# Open and closed services in the treatment of alcohol and other drugs from the user point of view

## Serviços abertos e fechados no tratamento do abuso de álcool e outras drogas do ponto de vista do(as) usuário(as)

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## Abstract

Deinstitutionalization is meant to rescue the citizenship of people in psychological distress and use of drugs, by using an expanded network of services that provide integral care. This article is aimed at discussing how the treatment modalities offered by mental health services in the formal health network contribute to or prevent the deinstitutionalization process by analyzing integral care. To accomplish this task we used the techniques life history and participant observation. We analyzed the data based on critical and reflective hermeneutic perspectives of the subjects' narratives and daily practices. The results showed that the functioning of closed services is more in tune with the legal-moral and medical models of drug use analysis and more distant from the principles of integrality, fulfilling roles related to social inequalities and the absence of public policies. The Psychosocial Care Center (CAPS) is closer to the psychosocial and socio-cultural models, moving towards an integral health practice. Such results point to the need of future research to deepen the role of these services in the Psychosocial Care Network (RAPS), the increasing dissemination and financing of closed services in Brazil and their effects on the deinstitutionalization of drug users.
**Keywords:** Substance-related disorders; Integrality in health; Deinstitutionalization.

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## Resumo

A desinstitucionalização visa ao resgate da cidadania das pessoas em sofrimento psíquico e usuárias de drogas, usando uma rede ampliada de serviços que propicie o cuidado integral. Este artigo tem como objetivo discutir como as modalidades de tratamento ofertadas pelos serviços de saúde mental da rede formal de saúde contribuem, ou obstaculizam, o processo de desinstitucionalização a partir da análise da integralidade do cuidado. Para tal foram utilizadas as técnicas da história de vida e da observação participante. A análise dos dados se pautou numa perspectiva hermenêutica crítica e reflexiva das narrativas e das práticas cotidianas desses sujeitos. Os resultados apontaram que o funcionamento dos serviços fechados está mais afinado aos modelos jurídico-moral e médico de análise do uso de drogas e mais distante dos princípios da integralidade, cumprindo papéis relacionados às desigualdades sociais e ausência de políticas públicas. Os Centros de Atenção Psicossocial (CAPS) estão mais próximos aos modelos psicossocial e sociocultural, caminhando no sentido de uma prática integral em saúde. Tais resultados apontam para a necessidade de futuras pesquisas que aprofundem a função desses serviços na Rede de Atenção Psicossocial (RAPS), a disseminação e o financiamento crescentes de serviços fechados no Brasil e seus efeitos na desinstitucionalização de usuários(as) de drogas.
**Palavras-chave**: Transtornos Relacionados ao Uso de Substâncias; Integralidade em Saúde; Desinstitucionalização.

## Introduction

Thinking about integral care for users of psychoactive substances (SPA) requires taking into account the enormous complexity of this phenomenon, covering aspects ranging from the history of use of a population and the vulnerabilities that can lead to such use (or arising from it) to the strategies formulated to address issues raised by problematic use. These include health problems, risk of precarious social life and discussions on legal and political issues. Alarcon (2012) uses the term "drug problem" to encompass relationships with drugs from damage to the body to damage related to anti-drug policies.

Until the beginning of the 20th century, the Brazilian government, specifically the health sector, remained away from the "drug problem," and recommendations for admission to psychiatric hospitals have occurred from the 1970s onward. Besides hospitals, psychoactive substance users have also been admitted to private therapeutic communities (TC), which are mostly religious, (Brasil, 2003; Machado; Miranda, 2007; Medeiros, 2018). Users in these institutions have been treated by staying away from their social environment, having as main therapeutic instruments physical and medication restraint and also disciplinary moral or religious practices, aimed at achieving abstinence. Such types of treatment have been questioned, adding to the numerous human rights violations that have occurred within these institutions. Despite the treatment they offer, TCs are growing in number and prominence in Brazilian public policies (Assis; Barreiro; Conceição, 2013).

According to the Brazilian Psychiatric Reform (BRP), the closure of psychiatric hospitals and the implantation of a substitute territorial network would be the most appropriate way to care for people with mental disorders and who are alcohol and other drugs users. A movement to change the care model begun to consolidate in Brazil from the enactment of Law No. 10,216/2001, which provides for the protection and rights of people with mental disorders and redirects the care model in mental health (Brasil, 2001), and subsequent ordinances. In 2011, Ordinance 3.088 (Brasil,

2011) was enacted, establishing the Psychosocial Care Network (RAPS), aiming at advancing the formation of an integrated and articulated service network, involving the different levels of the Brazilian National Health System (SUS).

In view of the variety and confrontation between types of care for people with problematic use of drugs in Brazil, it is of utmost importance to build and expand knowledge on changes in these types of cares and how they have materialized in the concrete trajectory of the affected people. To achieve this goal, we focused on the concept of integral healthcare, understanding that the more this principle is reached in concrete practice, the greater is the possibility that, through it, the individual's needs arising from multiple dimensions of life - such as the biological, psychic, social, economic, among others, as well as their interconnections - be worked out. These confrontations would expand the possibility of deinstitutionalizing people in problematic drug use.

In this article - which is the result of a master's dissertation on the trajectory of people with history of problematic use of psychoactive substances (PAS) and integral care as an operator for deinstitutionalization in mental health - we discuss how the treatment modalities offered by the formal network of mental health contribute to or obstruct the process of deinstitutionalization, based on the comparison of open and closed services in the experience of PAS users. We resumed the two models of care based on in depth monitoring of users for a long time, using the techniques of life history and participant observation, which allowed us to identify tensions and critical nodes, in addition to a more complex analysis of the care reality as well as the models of care for drug users in concrete practice.

## Models of care for users of psychoactive substances

Brazilian legislation in the field of treatment of drug users started with a law that provided for mandatory internment (Law 891/1938), which was repealed in 1976 and replaced by Law 6,368/1976, which provided for the creation of outpatient treatment services and indicated mandatory internment only for cases deemed necessary (Brasil, 1938, 1976). In the 1980s, specialized reference centers started to offer outpatient care to PAS users and were mostly connected to public universities. In the late 1980s, the epidemic of the human immunodeficiency virus (HIV) emphasized the need to rethink care for this audience, as substance users were considered as "group of risk" at the time.

Brazil started to take a broader look at the PAS use from the arrival of harm reduction as a way of dealing with HIV and, more recently, as a logic to be used with drug users in general (Trigueiros; Haiek, 2006). Harm reduction seeks to diminish health, social or economic damages related to problematic use of drugs. The objective is, in whatever situation the user is in, and regardless of what he says he/she wants to do in relation to his drug use, respect his rights and build alternatives with him/her to improve his quality of life and the community where he lives.

Within the scope of SUS legislation, the first care solutions for users of alcohol and other drugs were the Psychosocial Care Centers for users of alcohol and other drugs (CAPS AD). These centers aim to provide psychosocial care through individual and group care to users and family members, in addition to the development of territorial actions, such as home visits, supervision and training of other health teams and activities that promote the social reintegration of users (Brasil, 2002).

With ordinance 3,088/2011, new solutions appeared as an integral part of this care network, including reception units, mental health beds in general hospitals, Mobile Emergency Service (SAMU), Emergency Care Units (UPA), Basic Units (UBS), community centers and street offices. These solutions must operate under the logic of harm reduction and in an articulated manner, to offer integral attention to the needs of users (Brasil, 2011).

However, professionals and family members of PAS users, as well as the users themselves, have still resorted to the old models of treatment that, despite being questioned from the point of view of the BRP, continue to multiply in Brazilian territory. Even from the point of view of public policies, they are guaranteed a place and funding, such as therapeutic communities that have funding provided both by

the Ministry of Health (MS) since Ordinance No. 3,088 / 2011, and by the Ministry of Justice, through eligibility notices.

The TC emerged as a proposal to reform the traditional psychiatric model in England. Later, from 1960 onward, this type of approach was also used for the treatment of chemical dependency, based on the Alcoholics Anonymous (AA) model combined with other interventions (Brandão; Carvalho, 2016). In Brazil, these institutions are largely based on religious institutions or are built by former users. Most of them operate with the work of pastors, volunteers and former users, in a closed regime and with internments ranging from six to nine months. Their activities are usually of working nature, with a well-defined schedule of agendas and responsibilities. In those with a religious base, moments of prayer are among the treatment activities. Failure to perform activities is subject to punishment and humiliation in some of them. Others follow a model closer to private clinics for the treatment of chemical dependency, counting on a multidisciplinary team (Raupp; Milnitisky-Sapiro, 2008; Sabino; Cazenave, 2005).

The counterpoint that the MS presented to the social demand for residence and treatment of these users was the reception unit (UA). This unit is a point of care that operates 24 hours a day and offers continuous health care and a stay of up to six months in a residential environment. The reception is exclusively defined by the reference CAPS team that is responsible for the elaboration of the user's proper therapeutic project (Brasil, 2012a). However, the pace of implementation of such units in Brazil has been quite slow, as after almost five years of publication of the RAPS ordinance, there are only 60 units enabled in the country.

Nevertheless, the demand for TC and the clamor for the return of long-term internments to hospitals are still present. The motivations and consequences of this are part of a complex spectrum of issues involving political-ideological discussions about the phenomenon of drug use. Some issues about care of PAS users need to be constantly problematized so that its reconstruction is really based on integrality and in tune with the BRP, especially with regard to the emancipation of the subject as the central objective of these new practices.

## Integrality and deinstitutionalization

Regarding integrality, Mattos (2001) points to three major sets of meanings: (1) **desirable attributes of health policies**; (2) **attributes related to the organization of health services**; and, finally, (3) **attributes related to health professionals' good practice**. On **health policies**, the author emphasizes the need for a more comprehensive view of the population to be served, a refusal to isolate problems to be dealt with, as well as the reach of the most diverse groups. In relation to the **organization of health services**, the objective is to broaden the perceptions of the groups' needs and the search for the best way to meet them, without reducing them to their suffering or its prevention, but taking a broader look at possibilities of action and in a dialogical way with the population to be served. Regarding the **good practice of professionals**, Mattos (2001) associates it with the non-reduction of subjects to suffering, a body or a set of risk situations, but an integral look at their needs, with the prudence of not incurring a medicalization of its existence.

In the field of health aimed at problematic users of alcohol and other drugs, integral care has some particularities, because they concern a population largely affected by multiple situations of vulnerability. Often, they are people in very precarious social conditions, many of them on the street, socially marginalized and doubly stigmatized, due to the condition of poverty and the situation of illegality (of those who use illicit drugs). Their personal histories usually add psychological and social suffering, many beginning in childhood and prolonged over years, which also tends to create psychological and emotional vulnerability. The accumulation of low social protection, insufficient social and cultural capital and weakened social ties increases the condition of social vulnerability. Poor living conditions lead to biological vulnerability. This sum of vulnerabilities generates profound health needs that deserve to be answered by a complex and rich network of

equipment and actions, sectoral and intersectoral, formal and informal.

In this sense, another important dimension of integrality concerns intersectorality. This is materialized by the articulation of each health service with other services of a complex network, also formed by institutions from other sectors. It is the integrality of care from a service ("focused integrality"), which is extended to a network of services in order to include other technologies and a range of services necessary to improve quality of life (Cecílio, 2001).

To think about integrality in the context of mental health, Alves and Guljor (2006) propose a reflection on mental health care based on some founding premises. The first is **freedom in denial of isolation**, refusing the need to treat the subject in a closed environment to identify his diagnosis and readjust him to living in society. The second is that of **care based on integrality in denial of selection**, i.e., the look at the subject must be expanded to encompass the different fields of life, and the disease is no longer the central element of care. The third is **to face the problem and social risk, instead of seeking a cure**, based on the nosological model. The complexity of psychological distress and the issues surrounding social risk should guide the therapeutic approach, as opposed to simplifying the diagnosis.

The fourth premise is the **overlap of the concept of right over the notion of repair**. The notion of repair gives technicians the power to choose what is best for the subjects, while the notion of right means expanded care, and the right is strengthened as the subject gains autonomy. The fifth premise is that **the search for autonomy must be carried out respecting the singularity** within a possible margin for each subject, seeking to increase contractual power and the potential for social exchanges. Finally, the authors put as a sixth premise **the permanent incorporation of the role of agent**, i.e., the availability of the team to accompany the subjects in their trajectories without fragmenting their demands or delegating care in an uncompromised way to other services (Alves; Guljor, 2006). Such premises and the meanings of integrality previously mentioned were our guiding principles for the analysis of how the actors and agencies, present in the studied therapeutic itineraries, pointed to integral care processes and aimed at deinstitutionalization.

## Method

This research is part of a larger study entitled *Integrality of care and social reintegration as operators of deinstitutionalization for people with psychological distress and/or abuse of alcohol and other drugs belonging to vulnerable groups*, coordinated by the Center for Interdisciplinary Studies in Mental Health of the Institute of Collective Health at the Federal University of Bahia (Nisam/ISC/UFBA). This "mother research" aimed to analyze trajectories of (de)institutionalization of people with experience of severe psychological distress and abuse of alcohol and other drugs in different socio-cultural contexts, in order to highlight and describe the ways of putting into practice the deinstitutionalization operators: autonomy, integrality and social equity.

As for data collection we combined the techniques of life history and participant observation. According to Minayo (2004), life history includes observation, introspective reports of memories and relevant facts and scripts more or less centered on some theme. This choice allowed us to reconstruct the therapeutic itineraries and analyze how the integrality operator appears in those trajectories, starting from the experiences and meanings attributed by people to their itinerary, participating in their daily lives by means of the tools of participant observation and finally arriving to the analysis of meanings and what they expressed about the way networks, formal or informal, contributed to the deinstitutionalization process.

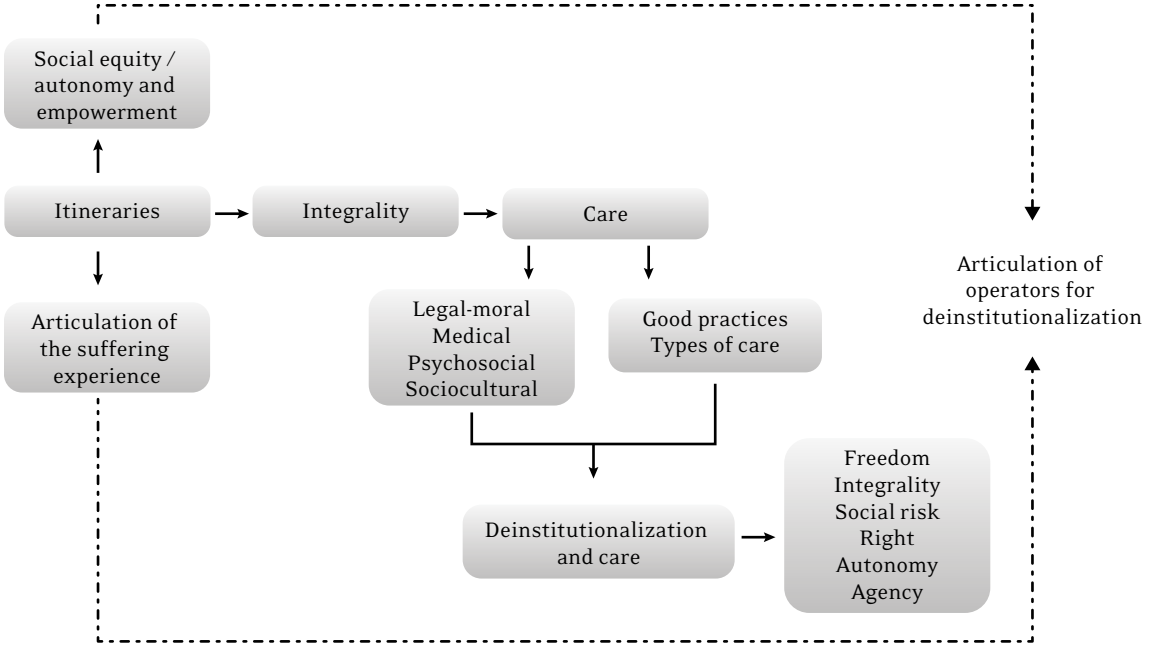
In this research we analyzed four in-depth cases in the city of Salvador, chosen according to the following criteria: (1) being over 18 years of age; (2) having already experienced at least one psychiatric internment in a TC or private clinic in life, for at least six uninterrupted months or three internments within two years; and (3) having experience of problematic drug use (Nunes et. al., 2014). As the objective was to observe how aspects of integrality were involved in the deinstitutionalization process,

we chose people who, in addition to having already undergone internments, at that moment in their trajectories had already interrupted the "revolving door" cycle (frequent readmissions in a short period of time). We also chose people with different genders (two men and two women) and from different social classes (two people from the middle class and two from the low middle class to vulnerable class). We made no distinctions regarding the drug used: among them one person used alcohol, one used crack, and two used multiple drugs.

We conducted the interviews with four participants due to the methodological strategy used, which emphasizes not the number of subjects, but the depth of the information collected, which required the researcher to spend a long time with each participant until the information was saturated. We carried out an average of six interviews per participant, four with family members and four with professionals indicated by the interviewees as key informants on their life stories. The places where the interviews and observation were performed were a CAPS AD II, a support house for people with acquired immunodeficiency syndrome (AIDS), the interviewees' family homes, an AA headquarters, a general hospital, an Adventist church, a Spiritist center and a cafeteria. All of these spaces and the entire network of services referred to in this work are part of the municipality of Salvador, state of Bahia, Brazil. We conducted the fieldwork from November 2014 to June 2016 and the observation with each person lasted an average of eight months. It is important to note that all the names of users and institutions used in this work are fictitious.

We conducted individual qualitative in-depth interviews of a narrative type during the research. Before conducting the interviews, we elaborated a **guiding topic** that oriented the research process based on: theoretical knowledge on the topic, previous recognition of the field, discussions with other colleagues and the researcher's creativity. We predefined some categories to analyse the contents generated by the narrative interviews and **field diaries**, based on indications of the bibliographic review of the "mother research." We also designed a scheme to assist the analysis based on those categories and the objectives of the work, which is represented in Figure 1.

**Figure 1 – Scheme developed to support the analysis**



We conducted the interpretative analysis of these data from the important contribution of critical hermeneutics to the understanding of the experience. The hermeneutic perspective is based on the "dialogic" relationship and the "fusion of horizons" as conditions of knowledge. In this sense, there is interpenetration between the cultural horizons of the researcher and the researched, as well as between the researcher and his own theoretical horizon. Scientific objectivism is questioned by this "intersubjectivity" and the "dialogical" relationship that places the observer and observed in distinct semantic fields, but in symmetrical positions. Thus, it is possible to conceive the encounter between the researcher and the researched as a dialogical relationship in which there is a communication of cultural universes that interpenetrate without canceling each other (Costa, 2002). In this sense, we believe this is a potent approach to analyse the collected information in order to achieve, as we have already said, the meaning that these subjects attribute to their use of substances and how they walk the paths in search of care within their sociocultural reality.

We followed the resolution of the National Health Council (CNS) No. 466, of December 12, 2012 (Brasil, 2012b), which defines the guidelines and regulatory standards for research involving human beings. This research was submitted to an ethics committee and approved with opinion number 023-12-CEP-ISC.

## Psychosocial Attention Centers from the user's point of view

When narrating their therapeutic itineraries, our interlocutors highlighted the performance of CAPS, bringing positive aspects and contribution of this service to the integrality and the deinstitutionalization process, but they also punctuated criticisms to its mode of operation, which prevent the process of deinstitutionalization.

Among the aspects considered to be positive are the presence of welcoming activities that provide the bond; actions related to the territory, such as articulation of the intersectorial network, home visits and institutional visits; joint construction of the therapeutic project, characterized by the centrality of the user and his/her freedom; monitoring by technician or reference team; family care; intensification of care in times of crisis or greater vulnerability; presence of actions consistent with the harm reduction logic; presence of integrative and complementary practices; activities that denote the presence of teamwork; and the interruption of the internment cycle. We can observe such aspects in some of the following interview excerpts:

> *But I had a lot of support at that time. I had the support of Carla, of Elisa, I had the support of the entire CAPS. Thus CAPS was crucial, also to my treatment and recovery process.* [...] *It was more than three years. I was before at Nova Vida, Casa da Harmonia, Renascer, Integral, until I arrived at CAPS and it all ended, because when I arrived at CAPS, I had asked to be hospitalized, yes, at CAPS, that's where I've deconditioned myself, because I was conditioned, because I was conditioned. In the end, I found that I couldn't stand living in my house.* (Alma)

> *And it was so interesting ... I felt welcomed by CAPS.* [...] *"How are you, Mara?! You've been gone!". I was away for many days because of the drugs, right? I were using crack. But I felt that need to go, to talk and relax.* (Mara)

> Matias: *Then I continue, I start the treatment at CAPS again, as I'm doing now, ok?* [...] *Yeah, I spent some time without going to CAPS, without the service of Dr. Raul, from the dream group, I gave up, and now I'm returning again. The CAPS never left me ...*
>
> Matias' mother: *Never.*
>
> Matias: [...] *I abandoned CAPS, but CAPS never abandoned me.*

> *I don't know if I come here to run around the bottom of CAPS, escorting you to give me strength, as you already gave me a lot of strength, and you know that almost everyone here is my family, and I have my treatment.* (Agnaldo)

In addition to the positive aspects, they also made criticisms to the services provided by CAPS. They are related to aspects such as the technical capacity of the professionals, the quality of group activities offered, the occurrence of drug use within the services, the inability to offer a geographical distance from drugs, the lack of some medications or problems with their replacement and treatment sometimes centered on drug therapy.

> Researcher: *Is it the medicine you didn't find in* CAPS [CAPS AD]?
>
> Matias' mother: *Yeah, when there's no medicine there, understand? Because there is all the medicines at CAPS, but when it doesn't, the docs give me a prescription to buy them, right? When there is medicine here I bring them [home]. But as they don't have this one, they give me a prescription to buy it.*

> *Ah, it was terrible* [CAPS II]*, and ... some therapies were absent there. It was very precarious. But there were some things, like sewing workshops, and some gossip too. I remember there was a man attending such workshops. And there were other workshops too, a group that used to get together I don't know what for. But they got together as a group. Other than that, the doctor got there, but didn't even look at us. She... Dr. Sinara used to prescribe medicines but she didn't even look at us, she didn't ask how we were doing ... there was no such patient and doctor thing. It was a mechanical thing ... just to compose her resume.* (Mara)

> *Yes, and things seem to be declining here at CAPS* [CAPS AD]*, keep on declining. There were good times when CAPS was rising, but, now things are just declining.* [...] *Here at CAPS I have been... I think since 2011 I have been here at CAPS, but I have come and gone. No psychologist worked my problems out here at CAPS.* (Matias)

According to the interlocutors, what differentiated CAPS from other services are the bonds created between them and the service, and how they position it as an important agent with respect to changes in their usage patterns, support at decisive moments of their trajectories and the possibility of interrupting the internment cycle. Such possibility of interruption, added to the potential for psychosocial rehabilitation, also present in the subjects' discourses, draws attention to the institution's role in integral care and deinstitutionalization. Such recognition of CAPS role is in line with the previously brought Alves and Guljor (2006)' premises, which concerns integrality in mental health regarding especially treatment in freedom and the important role of agency of CAPS teams. Such teams, by means of the bonds created, can accompany the subjects in their trajectories, without fragmenting their demands or delegating care in an uncommitted way to other services.

CAPS aims to provide psychosocial attention to users and their relatives by means of individual and group attendances and develop territorial actions, working with the logic of harm reduction and offering integral care and promoting the social reintegration of users (Brasil, 2002, 2011). In this regard, narratives showed us that the assistance in this service works as an enabler of deinstitutionalization processes as an integrated care, even though it is still criticized by users.

These criticisms are related to some difficulties encountered by the CAPS service in realization its activities. The first concerns the precariousness of the institution configuration: the hiring of low technically qualified professionals, the absence of inputs and materials and the poverty of the activities offered. Ramminger and Brito (2012) emphasize how the discrepancy between academic training in relation to the demands of CAPS services, added to the lack of conditions and fundamental means for carrying out activities results in professionals in "exacerbated use of themselves," demanding them an inventiveness that over time exhausts the workers and weakens assistance.

The second difficulty regards the service's own logic, i.e., operating open doors within the user's territory according to the harm reduction logic. Such context fosters the need of discussion and construction of a different orientation for the services aimed at drug users. Such construction is accompanied by many hindrances, which have been translated by interlocutors' complaints as the use of

drugs within the services and the impossibility of keeping geographic distance from the area of use, as in the case of professionals reporting the enormous challenge in managing such situations. These occurrences point to a difficulty in constructing such new logic in concomitance with the maintenance of asylum practices (Assis; Barreiro; Conceição, 2013; Schneider; Lima, 2011).

> *Here* [CAPS AD] *I see a lot of people who... I don't know! I go... I come back here, I find a partner, you know, 70 years old, he takes medicine here with me, when we're leaving he says "so, are you going to get crack?", "I'm going, I'm going, let's go down here," then the 70 year old guy start smoking stone! He comes here to get the medicine and go smoke stone! Or takes the medicine and go drink!* [...] *And here you see people who are fucked up and the guy comes here to get medicine and will fuck himself even more. But there* [AA] *I see people who are looking for life, who want to live, people who are 20, 29, 30 years old all clean, ... here the guy can't spend a week clean.* (Matias)

> *A mother who never managed to make it right?! So she* [Alma] *said: "I always did everything I wanted. Nobody ever stopped me." And then, when she starts to get closer to me, she starts asking me for an edge, right? So she takes it* [alcoholic drink] *and then ... I don't say anything, because it's the first time I see it and I say nothing, because I didn't know what to do. Then, on Monday, I decide that it needs to be said. Then, on Monday, she takes it again... and we talk about it and we agree that, at least while she is in the room not to drink, if possible. That it would be cool if it was possible for her to keep that pact.* (CAPS AD III psychologist)

Nowlis (1975) refers to four models of understanding about the phenomenon of psychoactive substance use: (1) the legal-moral; (2) the medical; (3) the psychosocial; and (4) sociocultural. The legal-moral model leads to so-called educational, preventive and repressive measures. The medical or public health believes that the addict, as a subject sick with the drug, needs treatment or cure. The psychosocial takes into account that the drug has a role in the subject's life and that the relationship with it is crossed by the social context where it is inserted. And in the sociocultural model, this context is the central point of analysis and the changes in the way society sees such use and the social determinants involving it would be the most effective way to deal with problematic drug use. Thus, there remains the challenge for the CAPS to cross from the asylum practices, based on a legal-moral and medical view of drug use, to strategies based on psychosocial and sociocultural models. Working with anti-asylum and harm reduction logic requires this crossing. What the narratives of this research indicate is that this passage is ongoing, but users and professionals reflect in their actions the contemporary social conflict surrounding the complex phenomenon of the PAS use.

## Inpatient units

Three types of services destined to the internment of PAS users appeared in the narratives: (1) the private clinic (PC); (2) the TC; and (3) the psychiatric hospital (PH). Our interlocutors positively evaluated some aspects and criticized others of such services.

Among the positively evaluated aspects, there was the possibility of keeping geographic distance from the use environment; the possibility of reflecting on life and drug use; the learning of new social skills related to work, religion, the use of PAS and art; and the "rest" from the deadly use in an environment that allows for a more comfortable routine than that found in family and social environment. The following excerpts that bring examples of this assessment:

> Researcher: *Why do you love work so much?*

> Agnaldo: *Wow! I don't know where it came from inside me, because it was something that opened my eyes, you know? As I told you, back at the recovery center, this was also a blessing that I have never seen in my life.* [...] *I learned the job and also learned to like the job, for is from work that things come from, understand?*

> [...] *Since I came to the recovery clinic* [PC]*, I didn't want another life, because I had a balanced diet, I*

*had food on the table at the right time, I had a room, which, depending on the clinic, was only for me.* [...] *When I left it in the morning, the girl went and cleaned it. I went for those treatments there, to the pool to do my exercises, so what else did I want? And without the world to agonize me, I wanted more of life, right?!* (Alma)

*It was a good time, because I was very skinny, very bad, so I started to eat. I was in abstinence, wanted to use drugs, so I ate too much, too much. And the food is good there* [PH]*, good and in large quantities and everything is very tasty.* (Mara)

*So, yeah... I did a lot of theater in there* [PC]*, because I had a relationship with the guy who was an art-therapist there, very cool! That made me change my focus in relation to what I saw in art, he was showing me things as if I were in the clear part of art, the positive part of art.* [...] *I saw the other side, the softer thing, and I did a lot of theater there.* (Matias)

Our interlocutors also pointed out some aspects seen as negative regarding these services, such as a feeling of isolation and abandonment; treatment centered on the medication (in the case of PHs) or with the prohibition of medication (in TCs); hostile, violent environment (physical and psychological violence) and under constant surveillance; precarious physical structure; imposition of belief and religious activities (in TCs); dull, repetitive and alienating routine; strict rules and authoritarianism; exploitation of labor for work; and low resolution rate in relation to compulsion to use SPA. Some of these aspects are exemplified in the following narratives:

*I looked at her like this* [pastor of the therapeutic community]: *"My God, are you a Christian? Really? A bishop, a pastor?* [...] *Do you have the courage to call us a slut, a marginal, a drug addict? It has no conditions! We are here treating ourselves, trying to get clean... "; "You are a very daring nigger. You have to respect me"; "I don't have to respect you. You have to respect me too. I am paying. I'm working for free here, doing everything for you. I fast, I pray and do everything. I strive for my well-being. Who likes me is me and my family. You like no one."* (Mara)

[...] *There was no snack, no good word in the place, and away from relatives. Maybe someone in jail was not as isolated as I was there. There are people who are in jail who have family, right?* (Agnaldo)

*Yes ... right after leaving São Daniel* [PH]*, I relapsed and went to João de Deus* [PH]. [...] *That place was hell, that's where the son cries and the mother doesn't see, it's the end of everything. You know, of all the centers I went to, houses of recovery the São João de Deus is hell, a nightmare. It is as if you arrived at a place in purgatory and on the edge of hell is the São João de Deus.* [...] *I remember that there were beds piled next to each other, people walking around naked, defecating anywhere, it's bad, it's too bad.* (Matias)

*I hear people talking about the clinic* [PC] *as if it were the last bastion. But it is an illusion, as you only delay your recovery, because you start to live in an artificial world. And you think that there, the addict, the drug addict, the compulsive, whatever the name, he has to be in the world because only in the world he'll be able to see how far he can go. I think they are valid in certain circumstances to preserve life, but they these extreme cases, and not what is seen today.* (Alma)

The emerging themes related to places of internment are closely related to the legal-moral and medical models, predominantly, in the criticisms made by our interlocutors, the actions aimed at education of a repressive nature, with the goal of reaching abstinence and the control of compulsion ("cure") according to Nowlis' models (1975). To achieve these goals, each institution uses its own methodology. PCs focus on isolation combined with individual and group therapeutic activities, in a materially comfortable environment. The TCs combine isolation with work and religious activities. PHs add isolation to the predominantly drug treatment.

As shown in the positive evaluations that people made about their experiences in these spaces, such methods can provide some advantages and level of comfort for these people, especially with regard to the gains related to the distance maintained from the substance or their social

environment. However, TCs, for example, appear in the narratives as an often hostile and alienating environment, which is not characterized, to these subjects, as a place of treatment. TCs inspection reports led by the Federal Council of Psychology (CFP) in 2011 and 2018 to show clear evidence of human rights violations in the units inspected. The practices found are based on the trivialization of the rights of interned people through actions such as interception and violation of correspondence, physical violence, punishment, torture, exposure to situations of humiliation, imposition of creed, demand for clinical examinations, intimidation, disrespect regarding sexual orientation, vexing search of family members and violation of privacy, among others (CFP, 2011; CFP et al., 2018).

Such a picture brings us back to the question about the cost-benefit of the isolation in relation to the losses caused by it. The narratives of those followed up lead to a relationship in which the costs become greater than the benefits, especially with regard to the effectiveness in dealing with problematic use in the post-internment period, as well as the effect on health when taking the personal history in the long term.

> *This was the second of six internments that I went through. Six, attempts. None of them solved anything. None of them worked be it detoxification, cure, or any kind of liberation.* (Matias)

> *I couldn't get stuck, that closed place, that thing. I couldn't see my family, it was a distant place, far from home, it was in the countryside...* [...] *But then I went and I couldn't stay for nine months. I stayed seven, because I got depressed there. I wasn't taking any medicine.* [...] *It is not a recovery center that will save anyone. It may get you away from drugs, from the place you live, just. But it doesn't get anything out of your head.* (Mara)

> *I think I wasted some time [internment time] that I could be investing in myself, in my profession, because they didn't have a practical effect in my life, they didn't, I spent three months at Renascer, three months there without drinking; but the day I left, I stopped right at the beach and drunk it all.* [...] *Only, today, I realize that I had losses, because I failed to graduate properly, today, I have difficulties in my profession, because I didn't study at the proper time, as I should have.* (Alma)

Thus, the consequences of institutionalization need to be taken into account when choosing an internment as a form of treatment, especially if this internment is long term. Other issues that are not directly related to health problems due to the problematic use of SPA can have a bearing on this choice, such as social issues, involving high social vulnerability, crime/trafficking or "sweeping" of the circulation spaces of cities. The complexity of the relationship between social vulnerability and drug use poses new questions around these models of care, as they bring to the discussion reflections related to the way Brazilian society has historically dealt with these SPA users, often making mere associations of cause and effect (Assis; Barreiros; Conceição, 2013). In addition, drug use within the most precarious social classes has always received a different look. At the end of the 19th and the beginning of the 20th centuries, the reasons for the prohibition of use were related to a specific social class and population, black and mixed race. The effect of substances was associated with madness and criminality (Trad, 2010).

In recent years, the association of crack use with violence is an example of this. This type of emphasis paved the way for a series of discussions and the emergence of new research on the use of this substance. Some states, such as São Paulo and Rio de Janeiro, have taken actions to "clean" the streets with measures of compulsory internment for users of "Cracklands." Despite all the discussions on human rights led by the BRP, the State often has this type of action legitimized by public opinion, as society claims that these users need treatment, whether they want it or not. There are other intentions hidden behind this discourse: cleaning the streets, increasing the feeling of security, making more invisible what keeps on appearing.

Finally, it is also important to point out the association between the various internments that appear in the trajectories and the phenomenon of the "revolving door." In the transition between the

hospital-centered and psychosocial models, the precarious mental health network, the inadequate functioning of substitute services and the slow and gradual cultural change of society are factors for the continuity of readmissions of people with mental disorders in psychiatric hospitals (Ramos; Guicrises; Enders, 2011). In the case of the use of SPA, there is also an aggravation of issues related to crime and trafficking.

## Conclusions

When we talk about the use of SPA, we are talking about "uncontrolled" desire, the loss of some desires, and fear of contradicting desires. We are constantly in the field of desire. Where the "problem" lives is also where lives the power to deal with it. For Guattari and Rolnik (1996, p. 215), desire could be called as "all forms of will to live, create, love invent another society, another perception of the world, other value systems." This is the desire that can prove itself to be deadly, but still speaks of what moves the subject. Desire is this driving force that society tries to shape and discipline and that it must adapt to a certain social order. What is the measure that differentiates the care that protects and guides this desire for less deadly paths from the other that imprisons and incapacitates the subject?

The intention of controlling SPA users, curing or even banning them, cuts across many of the State's actions and are also at the heart of legal-moral and medical models. So, this way of dealing with desire, which is also in line with the asylum way of dealing with madness (through isolation and control), shows itself as an obstacle with regard to the reach of personal projects and the experience of these wishes. The narratives analyzed point to actions of control, restraint, isolation and violence as actions that have not contributed positively to deinstitutionalization, regardless of where they started from. On the other hand, in terms of formal network services, it was evident that these actions were present, for the most part, in services that worked according to the legal-moral and medical model (TC, PC and PH).

The aforementioned services (TC, PC and PH) presented in the narratives appeared to be far away from the premises presented by Alves and Guljor (2006) as essential for integral mental health care, especially in terms of isolation, search for a cure and exclusion of social issues. In addition they seemed to lack actions related to guaranteeing rights, autonomy and singularity. Conversely, the services more tuned with the psychosocial and socio-cultural models (CAPS) seemed closer to a comprehensive look towards deinstitutionalization, in terms of maintaining the freedom and trying to look at the biopsychosocial dimension of subjects. Also, regarding issues related to social risk, these services can assist in the search for users' rights, because they present some of their professionals as agents of care networks and the Singular Therapeutic Project (PTS). However, we must recognize that such services also presented some flaws and difficulties in their attempt to take a comprehensive view, mainly with regard to the offering of activities aimed at the production of autonomy, as well as in the limits to deal with the great social risk experienced by users.

The findings of this research point to important aspects in terms of the organization of health networks and services and the formulation and implementation of policies aimed at the attention of SPA users. These results reinforce the importance of continuing to discuss the trivialization of internments for these individuals, the political and marketing issues involved in choosing internment as a treatment method and the increasing number of TCs, being even recognized as health services belonging to RAPS. This advance makes us question how to deal with the need that some users have to temporarily stay away from their territory, away from the drug use environment, in a protected space and with an organized routine, in a place that provides them with a "stopover to think."

Such needs presented by these users are mainly related to social issues, such as the difficulty of accessing certain consumer goods, social inequality, structural and intra-family violence and weak social networks. Do the TCs grow because they fill this gap, even with all the criticisms directed at them? Would social needs, confused with clinical problems not be used as a pretext for the isolation and exclusion of drug users? Do open services, as long as they are implemented with nightly reception and in sufficient quantity, as foreseen in the BRP fulfill this function

in a more qualified, effective and inclusive way? Such questions, which were raised by the narratives of our interlocutors point to the need of future research with greater number of users in other parts of Brazil, in order to deepen the knowledge about the function of open and closed services in RAPS, the increasing dissemination and financing of TCs and its effects on the deinstitutionalization process of SPA users.

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## Authors' contribution

The authors have participated equally in all stages of writing the article.

Received: 07/11/2019
Resubmitted: 01/16/2020
Approved: 01/27/2020