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Integrated embracement in Psychosocial Care Centers for Alcohol and Drugs in the perspective of the protection of human rights

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Abstract *This article aims to assess whether or not the results of integrated embracement in Psychosocial Care Centers for Alcohol and Drugs III (CAPS AD III) meet the quality standards necessary for the protection of and respect for users' human rights. An evaluative, quantitative, and longitudinal design was developed through a study with 122 users, embraced in two CAPS AD III follow-ups after 14 and 90 days. This study analyzed the quality of life indicators, consequences of substance abuse, and psychosocial rehabilitation in the light of the QualityRights framework. Three themes and nine patterns were evaluated. In this study, four patterns were classified as total reach, four as partial reach, and one as initiated reach. The right to enjoy the highest possible standard of physical and mental health was the standard most achieved by integrated embracement (theme 2). The right to exercise legal capacity and the right to personal freedom and security were achieved, but with some weaknesses (theme 3). The right to live independently and be included in the community requires other social resources, in addition to specialized mental health care in order to be improved (theme 5).*

Key words *Substance Abuse Treatment Centers, User embracement, Health Impact Assessment, Human rights*

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Introduction

Problems resulting from the use of alcohol and other drugs has been on the rise, especially in developing countries, related to a series of biopsychosocial and social determinants, which demand specific approaches from healthcare services. The United Nations (UN) affirms that to deal with the global question of drugs, it is necessary to respect one's human rights, given that the complexity that involves the substance abuse and its relationship with stigma and consequent exclusion, rejection, and marginalization of users has direct implications on guaranteeing human rights[1].

The violation of human rights in the context of mental health is significant and appears within erroneous concepts of "people with disabilities", in turn justifying conducts of the deprivation of liberty, the inability to make decisions, the negation of spaces for work, health, and education, among others, which generally occur in fully psychiatric hospitals[2]. In this sense, this connection (mental health and human rights) generates controversies in the face of interventions, such as the involuntary actions that have already been regulated by certain policies, including "medical conduct". In a broader sense, the recognition of enforcement practices in this field needs to break the paradigms and include social, political and economic factors that discriminate the rights of people with mental health problems in its discussion through healthcare services[3].

This globally recognized scenario is no longer acceptable, and one concrete initiative to guide this restructuring is the QualityRights (QR) framework from the World Health Organization (WHO). QR was developed to evaluate mental health services from the point of view of protecting the human rights of those with some form of intellectual deficiency, those with mental health problems, and those who use alcohol and other drugs. It is a reference that aims to contribute to the identification of negligent practices and to improve the quality of the care and the respect for human rights within healthcare services[2].

This was structured by means of seven articles defined by the UN Convention on the Rights of Persons with Disabilities (CRPD) and organized in five themes, which define human rights as: (1) The right to an adequate standard of living (Article 28); (2) The right to the enjoyment of the highest attainable standard of physical and mental health (Article 25); (3) The right to exercise the legal capacity and the right to the person's liberty and security (Articles 12 and 14); (4) Freedom from torture or cruel, inhumane, or degrading treatment or punishment, and against exploitation, violence, and abuse (Articles 15 and 16); (5) The right to live independently and be included in the community (Article 19). For each theme, the QR framework determines between four and seven standards that are the criteria of quality assessment and the guarantee of human rights, which must be guaranteed by the services. The assessment of each standard allows one to determine if the global theme has been met[4,5].

The QR model has contributed to systematically document the assessment results from hospital and outpatient mental health services and to improve the quality of the services, with a reduction in the enforcement practices and the respect for human rights[6,7]. QR assessment studies have been documented in Chile[8], India[9], and Brazil[10,11], in general mental health community services, where the approach and discussion surrounding human rights is apparently more present[7].

More specifically in Brazil, Adult Psychosocial Care Centers (CAPS, in Portuguese) have been assessed in the Midwest, Northeast, and North regions of the country[10,11]. Assessments of CAPS on Alcohol and other Drugs (CAPS AD) using QR were not identified, nor were assessments of the integrated embracement model (CAPS AD III).

CAPS AD is a recent and unique care model that takes on a central role in the Brazilian Psychosocial Care Network (RAPS, in Portuguese) and guides the specialized care for alcohol and other drugs, within the logic of Harm Reduction (HR). This was implemented through the process of the reform of Brazilian psychiatrics and has the aim of redirecting care to psychosocial care and guaranteeing the security and the rights of the person who presents a problem of substance abuse through a social and healthcare policis[12]. Modality III encompasses the full, 24-hr embracement in CAPS AD, including overnight stays, at most, 14 days per month, in the same service, representing a private character model when compared to other communitarian forms of care in the international scenario. It is geared toward the people that need support for more complex and serious needs, crisis situations, risks considering one's state of health, social vulnerability, among others, which must guarantee the protection of their human rights[13].

In this sense, the assessment of services to treat substance abuse by applying the QR framework can contribute to expanding the views on

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different care models, filling in the scientific gaps, and subsidizing public policies to affirm mental health as a human right[14]. Therefore, this study seeks to assess whether or not the results of integrated embracement in CAPS AD III meet the standards of quality for the protection of and respect for human rights.

Methods

This work was an evaluative, qualitative study, using a longitudinal design, and was part of the core Project: "Results of the treatment for alcohol and other drugs in Psychosocial Care Centers, modality III: cohort study", which intended to assess the impact of integrated embracement in two CAPS AD III of the central region of São Paulo through biopsychosocial indicators: quality of life, consequences of the substance abuse, and psychosocial rehabilitation (defined based on preliminary studies and public policies regarding drugs)[1,8,15-18].

The present study proposes an evaluation in the perspective of the protection of human rights in order to verify if the results obtained through integrated embracement meet the quality standards for the protection of and respect for human rights of the users of the services proposed by the QR framework.

The assessed CAPS AD III are references of a territory marked by social vulnerability, in which 45% of the homeless population of the city of São Paulo and includes the largest scene of the public consumption of crack in Brazil. The data were collected with 122 users, selected by convenience in the two CAPS AD III, from February 2019 to February 2020. These were accompanied for 90 days and interviewed in three moments: (1) T0 - Embracement (n=122); (2) T1 - after 14 days (n=67); (3) T2 - after 90 days (n=49). The participants were approached by the researchers on the day of admission to integrated embracement in the CAPS AD III. Those that accepted to participate in the study filled out a form containing personal data, telephone numbers, addresses, and information from other people who could establish contact with the participant. These data were used for follow-up, which included five attempts to locate the participants. Those who were not found and/or did not finish filling out the answers in T2 were considered sample losses.

The study was interrupted due to the COVID-19 pandemic, which hampered the inclusion of more participants in the sample and the continuance of the study. The inclusion criteria were individuals aged 18 years and over, in CAPS AD III treatment, admitted for integrated embracement during the period of the study and who answered at least one follow-up interview. All sample losses were excluded.

To assess if the results from the integrated embracement in the CAPS AD III meet the quality standards for the protection of and respect for human rights, this study followed the QR guidelines described in the "WHO QualityRights tool kit"[5]. An assessment team was put together, consisting of three specialists in the area of alcohol and other drugs in order to assess the standards of the themes 2, 3, and 5 of the QR through user answers. Theme 1 (seven standards) – The right to an adequate standard of living – is not applicable to outpatient services, such as the CAPS AD III, and theme 4 (five standards) – Prevention against torture or cruel, inhumane, or degrading treatment or punishment, and against exploitation, violence, and abuse – does not meet the aim of the core study and could not be assessed. Therefore, these themes were not included in the assessment.

Among the 13 standards of themes 2 (five standards), 3 (four standards), and 5 (four standards), nine were assessed. One standard of theme 2 (2.2. The service counts on qualified professionals and offers high-quality care in mental health); two standards of theme 3 (3.3. The service users can exercise their legal capacity and receive the necessary support to exercise their legal capacity; 3.4. The users of the service have the right to confidentiality and to the access to their personal health information); and one standard from theme 5 (5.3. The right of the users of the service to participate in public and private lives and to exercise the freedom of association is supported), could not be assessed according to the indicators selected in this study.

Each assessed standard contains the following hypotheses of classification determined by the WHO tool kit: Achieved in Full (AF): There is evidence that the criteria, standards, or themes were achieved in full; Achieved Partially (AP): There is evidence that the criteria, standards, or themes were conducted; however, improvements are still necessary; Initiated Outreach (IO): There is evidence of the measures that are to be taken to comply with the criteria, standards, or themes; however, significant improvements are still necessary; Not Initiated (NI): There is no evidence of compliance with the criteria, standards, or themes; Not Applicable (NA): The criteria, stan-

dards, or themes are not applicable to the service in question[5].

The following were considered to be evidence to classify the answers to the standards of the QR themes: the longitudinally assessed biopsychosocial indicators (quality of life, use of alcohol and other drugs, consequences of substance abuse and psychosocial rehabilitation axes) that presented a significant difference throughout the follow-up, in addition to the characteristics of the population, other descriptive variables, and guidelines of the CAPS AD III model.

The indicators were measured by: 1) the WHOQOL-BREF scale, which contains 26 items that assess the overall quality of life and the dimensions: (a) Physical, (b) Psychological, (c) Social, and (d) Environmental. This is an instrument indicated by the WHO to assess results of community treatments within a broader scope than the symptomatology of diseases or biomedical indicators[19]; 2) Substance Addiction Consequences (SAC) scale was used to assess the consequences related to the consumption of substances at home: (a) Psychological and family; (b) Functionality; (c) Self-care; (d) Economic and Work. It consists of 16 items that allow one to measure the level of severity of the consequences of consumption[20]; 3) Psychosocial rehabilitation of the users was assessed by the reach of the axes of work, productivity, housing, and support network, as indicated by the Brazilian mental health policy and the QR framework[4,15].

The group of assessment instruments, in addition to the identification data and socioeconomic questions and substance abuse, were added to an instrument applied in the three stages of the study (T0, T1, and T2), with help from the Google Forms platform. Also included were questions about the reasons for admission, time of stay, and type of release from integrated embracement, developed activities (groups, individual care, use of medication), as well as other current follow-ups, which served as control variables in the analysis in order to avoid bias.

The data were analyzed by the R 3.5.1 program with a descriptive analysis (average, median, standard deviation (SD), frequencies) and the mixed effects logistics regression model. A p-value of less than or equal to 0.05 was considered, and a 95% confidence interval (CI) was used. The results are presented in tables organized according to the QR themes.

This study was approved by the Research Ethics Committee of the Nursing School of the University of São Paulo (2.759.176/2018) and by the Municipal Health Secretary of the city of São Paulo (2.832.670/2018).

Results

Of the 122 participants included in the baseline (T0), the majority were cisgender men (79.5%/97), with an average of 44 years of age (SD=10.3), single (72.1%/88), homeless (81.1%/99), with an average level of education of eight years (SD=3.7) and an average time of 25 years consuming alcohol and other drugs (SD=11.8). Regarding the consumption in the last 30 days, in order of prevalence, they reported the use of tobacco (22 days), alcohol (21 days), cannabis (9 days), and crack (8 days).

The average time of treatment in the CAPS AD III was of three years (SD=6.3) and each participant had already been fully embraced twice before the study. In the embracement studied herein, the average time of stay was seven days, and the reasons for admission were the reduction of drug consumption (82%/100), detox (69.8%/85), and the situation of social vulnerability (46.7%/57). The majority of participants used some type of medication (88%/107), were undergoing individual follow-up (98,5%/120), and participated in group activities (86.6%/105).

Release from integrated embracement was planned with the aid of openings in temporary embracement centers (52,2%/64), and integrated embracement was assessed as positive by 83.6% (102) of the participants. Only the follow-up in Basic Health Units (UBS, in Portuguese) at the same time as in the CAPS AD III was reported by 25% of the participants.

The assessment of the results of the integrated embracement in the CAPS AD III in light of human rights is presented in Chart 1. The QR themes were assessed based on the evidence of the answers for each standard, which were: user characteristics, CAPS AD III guidelines, the use of substances and their consequences (SAC scale), quality of life (WHOQOL-BREF), and axes of psychosocial rehabilitation. These were then classified into groups according to the level of achievement.

Of the nine assessed standards, only one standard from theme 5 – access to opportunities of education and work – were considered to be IO, four were AF, and four AP.

Table 1 described the results of the longitudinal indicators that subsidize the assessments of the QR themes. More significant results were

Chart 1. Assessment of integrated embracement in CAPS AD III according to QR themes. São Paulo, Brazil. 2020.

QualityRights (QR) Theme	Evidence	Level of achievement
Theme 2 - The right to enjoy the highest standard of physical and mental health		
Standard 2.1: The service is available for all who need treatment and support.	-Low access of cisgender women (19=8.9%) and transgender persons (1.6%) to integrated embracement; -WHOQOL-BREF: Improvement in the environmental dimension that assessed the availability and quality of health care and social care.	AP
Standard 2.3: Treatment, psychosocial rehabilitation, and interactions for support networks are elements of a therapy project geared toward user needs and contribute to their capacity to live independently in the community.	-The care provided in integrated embracement is geared toward user needs and has psychosocial rehabilitation as an intervention axis; -Reduction in the days of consumption of all of the substances, especially alcohol, cannabis, and crack, and an increase in the days of abstinence; -WHOQOL-BREF: Improvement in the overall quality of life; Improvement in the physical dimension, which assessed the capacity to work, mobility, and daily routine activities; -SAC: Reduction in the severity of the consequences of using psychosocial substances in all dimensions. -Reach of the axis of psychosocial rehabilitation performance.	AF
Standard 2.4: Psychotropic medications are available, are accessible, and are used appropriately.	-In integrated embracement, 88% of the users had access to the use of medications.	AF
Standard 2.5: Adequate services are available for overall and reproductive health.	-Embracement in Primary Health Care was reported by 25% of the participants and did not change in the follow-up.	AP
Theme 3 - The right to exercise one's legal capacity and the right to personal liberty and security		
Standard 3.1: The preferences of the users of the services, as regards the place and way they were treated, are always a priority.	-CAPS AD III follow the HR principles; -83.6% of the releases from integrated embracement were planned with the team according to the therapy project; -User commitment in group activities and in individual care with respected professionals in the field; -SAC: Reduction in the consequences of substance abuse in the functionality domain, which assessed the incapacity to make day-to-day decisions.	AF
Standard 3.2: There are procedures and safeguards to prevent the deprivation of liberty and treatment without one's free and informed consent	-No signature of free and informed consent was identified during integrated embracement; -The agreement for admission and release from embracement is voluntary; -Users participate in building their own therapy projects.	AP
Theme 5 - The right to live independently and to be included in the community		
Standard 5.1: The users of the service receive support to have access to a place to live and have the necessary financial resources made available to them to live in the community.	-The access to income was possible through social benefits; -WHOQOL-BREF: Improvement in the environmental dimension that assessed financial resources and the home environment; -The housing axis saw no significant changes, but many users left the condition of homelessness and were referred to temporary embracement centers.	AP
Standard 5.2: The users of the service can have access to education and work opportunities.	-Low level of education, with 23.2% of the participants with only four years of study; -The work axis saw no significant changes.	IO
Standard 5.4: The users of the service receive support to participate in social, cultural, religious, and leisure activities.	-WHOQOL-BREF: Improvement in the environmental dimension, which assessed the opportunities of acquiring new information, abilities, and opportunities of recreation/leisure; -Improvement in the psychological dimension, which assessed spirituality/religion/personal beliefs; -SAC: Reduction of consequences in the psychological and family domains, which assessed isolation and loneliness.	AF

AF - Achieved in Full; AP - Achieved Partially; IO - Initiated Outreach; WHOQOL-BREF - Quality of Life Scale; SAC - Substance Addiction Consequences Scale.

Source: Authors.

observed in T1 with an increase in the days of abstinence, reduction in the days of the use of substances and their consequences, and improvement in the quality of life in nearly all dimensions. In T2, the result remained the same, especially in the quality of life, and the axis of the productivity of psychosocial rehabilitation was also positively affected.

Discussion

The right to enjoy the highest standard of physical and mental health

The questions of physical and mental health were those that most benefitted from the integrated embracement in the assessed CAPS AD III. This result was partially expected due to the policy guideline of the embracement model defined in human rights, which guarantees 24-hour nursing care to its users; a protected location to satisfy the basic needs of food, hygiene, and rest; in addition to access to the use of medications, when necessary[13].

Moreover, being in the integrated embracement improved the capacity of the participants to live independently in the community and to enjoy higher standards of physical and mental health, because they were able to reduce the problematic consumption and negative consequences of the consumption of alcohol and other drugs. They also experienced an expressive improvement in their quality of life in all domains and availability of medication, when necessary.

Nevertheless, through the assessment of this theme, two challenges were found that limited the total reach of the right to enjoy a higher standard of physical and mental health: the lack of availability of integrated embracement in the CAPS AD III for all who needed it and the difficulty to work in a network.

These challenges have already been pointed out by other studies that identified the existence

Table 1. Longitudinal results of the indicators of integrated embracement in CAPS AD III. São Paulo, Brazil. 2020.

Indicators	T0 (n=122) - T1 (n=67)	T0 (n=122) - T2 (n=49)
	p	p
Use of psychoactive substances		
Abstinence	<0.001*	0.685
Alcohol	<0.001*	0.143
Crack	<0.001*	0.021*
Cannabis	<0.001*	0.021*
SAC scale		
1. Psychological and family	<0.001*	0.097
2. Functionality	<0.001*	0.252
3.Self-care	<0.001*	0.747
4.Economic and work	0.031	0.776
Total	<0.001*	0.187
WHOQOL-BREF		
1. Physical	<0.001*	0.241
2. Psychological	<0.001*	<0.001*
3. Social	0.137	0.678
4. Environmental	<0.001*	0.021*
Total	<0.001*	<0.001*
Psychosocial Rehabilitation Axes		
Housing	0.582	0.410
Work	0.163	0.166
Income	0.768	0.025*
Support network	0.110	0.102

*p-value ≤ 0.05; SAC - Substance Addiction Consequences Scale; WHOQOL-BREF - Quality of Life Scale.

Source: Authors.

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of access barriers to hospital beds in the CAPS AD III, especially in relation to gender, since women and transgender persons find it hard to be embraced in the treatments offered due to the lack of singularity in the actions[16,21].

The international guidelines consider the women to be one of the priority groups of political obligation, resulting from human rights of specific groups. This reinforces the fact that "women that use drugs have the right to access to health services, including the sexual and reproductive, in a non-discriminatory manner, and in this sense, the state should take the necessary measures to guarantee the availability and access to the necessary services "of good quality and gender sensitive"[1].

Another challenge includes network actions. As identified in another study that used the QR assessment in Adult CAPS, the specialized mental health services tend to centralize all the user health needs due to the link and the relationships of trust that are established, which facilitates care[10]. However, to guarantee the high standard of health for this population, the integrality of the actions should be shared with the Psychosocial Care Networks (RAPS, in Portuguese), especially with primary care[22], as indicated in article 25 of the CRPD.

Standard 2.5, which assessed the availability of adequate services for overall and reproductive health needs, was partially attended to because only 25% of the participants received support from the BHS at the same time as in the CAPS AD III, despite the good coverage of these services in the studied region. It is important to highlight that the social determinants of health of the studied population may have interfered in the maintenance of the more positive results and reflect the inequalities experienced daily by this population when accessing adequate health care and, consequently, in guaranteeing human rights.

The right to exercise one's legal capacity and right to personal liberty and security

This theme treats subjective questions that would be better proven by qualitative data, and we were therefore only able to treat two of the four predicted QR standards. This basically treats the autonomy and concept of "supported decision-making", where people have access to support options (people they trust) to make the choices for themselves[5]. This runs in line with what we call the promotion of contractuality in the CAPS; it means "being with" the users in their daily routines, measuring relationships to create new spaces and broaden opportunities[12].

Concerning what was possible to assess, standard 3.1 was assessed as AF, since integrated embracement in the CAPS AD III is a completely voluntary care model and is agreed upon between the team and the user regarding the therapeutic project. In addition, when embraced for 24 hours, there is a considerable increase in the care provided by the multidisciplinary team, especially with the experienced professionals, or the case managers, and the users can opt to receive individual care and participate in the group activities of their choice[17].

The weakness of this theme was proven by the absence of a specific informed consent for the period of integrated embracement, which guarantees the total security and liberty of the users, which was therefore assessed as "not initiated". Findings from Pitta *et al.*[10] considered, in the assessment of the QR, standard 3.2 as AP, given that, as the consent of care is signed when the therapeutic project is built by the user and the case manager, it is understood that it guarantees the right of participation of the subject in the treatment and the co-responsibility of the professional in the choice of therapeutic approaches.

Nevertheless, our study identified a specific consent that prevents the deprivation of the user's right to integrated embracement, such as the right to participate in the decision about the time of stay, as well as in being released before the expected time, in turn ensuring one's full right to liberty and capacity to make decisions regarding their own care, given that in clinics for alcohol and drugs, in addition to the questions inherent and common, mental health presents concerns about the criminalization of the users[1].

Another aspect considered was the care model of the CAPS AD III, guided by the principles of HR. This evidence sustains the reach of standards, both in theme 2 as well as in theme 3, as it does not refer only to the expansion of the possibilities of care provided by the healthcare services, but to the guarantee of the choice and decision made by the users, respecting the limits of each one and encouraging citizenship. HR practices are set forth in the UN guidelines for public policies on alcohol and other drugs as one of the obligations for the guarantee of the right to the highest possible standard of health for drug users, including voluntary access to services and to information about HR and the use of drugs, as a practice proven to be effective in guaranteeing the rights of this population[1,6,16].

The right to live independently and to be included in the community

This theme, related to psychosocial rehabilitation, represents the axes of greatest difficulty not only for integrated embracement in the studied CAPS AD III, but also in the short (T1) and middle (T2) terms, as well as for other assessed contexts that used the QR framework[8,9]. It treats the rights of people to live in the community and to have access to work, education, and social and financial aid, which are minimally necessary to exercise citizenship[4].

One study that assessed 15 mental health community services in Chile, identified that theme 5 presented the greatest difference among the interviewed groups. Both users and family members meet all of the standards from theme 5 with lower scores than the professionals, that is, the professionals considered that the criteria to live independently and to be included in the community had not yet been achieved, while users and family members reported the contrary, pointing out the difficulty of the services to support the questions of housing, work, and education[7]. No assessments were found about theme 5 in other studies.

In the case of this assessment, the most important thing to be considered is that the 24-hour embracement is short (average of 7 to 14 days) and has the core aim of dealing with the most severe situations related to drug use in the community. However, in general, a positive interaction among the professionals was found during integrated embracement, achieving social support, which changed the condition of the participants' right to income, with access, especially to social benefits, after 90 days of embracement, which may well have contributed to important changes in the axes.

As regards the housing, work, and education axis, these services support the users in the search for openings in temporary embracement centers after having been released from integrated embracement, which changes their housing condition, and does not restrict their access to educational and work opportunities. By contrast, it was observed throughout the study that many participants resumed their involvement in these activities due to the support provided in integrated embracement, and for this reason, they were assessed as achieved.

Nonetheless, it is important to highlight that the tools used were insufficient to promote a significant change in these axes. This is backed by evidence that highlights a difficulty in the support provided by the service teams regarding strategies to guarantee the rights of users to live independently and to be included in the community through access to housing, income, work, and education[8,16]. As highlighted in article 19, people have the right to decide where and with whom to live, to choose where and what to study, and in what job they would like to work[4], which expands the concepts of inclusion and participation in the community and, consequently, the approach of these services when faced with these questions, which was not possible to assess in this study.

The standards assessed by this theme are important results for mental health services, as they indicate patient recovery and not merely a diminishing of symptoms or of illegal drug consumption[4,23]. In the services of treatment for alcohol and other drugs, mainly those that provide medical care for the homeless, there are even more challenging aims to be achieved, given that this phenomenon still needs heavy investment in the social determinants of health and interaction among the public powers to guarantee more effective public policies, such as Housing First and social inclusion through work[24].

Concerning standard 5.4, it was observed that the integrated embracement for the participants of this study contributes to the opportunities to acquire new information and abilities, have recreation/leisure activities, and spiritual/religious connection, as well as reduce the damage caused by isolation and solitude caused by the problematic use of alcohol and other drugs, measured by the scale. Similar experiences have already been reported in mental health services in India after having received the QR intervention, where they observed a significant improvement in the feeling of capacity and satisfaction on the part of the participants[9]. In Brazil, it was found that the Adult CAPS ensure user rights to participate in the treatment and support their protagonism in the community through the promotion of social, cultural, and leisure activities[10].

The limitations of this study include the following: the sample losses in the follow-up, which may have interfered in the significance of some results; the impossibility of achieving all of the standards of the QR themes, which could expand the assessment of the protection of human rights; the impossibility of generalizing the data, given that they correspond to two services from a specific region of São Paulo, Brazil.

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Conclusion

When assessing the results of the integrated embracement of the two CAPS AD III from the central region of São Paulo, it was identified that this resource partially achieved the standards of quality for the protection of and respect for human rights. Staying in the 24-hour embracement improved the overall health conditions and well-being of the users, reducing the severity of the negative consequences stemming from the use of alcohol and other drugs, and made it possible to make changes toward psychosocial rehabilitation and inclusion in the community.

The weaknesses pointed out by the QR assessment can be reanalyzed and improved with support from the psychosocial care network. The challenges identified to achieve high-level quality in guaranteeing human rights correspond to the common question experienced in the care provided to people who use drugs and live in a situation of vulnerability, and who consequently benefit from the support resulting from inclusive public policies.

We therefore suggest conducting a realistic analysis of the application of the QR in CAPS AD III so as to adapt the assessment to this full answer model, as well as a qualitative assessment to expand the answers concerning the quality of other standards. We feel that it was possible to fulfill the objective of this study and contribute with scientific knowledge on the theme of the human rights of people who use drugs in the context of psychosocial care.

Collaborations

GA Boska participated in the research conception and design, data collection, data analysis and interpretation, writing of the manuscript. MAF Oliveira participated in the conception and design of the research and critical review of the manuscript. PRC Seabra participated in the analysis and interpretation of data and critical review of the manuscript.

References

1. United Nations (UN). *International guidelines on human rights and drug policy.* New York: UN/UNAIDS/UNDP/WHO; 2019.
2. Funk M, Bold ND. WHO's QualityRights initiative: Transforming services and promoting rights in mental health. *Health Hum Rights* 2020; 22(1):69-75.
3. Cirulli F, Venerosi A. A focus on the rights to self-determination and quality of life in people with mental disabilities. Editorial. *Ann Ist Super Sanita* 2020; 56(2):133-134.
4. Funk M, Drew N. WHO's QualityRights: transforming mental health services. *Lancet Psychiatry* 2017; 4(11):826-827.
5. Brasil. Ministério da Saúde (MS). *Direito é Qualidade QualityRights Kit de ferramentas*. Brasília: MS; 2015.
6. Sugiura K, Mahomed F, Saxena S, Patel V. An end to coercion: Rights and decision-making in mental health care. *Bull World Health Organ* 2020; 98(1):52-58.
7. Zgueb Y, Preti A, Perra A, El-Astal S, Aviles Gonzalez CI, Piras M, Testa G, Kirolov I, Tamburine G, Ouali U, Kalcev G, Romano F, Kovess V, Carta MG. Staff perception of respect for human rights of users and organizational well-being: A study in four different countries of the Mediterranean area. *Clin Pract Epidemiol Ment Heal* 2020; 16(Supl. 1):109-114.
8. Minelotti A, Toro O, Alvarado R, Rayo X. Differences on perceptions of quality of care and respect for rights in mental health between user, family and staff. *Rev Fac Cien Med Univ Nac Cordoba* 2015; 72(4):261-269.
9. Pathare S, Funk M, Drew Bold N, Chauhan A, Kalha J, Krishnamoorthy S, Sapag JC, Bobbili SJ, Kawade R, Shah S, Mehta R, Patel A, Gandhi U, Tilwani M, Shah R, Sheth H, Vankar G, Parikh M, Parikh I, Rangaswamy T, Bakshy A, Khenti A. Systematic evaluation of the QualityRights programme in public mental health facilities in Gujarat, India. *Br J Psychiatry* 2019; 1-8.
10. Pitta AMF, Coutinho DM, Rocha CCM. Direitos humanos nos Centros de Atenção Psicossocial do Nordeste do Brasil: um estudo avaliativo, tendo como referência o QualityRights - WHO. *Saude Debate* 2015; 39(106):760-771.
11. Soares MS. *Navegando pela Saúde Mental do Centro -Oeste e Norte do Brasil: uma pesquisa avaliativa* [dissertação]. Brasília: Universidade de Brasília; 2016.
12. Brasil. Portaria nº 130, de 26 de janeiro de 2012. Redefine o Centro de Atenção Psicossocial Álcool e outras Drogas 24h (CAPS AD III) e os respectivos incentivos financeiros. *Diário Oficial da União* 2012; 26 jan.
13. Boska GA, Oliveira MAF, Claro HG, Araujo TSG, Pinho PH. Night beds in psychosocial attention care centers for alcohol and drugs: analysis and characterization. *Rev Bras Enferm* 2018; 71(Supl. 5):2251-2257.
14. Mezzina R, Rosen A, Amering M, Javed A. The practice of freedom: Human rights and the global mental health Agenda. In: Javed A, Fountoulakis KN, editors. *Advances in Psychiatry*. New York: Springer; 2019. p. 483-515.
15. Brasil. Ministério da Saúde (MS). *A política do Ministério da Saúde para atenção integral a usuários de álcool e outras drogas*. Brasília: MS; 2003.
16. Machado AR, Modena CM, Luz ZMP. Das proposições da política às práticas dos serviços: há novidades nos Centros de Atenção Psicossocial Álcool e Drogas? *Physis* 2020; 30(1):e300118.
17. United Nations (UN). *Sustainable development goals*. New York: Department of Economic and Social Affairs/UN; 2015.
18. Onocko-Campos R, Furtado JP, Trapé TL, Emerich BF, Surjus LTLS. Indicadores para avaliação dos Centros de Atenção Psicossocial tipo III: resultados de um desenho participativo. *Saude Debate* 2017; 41(Supl. 1):71-83.
19. The WHOQOL Group. Development of the World Health Organization WHOQOL-BREF Quality of Life Assessment. *Psychol Med* 1998; 28(3):551-558.
20. Seabra PRC, Amendoeira JJP, Sá LO, Capelas MLV. Clinical Validation of the Portuguese Version of "Substance Addiction Consequences" Derived from the Nursing Outcomes Classification. *Issues Ment Health Nurs* 2018; 39(9):779-785.
21. Leão NMF, Boska GA, Silva JCMC, Claro HG, Oliveira MAF, Oliveira MSR. Perfil de mulheres acolhidas em leitos de um Centro de Atenção Psicossocial Álcool e Drogas. *Enferm Foco* 2020; 11(1):63-68.
22. Costa PHA, Ronzani TM, Colugnati FAB. No meio do caminho tinha um CAPS AD: centralidade e lógica assistencial da rede de atenção aos usuários de drogas. *Cien Saude Colet* 2018; 23(10):3233-3245.
23. Keet R, De Vetten-Mc M, Shields-Zeeman L, Ruud T, Weeghel JV, Bahler M, Mulder CN, Zelst CV, Murphy B, Westen K, Nas C, Petrea I, Pieters G. Recovery for all in the community; Position paper on principles and key elements of community-based mental health care. *BMC Psychiatry* 2019; 19(1):174.
24. Alegría M, NeMoyer A, Falgàs Bagué I, Wang Y, Alvarez K. Social Determinants of Mental Health: Where We Are and Where We Need to Go. *Curr Psychiatry Rep* 2018; 20(11):95.

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