Social construction of drugs and crack and the institutional responses and therapeutic approaches[1]

Construção social das drogas e do crack e as respostas institucionais e terapêuticas instituídas

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Abstract

This article is a partial product of a research conducted in the metropolitan region of Belo Horizonte in order to understand the mechanisms involved in the social and symbolic link between trafficking of crack cocaine and the spread of violence, compulsive use of this substance, treatments and health care services attention tofor the users. We used qQuantitative and qualitative methods were used, with analysis of police investigations, interviews with police, drug dealers and, professionals, patients and managers of institutions that offer services to crack users. It is intendedThe aim is to discuss the social construction of the drug problem; socially constructed negative images about theof crack and the users of the this substance; institutional responses that, based on biomedical models, religious and legal models offer, manage and legitimize homogeneous bureaucratic protocols for different homogeneous types of users. Socially constructed representations directly affect lack of success in the treatment process, frustration and lack of faith on the part of the health care professionals and the frequent relapses and re-hospitalizations of patients, especially crack users. Besides playing reproducing an obsolete prohibitionist policy obsolete, they reinforce prejudices, and lead to discriminatory enforcement measures result, rejecting passing over citizens'hip rights.

Keywords: Social Problem; Social Construction of Crack; Crackers; Institutional Responses.

Resumo

Este artigo é produto parcial de uma pesquisa realizada na região metropolitana de Belo Horizonte com o objetivo de compreender os mecanismos sociais e simbólicos envolvidos na relação entre o tráfico do *crack* e a disseminação da violência, o uso compulsivo dessa substância, os tratamentos e os serviços de atenção ao usuário. Foram utilizados métodos quantitativos e qualitativos, com análise dos inquéritos policiais, entrevistas com policiais, traficantes, profissionais, pacientes e gestores das instituições que prestam atendimento ao usuário de *crack.* Pretende-se discutir a construção social do problema das drogas; as imagens negativas construídas socialmente sobre o *crack* e sobre os usuários da substância; as respostas institucionais que, baseadas nos modelos biomédicos, religiosos e jurídicos propõem, gerenciam e legitimam protocolos burocráticos homogêneos para diferentes tipos de usuários. As representações construídas socialmente interferem diretamente no insucesso do processo terapêutico, na descrença e nas frustrações da equipe de profissionais e nas frequentes recaídas e reinternações dos pacientes, particularmente dos usuários de *crack.* Além de reproduzir uma política proibicionista obsoleta, reforçar preconceitos, provocar medidas coercitivas e discriminatórias, preterindo os direitos de cidadania.

Palavras-chave: Problema social; Construção social do *crack;* Craqueiro; Respostas institucionais.

Introduction

Using psychoactive substances is common to all societies and cultures, differing only in the way they are manipulated, used, produced and treated (Escohotado, 1998). In the West, from the 19th century onwards, the increased intensity of drug use and the variety of substances, different methods of use and diversity of social classes and groups who use them is notable. Indeed, the subject became one of general interest and is viewed as a social problem which deserves special attention from the penal, medical and socio-cultural spheres. A social problem is a construction which requires a world view and social values and, therefore, should be analyzed based on social representations and in the historical-cultural context (Lenoir, 1998).

Modern society, marked by the growth of capitalist industrialized urban centers is characterized as rational, technological and overvaluing consumption which, among other factors, are important mechanisms for informing, intervening in and controlling specific social realities. These mechanisms are based on statistical indicators – mortality and morbidity, among others, which are deliberately manipulated in order to direct society's attention towards certain social phenomena, and away from others, catering to ideological, political, economic and social interests. Baratta's (1988) reading of this is that these strategies are aimed at concealing real, potential and supposed social conflicts. In the specific case of drugs which, currently, is seen as a "problem", when compared with issues such as poverty, traffic accidents, war, cruel deaths which often occur in large urban centers, comorbidity, among many others, have reduced relevance, although, the way things are constructed, they play an important part in bypassing structural problems, and end up, paradoxically, being transformed into essential factors in the social order.

In the United States, the social problem of drugs becomes of central, institutional importance through arguments based on Christian precepts of North American puritanism, in the elite's concern over the "behavior" and "excesses" provoked by an altered state of conscience in individuals of certain social classes and groups – deemed dangerous – as well

as the stimulus to use psychoactive drugs. These factors resonate with and underpin the hegemonic moral principles and emphasize the use of psychoactive substances as a health problem to be controlled. Thus, the "drug problem" destabilizes and threatens the moral order, health and public safety.

As a result of this, institutional bureaucratic models and specific, rigorous legislation were established to control production, commerce and use of specific substances. These measures were corroborated by a medical system which, through scientific studies, provided evidence of the consequences for health, especially in cases of addiction, and of the dangers for society. This combination contributes to constructing the "drug problem" and to the challenge of controlling it through criminalization (penalization), a tool to protect society which considers the use of certain drugs as deviating from and/or transgressing the norm, and, in the area of medicine (prescription), caring for the individual user, viewing them as having a disease, a type of mental illness. Both the penal and the medical model tend to focus on the user as an individual deviating from the standards of normality, labelling them as a delinquent, or as sick, the strategy of "creating" the deviant is intentional and implies unavoidable politic aspects. Becker, studying the category of *outsiders*, explains

social groups create deviance when they make rules the infraction of which constitutes a deviance and on applying these rules to certain people in particular, qualify them as outsiders. From this point of view, deviance is not the quality of an act committed by the individual, but rather a consequence applied by others (Becker, 1971, p. 19).

Deviance, therefore, is not a characteristic of a certain category of person, but rather a variety of social contingence, influenced by those with the power to confer this attribute.

From the 1930s and 1940s onwards, anthropological studies of primitive studies demonstrated the use of drugs in shamanic rituals (Lévi-Strauss, 1979; Harner, 1976; Furst, 1980), leading to new ways of interpreting drug use. At the end of the 1940s, inspired by the Chicago School, socio-anthropological and ethnographic investigations into the so called drug world in the industrial urban area began, and it stopped being the exclusive province of primitive societies (Waldorf, 1980).

At the moment drugs, especially crack, are a topic of universal concern which, perhaps for its paradoxical, enigmatic, complex and multi-dimensional character, is capable of mobilizing intellectual, conceptual, scientific, economic, political, aesthetic, religious, medical, psychological, legal, moral, ideological and symbolic interest. Although these interests are generally treated in a fragmented and disjointed way, the dividing line between them is tenuous, which translates into an interface between the different discourses on substances. According to Becker (1971, p. 182), "as drugs have so many effects, these can be interpreted in various manners and thus reflects extremely subtle contextual influences".

The meta-language surrounding the issue, as well as having appropriations corresponding to the interests, serves to widen the debate on society, lifestyles, power, knowledge and forms of social intervention. It is a plural, dynamic and controversial debate which calls into question traditional models and absolute certainties.

Thus as highlighted by Lévi-Strauss (1993, p. 238), "hallucinogens do not contain a natural message, the notion of which would itself be contradictory; they detonate and amplify a latent discourse in each culture, of which drugs allow or facilitate the creation". In other words, discourses on certain psychoactive substances reflect, in some way, experiences, forms of classification, different interests, symbolic efficacy and interpretations of different social situations.

Crack in the contemporary context

Crack, nowadays, is a central issue covered by mass media, research and treatment bodies, the areas of justice and religion and, in general, with sensationalist, moral, legal and biomedical connotations. The way in which crack is presented, it has the power and skill to mobilize chemical-pharmacological qualities, as well as the power to act on the individual, and that individual upon society, which becomes a victim of this powerful drug, it is common for crack to be gifted with a life of its own, able to

bring society to a thunderous collapse, especially due to its destructive capacity. Interpreted in this way, it acts upon the individual and the individual then, possessed by a satanic magical power, acts in a devastating way towards society. Reports abound of filthy and repugnant individuals "possessed" by crack, living in the decaying outskirts, the so called "urban drug territories" (Fernandes, 2000, p. 57). At the same time, narratives are articulated presenting individual cases, highlighting impressive characters, especially desperate mothers reporting their traumatic experiences, centered on family tragedy and violent episodes. Such narratives link, almost automatically, crimes and cruel acts of transgression and delinquency with drug users and, especially, with crack users, justifying and silencing broader discussions of the socio-economic, political, legal, clinical and cultural dimensions in which crack and other drugs are involved. It is not that these reports are not true, but the intention of information presented in this manner seems to establish and legitimize the demonization of the substance and the guilt of the individual, reinforcing the stereotype and, therefore, concentrating society's attention on the "social problem" while bypassing a structural reading which concerns the process of drug use (in many senses); the nature of use, characteristics of users, social and historical contexts in which specific drugs appear and the scale of use and dealing and its consequences.

Social images of the *crackhead*

Crack results from mixing cocaine with different types of solvents in a simple process not requiring specialized labor. This means it is cheap and widespread, it can even be produced by the consumer. This is a determining characteristic for access by populations on low incomes, living in the outskirts, in marginalized areas, who would have difficulty gaining access to cocaine. For this reason, the images created of crack and its users are immediately associated with dangerous or marginalized areas of the city, where groups live who should be avoided due to their propensity to cause urban disturbances. Delineating these "drug territories" provokes and reinforces contrasting social values, intolerance, discrimination, suspicion and fear. These factors are expressed in a succession of daily rituals of identification and humiliation and are presented by the mass media, leading to effective impacts of the stereotyped images and to the negative representations presented to the population in general. As a result, interventions, institutional responses in the legal, medical, religious fields and social reactions are articulated in consistency with these social representations.

It is true that the characteristics of crack, like *cachaça* (alcohol produced from sugar cane) and solvents, mean it is a substance which gives those in poverty access to the modern consumer dream and, principally, allows this category of individual to feel pleasure and to escape, albeit temporarily, the daily grind.

In spite of these characteristics, it is not only those in extreme poverty who are interested in using crack, perhaps because of its very nature of being marginalized and the possibility of transgression (shown by the media, which could have the opposite effect). It can be said that it is difficult to profile those who use crack. In a study in Belo Horizonte, between 2008 and 2010 (Sapori and Medeiros, 2011), it was identified that, in addition to young, black males from the lower classes, poorly educated and living on the outskirts, as commonly shown in the media, there was a population in the 50 to 85 year old age group, white, middle and upper class, with higher education, of both sexes, from the south of the city and areas other than the outskirts.[2] The symbolic frontiers, created by the mass media, although effective in delineating social spaces and classes, do not totally correspond to reality. It is worth noting that the users of specific substances face choices and lack of choices every day, conditioned by their own desires and the limits which they face daily, or at certain points in their lives. Thus, regardless of

2 Crack was initially used, not only in Brazil but in other societies, by marginalized groups. Nowadays, this situation has changed, either due to the financial condition of the population, the immediate pleasure caused by the substance, to avoid visibility, to disguise the use of drugs by smell, or by individual choices.

social class and other elements of social classification and hierarchy, other factors and situations of vulnerability can be clearly observed in crack users.

Given its prohibited character, dealing illegal drugs is generally located in the outlying zones and this, in order to get the substance, those belonging to privileged classes have to cross social barriers and territories in order to do business, to recognize rules and norms, understand forms of communication, the dealing of drugs and the punishments dealt out when any of these factors of the "business" are transgressed. Although the scene is shown like this, the negative image of the crackhead and of crack is privileged, which users can take advantage of, a social situation typical of marginalized groups. In other words, in knowing the parameters associated with users, specific individuals can manipulate situations to feedback into this image. For example, in health care services for crack users, it is common for individuals to simulate aggression, cravings or abstinence in order to be hospitalized or admitted to the treatment service.

Institutions responded to the crack problem individually, using particular strategies and unconditional and obsolete knowledge, contributing to recurrent hospitalization, treatment failures, reproduction and reinforcement of negative images of certain drugs and certain social groups.

Institutional parameters and health care for drug users

In Brazil, the institutions which provide health care to drug users are principally mental health care units (Psychosocial Care Centers – CAPS, Psychosocial, Alcohol and Drugs Health Care Centers – CAPS AD and hospitals) and treatment communities. In general, treatment parameters are based on the following models: the medical model, which works using the logic of the centrality in the case study and medicalization, hospitalization to detoxify and day or outpatient treatment; the religious model, which defends keeping the user from their day to day life, generally for a period of nine months, and prioritizes religion and work; and the legal model, which acts using the logic of crime and punishment. All of these models focus on the individual and the substance used and do not consider social context, lifestyle or the ritualization of the drug use.

Health care institutions

In health care units, treating drug addiction is the responsibility of a team of professionals, generally with training in the field of biomedical sciences and, in a few, rare cases, in the area of social sciences. The treatment follows bureaucratic, formal protocols and based on criteria of abstinence.

In the specific cases of crack patients, institutions based on negative images of crackheads are structured to deal with individuals who are unkempt, out of control, dangerous, immoral and irresponsible. As this "other" is unknown, the health care professionals lack the power they should have over this other, who presents in a "possessed" condition.

The health care system is organize based on ideological paradigms imbued with the political interests of those who subsidize planning and actions, aimed at their own merits, although political discourse focuses on treating drugs as a priority. In the case of drug user care centers, the physical structure itself reveals the lack of attention with which this population is dealt with. The majority of the institutions are housed ad hoc in unfinished, discolored, decaying buildings, with piles of paper and damaged equipment and scarce material and human resources. Added to the ideological schema and the physical structure, drug addiction treatment establishments expect the team to embody the proposals contained in the pre-defined protocols and goals, with no room for autonomy or creativeness. Quite the opposite, their actions are dominated and controlled through camouflaged strategies which define career paths, reinforcing dichotomized and mechanized performance and creating real internal cracks.

Moreover, the team is depleted, lacking in qualified training or ongoing professional education to enable them to meet the complexities of treating drug addiction. This contributes significantly to disillusionment with the job, with prejudices towards the drug using patient, especially those who use crack, and disdain for the conditions of these subjects.

Alternatively, some professionals take individual, onerous initiative to seek supervision or training courses; others rely on spontaneous knowledge and intuition and still others make themselves comfortable and limit themselves unreflectingly to automatized tasks. This results in inaccuracy in concepts, diagnosis, prognosis, mistakes in referrals and in dealing with delicate, unexpected situations which occur daily in such institutions and, of course, in efficacious treatment. These factors directly affect frustrated attempts on the part of the technicians and in doing a job in which they daily have to deal with a difficult working day, and with the suffering and distress of the users.

In this context, it is possible to risk the affirmation that the technical team reproduces the social structure, organized on order and sustained by the discursive logic of hegemony and subordination and, simultaneously, must judge the patient who has lost control of their life with their excessive drug use. Within this perverse structure, the institutions neutralizes social mobilization, protagonism, autonomy, political participation and exercising citizenship and reproduces the exploiter/dominated relationship.

As a result of this, the professionals shut themselves up within their own identities, making it difficult to exchange ideas, to be open to other fields of knowledge, to have contact with other institutions, other ways of caring for users and to see reality outside of the walls of the institution. Thus, in this context, working in networks, indispensable for the three-pronged approach of subject, substance and social context, is compromised, whereas private practices, subordinated to political macro-systems, to mechanization of professional activities and to unwanted results of treatment become routine. The team, disillusioned professionally and with the situation created by patients abusing crack and all it represents, try to play their role, limiting themselves to repeating packaged treatment procedures, under the discourse of "individuals cases", and disinterested in survival mechanisms used by the patients in establishing ties and constructing systems of social representation in their path, i.e. in the social universe in which they find themselves, which feeds back into relapses and the endless search for a silver bullet to solve their problem (Medeiros, 2008). In contrast, supported on unsuccessful treatment rates, the moralist models and obsolete physical structures, the political and ideological discourses responsible for circulating stereotyped images of patients gain more ground and lead to intensification of the fear of crack and crackheads.

According to the biomedical model, the ideological strategy of identifying drug/crack users as ill explains the hegemonic treatment response which, according to Menéndez (1990), is

> a set of practices, knowledge and theories generated by the development of what is known as scientific medicine which, since the end of the 18th century, has subordinated other practices, knowledge and ideology which dominated, until it came to be identified as the only way of dealing with illness, legitimized both by scientific criteria and by the State (p. 83).

From this point of view, illness is considered a deviance from the norms and precepts of normality, either by desire, by the irresponsible decision of the subject or by their inability to deal with, respect or obey social norms, and is something to be corrected. Thus, treatments projects based on curative practices, with medicalized and standardized activities prescribed by experts, aiming to reorder their path, their desires and their behavior, making them more obedient and useful to social mechanisms (Foucault, 1994), leading to a doctor/patient relationship that is based on social subordination to scientific technique.

In the case of crack patients, the strategy of discipline is not effective, as they drop out of treatment, reject the treatment team's prescriptions and return to the services when necessary, and are treated again. Thus, a vicious circle is created, compulsively looking for the substance, for treatment in health care units, dropping out of treatment, relapses and failed treatment.

On the other hand, these institutions can become a useful resource for drug users, especially crack users, who make use of them as a means of obtaining something beneficial to them, more clemency from Justice or as an escape from difficult situations with dealers or the police, etc. Thus, like any other human being, users make use of a wide variety of social games and tricks in their symbolic world, in a

bid to overcome their grotesque fate. The illness can also be a sort of talisman, used as an argument by lawyers in legal proceedings, trying to avoid a severe sentence for their client. For families, it can justify the offensive behavior of a family member, aiming to hide the organization of the family relationships or to play the victim of the "druggies" behavior, or even to reinforce and delineate the difference between the normal and the pathological. Although this process, with all its ills, is reproduced, the resistance of treatment institutions to recognizing the lack of success of the biomedical model is notorious, as is the difficulty of reviewing and reinventing forms of dealing with the problem of drugs, and everything it implies, in contemporary society.

Rehabilitation clinics

The paradigms which guide treatment in rehabilitation clinics – Rehab - are based on religion and on work and are related to diseased souls, morals and bodies provoked by excess or by transgressing social norms. To re-establish themselves, the individual needs to go through a process of taking responsibility and repairing the damage they have done, experiencing guilt and deeming their punishment to be deserved. In this case, the illness would be a curse stemming from disobedience and, to treat it, the subject needs to learn to obey and accept social order with humility. The method is the religious cult, organized by an authority, a professional from the team or for former "converted" patients. This ritual may require the subject to read the bible, or involve the 12 steps to recovery, or it may be verbal testimony, making spiritual energy and faith emerge from those who have experienced recovery, translated as abstinence.

The statements of those who have recovered serve as a model for those who are in the process of constructing their faith. The personal experience of ex-addicts and converts and the explanations on changes in life styles shown by them themselves has the effect of awakening acceptance of God's precepts and, thus, to be cured. The combination of the word of God with knowledge of human acts and belief may lead to the decision to submit to treatment. These messages contain Biblical precepts which affect patients' behavior and attitudes. The meanings of the texts are transformed and assigned new meaning using cultural codes which serve to educate, guide and exemplify correct behavior. The words are important tools in to distance the subject from "spiritual" evil, to implement behavioral norms and to motivate dedication to work as the justification for human existence. However, the subject can only learn the meaning given to the texts by recognizing their own error (disobedience or deviance), reflect and learn from their attitudes. Thus, deviations and sins are reinforced and marked anew with evangelical norms. The subject recognizing their own state in order to start the recovery process is a rite of passage which unfailingly requires guilt and victimization.

The individual has to have hit rock bottom. This moment is symbolic for the treatment teams in both rehab clinics and health centers. In this condition of complete vulnerability and humiliation, the subject, faced with the inevitable, lowers their guard and reaches out to seek help, giving the other the task of trying to care for their health, control their behavior, define and prescribe a "grammar" to follow every day to achieve their "salvation". At this time, the team is authorized to intervene and has the power to act for the other and be really empowered. In this ritual, the subject's emotional frailty is necessary to absorb the messages articulated by the authorities and by the team of professionals, and any decision, disobedience or error, or any infraction, is of an individual character, the subject – and only the subject – being responsible for their daily actions and efforts to recover normality. Normalization is translated into moral principles, through criteria of good behavior, faith, religion, work and total abstinence. This signifies being cured, limited to following norms set by religious conversion and a moral review of lifestyle. In this context, the professionals tend to attribute etiology of morbid processes to a form of metaphorical, symbolic causality, or to a moral transgression. The "illness" is configured as a sudden departure from social norms and the individual needs a relatively long time away from their social context and emotional, sexual, family and social relationships to avoid suffering "temptation". It is a struggle between good and evil, represented by the demonic power the drug has over the individual.

Challenges of drug addiction and crack clinics

The problem drug, in particular crack addiction clinics, be they health care institutions or rehab centers, is patients being officially discharged and authorized to leave. There are few who complete the treatment project, some drop out, others run away and others force the family to take responsibility for their leaving. This is due to the high incidence of relapse, regardless of the type of institution. This situation is even more serious when the substances being used is crack. Patients using this drug rarely manage to conclude their treatment cycle. This situation is the topic of clinical meetings and of scientific debate and is the driving force behind the feeling of medical failure in dealing with drug addiction. If the issue is examined from the point of view of being discharged and cured (based on the criteria of abstinence), we can be sure that there is no cure, or that the abstinence is probably an illusion.

In general, motivation for treatment occurs when drug use in considered a problem by the patient themselves, by their families and by the professionals following their progress, such as in the workplace, in health care institutions, religious organizations and legal institutions. In general, treatment is sought when the case is considered to be serious, either because of social, emotional and professional, or physical (the most common) effects and damage. This situation leads to suffering, threats and low self-esteem – not only for the addict but for those around them – and becomes a motivator for seeking help; in other words, the subject expects support to rid themselves of symptoms of drug taking which make them uncomfortable.

Throughout history, the inexplicability of afflictions, pain, suffering and worry about malaise was essential in creating medical explanatory strategies which, from the point of view of those who suffer, or those around them, clarify nothing. Thus, the responses formulated by these inconveniences are given in order of significance, related to world and social order (Herzlich and Pierret, 1986). Conception and understanding of the disease is only possible through socially constructed images, related to the body or to a part of it, and to the intensity of the suffering. So, treatment and its success are also a social construction. Thus, the motivation for the demand for treatment and treatment types which meet it are the result of how the disease is perceived. The combination of suffering – something inexplicable – and how biomedical techniques combat it result in a mix of spirituality and rationality. Anthropological studies have shown just how close this is to religious beliefs, concepts of disease and treatments using certain herbs in religious rituals (Laplantine, 1991).

The majority of diseases are, still, explained in terms of religious behavior, "it's God's will", especially by groups who have limited access to scientific knowledge, constructed to explain illness. In the case of drug addicts, the most convincing, and often comforting, explanation is structured within a religious framework – "because God wills it" -, and the formulaic response is to "put yourself in God's hands", an expression often used by both patients and their families in health care centers. However, the way of constructing and typifying the disease is out of tune with socio-cultural paradigms, social processes and the perspective of the professionals. These, based on rational technical standards, go beyond diagnosis and define and control prescribed behavior, medicines, prohibit and recommend "healthy" behavior for what is seen as a pathological state. In other words, physical discomfort, suffering and pain are recorded in order of significance and treated according to the order of symptoms. This mismatch results in the patient viewing the treatment services and the professionals with distrust and insecurity and blaming themselves for constant relapses.

Health care professionals' discourses on illnesses frequently have ethical and political connotations which end up naming and legitimizing specific institutions, professionals, families, religious figures and politicians to take control of the pain, the body, the other, the pleasure, and to set the boundaries between normal and pathological. In this process, the suffering patient is excluded, going from being the subject to being the patient – who is patient – who waits passively for the expert's decision. In contrast, in traditional medicine with the shaman or healer as a figure of spiritual power to cure, the rituals are organized to include the suffering subject and those around them. This me-

chanism is a condition for alleviating suffering, for stimulating and exchanging spiritual and collective energy and channeling it to the discomfort, aiming to encourage the sick person's return to everyday life as part of the collective. In this case, the suffering individual is the principal character in the healing process which takes place in their own context, involving other social figures.

Throughout history, health care has been discussed and studied, especially in the fields of medical knowledge and social sciences. According to the Catalan doctor and anthropologist Comelles (1998), health care is an ritual organized by technicians in a complex, sometimes ambivalent, process of mobilizing a series or normalizing tools, ethical and moral procedures and beliefs about disease and political strategies to deal with it, based on power relationships and social roles and spaces.

The principal motivator in seeking care, in the case of drug addicts and in the specific case of crack, is the loss of social ties, clinical problems due to snorting cocaine mixed with solvents, malnutrition and lack of sleep and legal problems or problems with drug dealers. Thus, for the patient, cure is associated with ridding themselves of these uncomfortable symptoms underlying their loyal and pleasurable relationship with the drug. Therefore, the patient wants to be free of the symptom, not of the drug. On the other hand, curing this "illness", from the point of view of professionals, is associated with abstinence, albeit provisory, in other words, the patient's ability to abstain from using the substance which gives them pleasure (Mota, 2009). This expectation is supported by the biomedical model of abstinence which, although controversial, has gained ground in the legal, medical and religious spheres and neutralizes the creation and use of different forms of care – different from pre-defined treatment protocols – during the treatment and after discharge. On the other hand, the meaning drug use and its effects are given by the individual user influences their perception of institutions and demand for treatment. If the use, compulsive or otherwise, s pleasurable, the user will not want to relinquish the enjoyment the drug provides. Thus, when the initial malaise is alleviated and the user feels free from these pitfalls, they deem themselves ready to return to their day-to-day existence, interrupting the treatment process idealized by the health care professional. This decision is individual and dispenses with the opinion of those who think they can control the pleasure of others. From this perspective, the patient does not refuse treatment, as is believed by professionals and managers in drug addiction treatment centers, rather, they feel themselves to be cured of what was bothering them. Thus, there is a mismatch between the two individuals involved in the treatment process; the professional and the patient.

Patients and crackheads: a necessary classification

It can certainly be said that it is an almost unforgivable mistake to determine one single profile for crack patients; it is equally possible to guarantee that the figure of the crackhead presented and created by the media is not totally accurate. Thus, it behooves us not to reinforce stigma attached to certain individuals and social groups.

In research conducted in Belo Horizonte (Sapori and Medeiros, 2011), four types of crack user were identified in the treatment institutions analyzed:

a) The Psychotic: this is a user whose psychiatric profile contains psychosis and who uses crack. In this case, crack may alter and/or worsen the profile, leading to hallucination and paranoia. In moments of crisis, this patient needs to be hospitalized and medicated to stabilize their condition. Post-discharge, they may be followed up in mental health units, on an outpatient basis, by doctors and other health care professionals. At some moments, depending on the patient's delirium, the drug, and especially crack, which can produce paranoia, may aggravate the pre-existing condition, placing the patient and those around them at risk. In this situation, for this particular profile, and only when there is danger to self or others, compulsory hospitalization is recommended. Bearing in mind that hospitalization in public hospitals is for a period of approximately 15 days; after discharge the case may be followed by in substitutive services, such as CAPS AD, CAPS I, II and in outpatient clinics. Whatever the situation, it is essential to maintain the psychotic profile

stable in order to approach the issue of substance use. Extra care is needed, due to the vulnerability of those with mental illness, who can be more easily influenced and/or "used" by dealers and other types of drug users. It is, therefore, essential to analyze their surroundings and the formal and informal networks of relationships.

b) "The marginalized individual disguised as a patient": this is an individual who uses the label of "crackhead" and simulates cravings and/or abstinence to seek/demand hospitalization or treatment in specialist institutions. This is a mechanism manipulated so as to escape from difficult situations, such as being on the run from dealers or from the police, to claim sickness benefit or other benefits or to escape from family pressures. These patients do not adhere to treatment, steal clothes and other personal objects from other patients and attack and threaten employees and other patients, as well as stealing objects they "find" in the care units. It is possible that these "users" make use of their "stay" to bring drugs into the institutions and sell to other patients undergoing treatment. In most of these cases, the family are complicit, and may bring the merchandise or other elements of the "business", acting as intermediaries between the internal and external contexts. In general, this patient makes use of different tools to manipulate impressions (kindness, participation, leadership) or to mark their territory (threats, indiscipline, violence). In general, they do not adhere to treatment, as their interest is in being "certified" as ill in order to distance themselves from critical situations resulting from drug use. They represent a risk to staff, with their constant threats, and to other undergoing treatment.

In these cases, using medication and following up the patient are not recommended and are not efficacious. This is not a subject who should be referred to or cared for in health care institutions, as care teams in hospitals, specialist treatment centers, outpatient and rehabilitation clinics are not equipped with the appropriate mechanisms to deal with this type of patient. It can be said that they are, invariably, cases of personality disorders neither wanting nor needing treatment; they want to "use" health care structures to obtain direct or indirect benefits.

c) The Compulsive Neurotic: this is a compulsive user who may present out of control use of crack and have a profile of cravings. They show lucidity and suffering and are able to analyze the context within which they find themselves, their networks and to recognize the weakening or loss of social, family and emotional ties. Difficulty in controlling their desire, associated with the perceptibility of the situation, increases anxiety, cravings and uncontrolled use. In general, this patient seeks help form family and friends to alleviate their suffering, or spontaneously goes to the health care services. In these cases, a precise and consistent approach on the part of the doctors and other health care professionals is important, whether in teams in health care centers or in rehabilitations centers. International evidence indicates that, in these cases, the combination of the treatment approach, the reception and the medical treatment, especially those that minimize anxiety, are beneficial to these individuals and to the institutions. This approach may vary, constructing moments of distance from social coexistence, as a way of breaking the certainty that they cannot control themselves, following treatment in an open regime, such as the CAPS and outpatient clinics, or admission in a program to reduce harm for the moments when, despite continuing to use, the patient is able to modify their lifestyle, their relationship with the drug, understand risks and harm and rescue their life themselves.

d) The Legal Patient: these users have committed some kind of crime related to drugs, are doing time in a judicial institution and are referred to drug addiction treatment by the judge. This proceeding became more frequent from 2006 onwards, when Law nº 11,343 was passed, especially concerning article 26: "The drug user or addict, serving a custodial sentence or subject to security measures due to committing criminal offence(s) are guaranteed access to health care, defined by the respective penal system"; article 28: "Whoever acquires, possesses, stores, transports or brings with them, for their personal use, drugs which are unauthorized or in breach of legal requirements or regulations, will be subject to the following penalties"; and § 7º: "The judge will request the Authorities to place free access to health care in an appropriate setting,

preferably outpatient, for specialized treatment, at the offender's disposition".

Based on these prerogatives, the judicial authorities understand that the y can refer individuals for treatment, in both hospitals and outpatient clinics, based on their understanding of the case, and even define the length of treatment necessary. In the majority of cases, the judge's clinical "diagnosis" does not correspond with drug addict experts' concept of the case. However, this is legal determination, not discussion of the case. Thus, the health care team are compelled to treat and to consider the referred case as a public health problem and, as such, provide care during the time set by the judge, even when this is not necessary. This procedure disempowers the health care team which, in addition to being deprived of clinical prerogative, have to submit to legal norms which transfer responsibility for a legal case to health care institutions, characterizing the jurisdiction of drug treatment.

Inmates referred may correspond to the psychotic user profile (which is rare), to the compulsive, neurotic user or the marginalized individual disguised as a patient (recurring) and each case merits particular attention.

Users referred for hospitalization, especially those who commit serious offences, are accompanied by security, guarding the door of the ward. The presence of a security guard provokes a bad atmosphere affecting the individuals, the hospital and, especially, the team directly involved in these cases. Moreover, cases of "marginalized individuals disguised as patients" being the most common, the inmate provokes countless problems, not only for the institution but for the professionals and for the other hospitalized patients.

The motivation for referrals made by judges may have been influenced by the inmate, knowing how to interpret the law and having thorough knowledge of symptoms - anxiety, insomnia, carvings. Treatment in health care institutions, even temporarily, enable them to get away from the prison. Knowing this possibility, which carries important secondary benefits, such as more freedom, making their crime appear less serious, and more opportunity to act (especially for dealers), subjects dissimulate and articulate a discourse produced with convincing symptoms of addiction. Finally, being under the auspices of health care provides them with more privileges than prison.

Although four type of patient were identified in the units researched, the treatment they received was identical. In drug addiction treatment institutions, there is no concern with reorganizing treatment practices with the aim of combining knowledge enabling an interdisciplinary reading of peculiarities, motivations, interpretations and symbolic meanings of using drugs and the socio-cultural context in which users find themselves. Thus, scientifically produced knowledge remains archived, or frozen in institutions' libraries, seldom used, even by those responsible for treatment. Part of these studies, especially those which are quantitative, are used to meet political interests and to feedback into negative images of drug users and, currently, crack users, reproducing hegemonic social models.

To conclude

It is possible to state that drug addiction treatment institutions may function as a type of public safety mechanism, receiving a series of functions, hiding others, reproducing an obsolete and uncommitted prohibitionist policy, reinforcing prejudices regarding drug users and triggering coercive and discriminatory measures which do away with citizens' rights. This form of management makes public debate involving not only treatment establishments and their professionals, but also other institutions and civil society, who should have access to correct information with which to make informed and responsible choices, take preventative measures and reduce damage to health and life, unviable.

It is true that crack, like other psychoactive substances, can lead to substance abuse and, in consequence, the user is subject to interventions which are simultaneously legal, political, normative and moral, clinical, religious, social and economic. Although the substance is surrounded by this tangle of issues, it is undeniable that its use cannot be understood without looking at the socio-cultural situation in which the user finds themselves, as it is in this context which he or she organizes the symbolic elements and process of singularization which serve to orient their life, to construct and

deconstruct identity, build a symbolic network of protection, of belonging, of solidarity, with which to create and reinforce cultural ties, to experience and interpret their own experiences, establish rules and norms to care for their own survival.

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