its impact on health workers' lives.

Descriptors: Psychology; Workplace Violence; Occupational Health; Mental Health; Centers for Psychosocial Care.

ORIGINAL

Introduction

In the late 1970s, two movements to fight for changes in the health care model for people with psychic disorders began in Brazil: the Psychiatric Reform and the Antimanicomial Movement1. The existing care model was a classic model of psychiatry, based on the hospital-centered system, which uses patient isolation as the main treatment strategy.[1]

After profound changes in the mental health care paradigm, there is a care model based on the Psychosocial Rehabilitation, based on Italian theory.[1] The reformulation of the care model in Brazil is the result of important discussions and changes in the political and care field of Mental Health in Brazil.[1] Psychosocial attention is currently community based and focused on the unique needs of each subject.[1]

The replacement of the hospital-centered model to the community-based care model evolved to the formation of Psychosocial Care Networks (RAPS) to meet the needs of the population living in a given territory.[2] RAPS aims to articulate the various health care points in a territory, offering effective and comprehensive care.[2]

Mental Health care includes health services for people who use psychoactive substances. The provision of a care network for people with demands arising from the use and dependence of PAS is fundamental, as currently 250 million people use these substances worldwide, among them, 11.8% (29.5 million) have problems. as a result of abuse, although only 1/6 of this population is being treated.[3]

In Brazil, a national survey on alcohol and drug use that 50% of the country's population consumes alcohol, and alcohol abuse is found in 3.87% of the total population.[4] Regarding the use of illicit substances (cocaine, marijuana, crack, ecstasy, among others), 31.1% of the population has already used it in their lifetime and 18.2% have used it in the last year.[4]

Psychosocial Care Centers for Alcohol and Other Drugs (CAPSad) is an example of a territorial based health service in Brazil to provide assistance to people with psychoactive substance abuse problems.[5] This assistance presents demands to meet needs in different aspects of people's lives, so it has been instituted different types of services for CAPSad, including type III.

CAPSad III provides 24-hour care and provides night hospitality to people in crisis situations.[5] In all CAPSad modalities, different individual and group activities are performed daily with a multiprofessional team, that is, with professionals from different academic backgrounds.[5] Working in a multidisciplinary team can be challenging, especially in the health field, because it is necessary to know oneself and seek, through empathy, to understand the other, accepting him / her in its entirety.[6] Therefore, promoting excellent care is the result. of constant construction, daily, and that can have many obstacles, including violence in the workplace.

Violence is a manifestation of aggression that can be expressed in different ways, including verbal, physical, sexual, psychological, institutional, structural, among others.[7] Environmental aggressions can be divided into three groups: external violence, internal violence and customer-driven violence.[8]

External violence is defined as violence caused by a person not belonging to the institution.[8] This violence reflects the aggressiveness that

occurs around the service (being able to enter it physically or not) and is directly related to the geographical location of the health service, that is, institutions located in more dangerous municipal areas are more vulnerable to situations of health. external violence.[8]

Internal violence occurs among workers of the same organization, whether they are in equivalent positions in the institutional hierarchy or not.[8] The violence caused by the client is that in which the perpetrator is the person receiving care.[8] Health services with developed care actions in direct and intense contact with their clientele are more vulnerable to the latter type of violence.

Health professionals are considered vulnerable to situations of violence because they work in risky environments.[8-9] Some of the main risk factors are[8-9]:

- Direct and intense contact with a possible aggressor;
- Health facility located in a region with a high rate of external violence;
- Care for psychiatric patients who may experience psychomotor agitation;
- Assistance for people intoxicated by psychoactive substance abuse.

Constant occurrences of violent situations at work can have serious consequences for health professionals such as: professional exhaustion, suffering, illness, absence from work, decreased efficiency of care and worker quality of life.[10-11]

In Brazil, the phenomenon of violence in health care networks is accepted as part of the work routine, this naturalization of violent phenomena contributes to the lack of measures and transformations of the work environment.[10-11] Thus, this study briefly describes the sociodemographic profile of workers of a CAPSad III, identifies the incidence of violence caused by clients of this service, the reverberations of these situations of violence for workers.

Method

This is a quantitative, descriptive and exploratory study, whose data collection was performed through an online form prepared by the authors and digitized to electronic form in the Google Forms application, so all answers automatically started to compose a data sheet exported in format compatible with Microsoft Excel software. The form was self-applied, although a research assistant was available for assistance on the computer used by health professionals to answer the survey form.

The field of study was a CAPSad of modality III located in an area of high hazard in the city of São Paulo (São Paulo, Brazil). The region occupies one of the top three places in the municipal ranking related to thefts, drug trafficking and homicides.[12] The area covered by the referred CAPSad III has about 450,850 inhabitants and has the largest number of homeless people in the municipal subprefectures of São Paulo.[13]

At all stages of the study development, ethical criteria were met, according to Resolution 466 of December 12, 2012.[14] Before the start of data collection, the research project was submitted to the consideration of two Research Ethics Committees. Acceptance reports to the study development

received the following protocols: CAAE: 62471416.3.3001.0086 and 62471416.3.0000.5392.

The criterion for inclusion of participants in the study was to be a CAPSad worker who served as a field for data collection. Data were collected in the first half of 2017. Data loss was considered to be the cases in which workers were away from work for some reason or did not consent to participate in the study. Data analysis was performed with the support of R Studio software version 3.4.3 (30.11.2017)[15], Rcmdr package version 2.4-4.[16]

Results

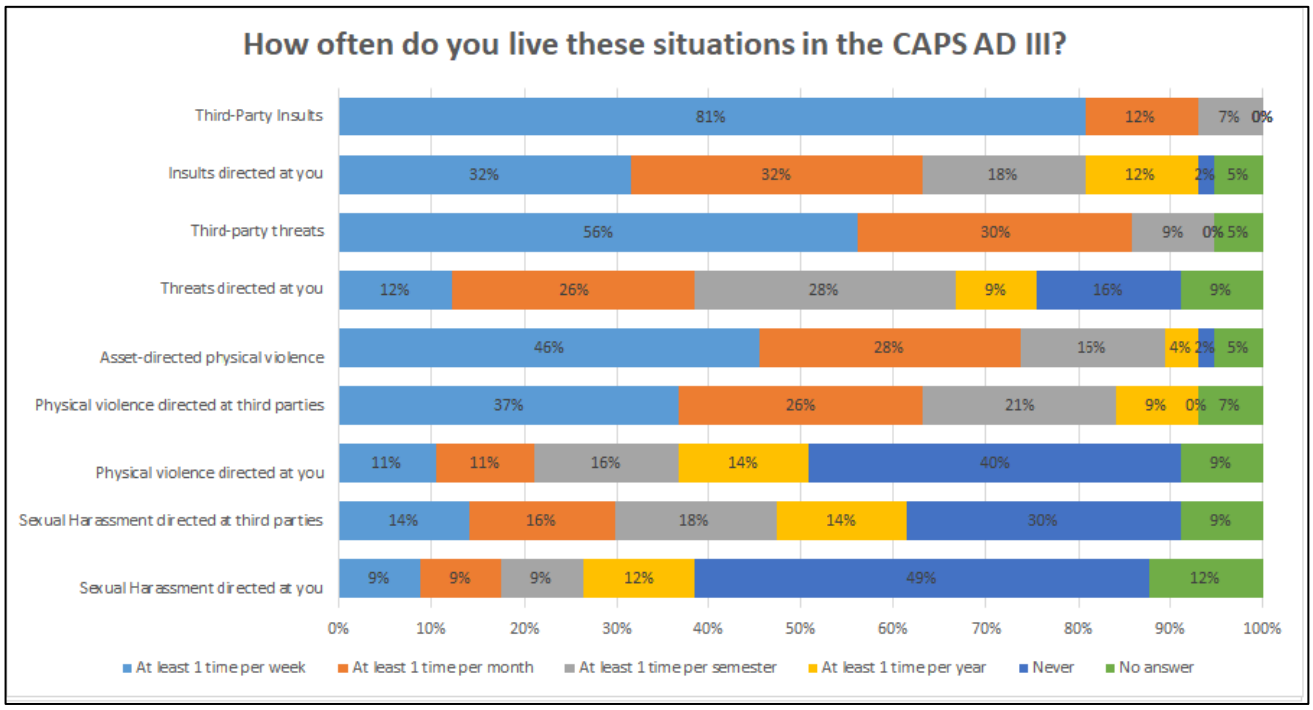
Data were collected from 58 professionals from different backgrounds, representing 98% of the total of professionals in the service. It was not possible to interview three professionals because they were away from work (two due to health problems and one due to aggression suffered in the workplace). Regarding sociodemographic data, most respondents were female (53.5%), non-white (56.9%), marital status married or with partner (58.62%), technical training as education status (49.1%) and no work experience prior to CAPSad III (91.2%), according to table 1. Almost all respondents (57 respondents - 96.55%) reported having experienced violence caused by CAPSad III users while working.

Table 1 – Sociodemographic data of respondents. Sao Paulo, São Paulo (Brazil), 2017 (n=58)

Variables		**Frequencies**	
		n	%
Gender	Male	27	46.5
	Female	31	53.5
Race	White	25	43.1
	Non-white or not reported	33	56.9
Marital Status	Without partner or not reported	34	59.7
	With partner	4	7.0
Education	Technical course	28	49.1
	College	16	28.1
Time of work at CAPSad	Less than one year	17	29.8
	More than one year	4	7.0
Work experience earlier to CAPSad	No	52	91.2
	Yes	5	8.8

The types of violence most observed by professionals were verbal (insults and threats), with 81% of insults and 56% of threats occurred at least once a week. Cases of physical and sexual violence were reported to occur at least once per semester (37% of respondents reported physical violence and 27% reported sexual violence).

Situations of physical violence directed at others were witnessed at least once a month by 63% of respondents. Although 92% of respondents reported that they have experienced some situation of physical violence directed at other workers. It was also found that 74% of respondents witnessed at least one situation of violence against property per month. (Chart 1).



* n = 57 of 58, as it refers to professionals who reported having experienced violence.

Chart 1 – Frequency with which each respondent experiences different situations of violence in CAPSad III, São Paulo, São Paulo (Brazil), 2017 (n = 57*).

When asked what type of violence affects them most, 42% of respondents mentioned self-directed physical violence as most harmful. The second most harmful type of aggression cited was the self-directed threat (28%), followed by physical violence directed at third parties (16%). Other forms of violence cited as very harmful were physical violence directed at assets (7%), threats directed at others (2%) and sexual harassment directed at themselves (2%).

According to the interviewees, the situations of violence suffered have different reverberations, divided here into three groups: a) Seeking support; (b) escape attitude; and c) Illness. Most respondents (96.5%) selected at least one reverberation considered resulting from situations of violence in the service. Only 3.5% of respondents did not select any response to this item (table 2).

Table 2 - Reverberations that situations of violence can generate in CAPSad workers, São Paulo, São Paulo (Brazil), 2017 (n=57*)

Variable		Frequencies	
		n	%
Escape attitude	Distancing from the most aggressive users	24	42.10
	Absences at work	22	38.59
	Decreased productivity	20	35.08
	Considering job change	20	35.08
	Increasing Intervals	17	29.82
Seeking support	Conversations with coworkers	33	57.89
	Chat with family members	22	38.59
	Psychotherapy	9	15.78
	Attendance at religious services	5	8.77
	Sports practice	3	5.26
	Cultural entertainment	2	3.50
	Communicate management	2	3.50
Illness	Absences due to illness	28	49.12
	Harmful change in sleep pattern	15	26.31
	Harmful change in diet	10	17.54
	Intensification of cigarette use	5	8.77
	Intensification of alcohol use	4	7.01
	Intensification of psychotropic drug use	4	7.01
	Intensification of illicit drug use	1	1.75

Note: Respondents were allowed to select more than one alternative.
* n = 57 of 58, as it refers to professionals who reported having experienced violence.

Discussion

This study corroborates the scientific literature by pointing out the existence of violent acts suffered by health professionals in their work environment and negative consequences arising from such acts, such as illness, sick leave and professional burnout.[17]

The data suggest that health professionals occupy the role of observers of the violence situation more often than the target of aggression, regardless of the type of violence (physical, verbal or sexual). One explanation for this could be the fact that, numerically, there are many professionals, increasing the likelihood of the professional occupying the position of observer of situations of violence. Another possibility is that professionals approach the place where a situation of violence is happening to try to handle the event, creating more observers than direct victims of aggression.

The results highlight the fact that the vast majority (96.55%) of respondents suffered violence regardless of their sociodemographic profile, i.e., all workers in this study could be considered vulnerable to situations of violence. Due to a historical and structural condition, it should be assumed that female professionals would be more vulnerable to violent situations in daily

service.[17-18] However, in the present study, apparently, professionals suffered violent situations in the workplace, regardless of gender.

Regarding the reverberations of situations of violence, women reported more frequently the behavior of moving away from the more aggressive users of the service as an attitude of response to situations of violence experienced (48% women and 35% of men).

Among the intensified behaviors facing situations of violence in the "seeking support" category, there is a collective conduct of cooperation among team members, specifically in seeking support through "conversations with co-workers", which can strengthen the bond between workers and improve coping with suffering linked to living violence in the workplace.

For the cooperation occurs, it is necessary to build trusting relationships between professionals. However[19]:

> " In a working group, we only give our colleagues lasting confidence only if we have a clear idea of the way they work... Each must make visible to others the way he cheats, the way he takes it. freedoms with the rules and even respect the spirit of those rules. This implies, among other things, a certain performance, a representation, a dramaturgy, passing through a specific gesture and discourse".[19]

Still regarding the category "search for support", apparently, the use of the word, talking with colleagues, friends and family stands out as of prime importance. The word directed to a third party can acquire a double function, initially promoting a discharge, a relief to the speaker and then associations.[20] When offering free listening without prejudice, a symbolic elaboration of the event is made possible. that was difficult for the speake.[20]

Therefore, the data suggest that the availability of qualified listening may be fundamental for a mental health service, both for service users and employees. Supporting the professionals could be a way of reducing the suffering, illness and escape attitudes, having a direct impact on the quality of the services offered.

Making qualified listening available may require changes to the structure of an organization. Lancetti describes the work situations in CAPSad as inconstant, sometimes repetitive, sometimes explosive, which leads to the demand for professionals' psychic plasticity, in order to allow the mobility and flexibility of affections and thoughts.[21] For such plasticity to be viable, the importance of investments in qualified listening spaces for mental health workers, such as supervision and psychotherapy, inside or outside the service, is reinforced.[21]

The category of escape attitudes highlights the "distance from the most aggressive users" and the "absences at work" as behaviors intensified by situations of violence. These behaviors can be considered as reactive and individual behaviors in the face of the violence experienced, being configured as examples of misuse of rules, because it neglects the user who, although identified as an aggressor, has the right to be attended by the professional team of the health service.

Understanding the specific reason for each violence of service users is only feasible with approach to the subject and promotion of qualified listening spaces. In this sense, the violent act could be understood as an attempt of expression when other communication strategies failed.[20] The subject, who cannot or is unable to use the word to handle a situation, would find in the violent act a flow to what the word cannot mediate.[20,22]

Instruct professionals on the management of situations of violence, make them aware of possible coping strategies, support health care clients to seek other forms of communication, promote activities that encourage nonviolent communication by both professionals and clients and other strategies could contribute to ceasing or reducing the violence occurrence.

The last category of responses to violence is "illness", which can be found in greater or lesser severity. When the disease is mild, in many cases, it generates tiredness and body weakness, which interferes with the quality of work of professionals. In addition, when the severity is higher, it may be necessary to leave work (Absences due to illness - 49%), which generates an overload of demands and, again, interferes with the quality of work performed by the health team.[23]

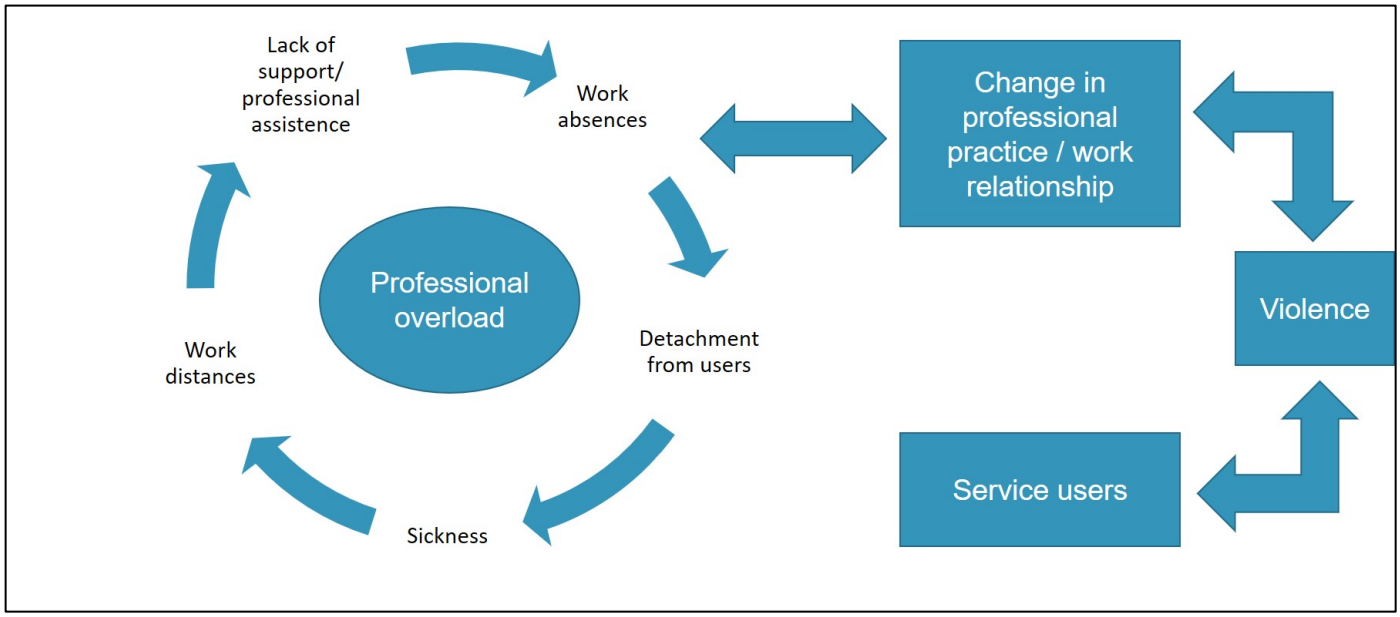
Being a constant victim of violence at work seems to generate a vicious cycle in which the overload of professionals as individual and collective subjects generates an unavailability of psychic plasticity, reducing the quality of work and the possibility of using the word as a mediator. This opens space for and making room for CAPS users to respond to different situations with violent acts.

A study on quality of life indicators at work suggests that occupational safety is only one aspect of the perception of quality of life at work.24 Other indicators are: 1) the opportunity to use skills; 2) the relationship with colleagues, supervisors and managers; 3) wages and benefits; 4) the positive affects; 5) organizational commitment and 6) job satisfaction.[24] However, all variables are crossed and impacted by the occurrence of situations of violence at work, demonstrating the fundamental importance of this discussion. These indicators could be, for example, the object of planning the organizational management of health services in which it is intended to promote effective coping with situations of violence.[24]

In addition, regarding the field of data collection, the service under study is in one of the most dangerous regions in the city and serves a large number of homeless people, important risk factors for situations of violence.[8-9] In this sense, the practice of violent actions could merely be a reproduction of what one lives, sees and learns on the streets that belong to CAPSad's territory, including as a means of survival.

Considering also the results of the study and the hypothesis presented here that there would be a vicious cycle in which actions of response to violence have repercussions on more acts of violence, an explanatory flowchart of the relationship between the results of this research and its study object (Figure 1).

Figure 1 – Vicious cycle formed by violence



Conclusion

There is a positive response from health professionals regarding the support of their co-workers in the face of situations of violence they experience in their daily lives. However, escape and illness responses are also present, pointing to failures in the work process, that is, moving away from the goal of providing care.

Far from placing the perpetrators as victims, it is expected that the results of this study will enable broad discussions about the situations of violence that occur in a service that should be promoting care and not suffering. In this sense, suffering is considered to affect both health professionals and their clients. In addition, violence in health environments cannot be allowed to be naturalized, as it can generate reverberations that interfere with all work dynamics..

A possible way out of every situation and improvement of working conditions could involve the availability of professional supervision, critical situation support, management support, work sizing review and psychotherapy for professionals working in places with high risk factors for situations. of violence.

Based on this, it is suggested to conduct studies focusing on users' view of the topic under study. Exploring from different angles this theme could help a deeper understanding of what generates these situations of violence in health environments for later planning strategies that promote better interpersonal relationships between health professionals and their clients.

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