

## POLÍTICAS PÚBLICAS E O USUÁRIO DE CRACK EM TRATAMENTO

### PUBLIC POLICIES AND CRACK USER IN TREATMENT

### POLÍTICAS PÚBLICAS Y EL USUARIO DE CRACK EN TRATAMIENTO

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#### RESUMO

**Objetivos:** compreender se as políticas atuais estão em conformidade com as demandas e necessidades dos usuários de *crack*. **Método:** trata-se de um estudo qualitativo, de natureza explicativa. A pesquisa ocorreu em um CAPS ad II e a amostra foi de conveniência. Foram realizadas entrevistas semiestruturadas com a aplicação da análise de conteúdo. **Resultados:** O usuário de *crack* é um indivíduo com demandas de reinserção social, tratamento, angústias e desejos que não encontra na maioria das vezes local ou pessoa, seja ela um profissional da saúde ou família, que lhe acolha. **Conclusão:** as políticas públicas atuais sobre drogas têm avanços significativos, mas ainda não conseguem abranger todas as nuances e complexidade do usuário de *crack* ou de outras drogas.

**Descritores:** Políticas públicas; Cocaína crack; Enfermagem.

#### ABSTRACT

**Objective:** To understand whether current policies are in accordance with the demands and needs of crack users. **Method:** This is a qualitative study of an explanatory nature. The research took place in a CAPS ad II and the sample of convenience. Semi-structured interviews were conducted with the application of content analysis. **Results:** The crack user is an individual with demands for social reintegration, treatment, anxieties and desires that do not find in most of the local times or person, whether a health professional or family that welcome them. **Conclusion:** The current public policies on drugs have significant progress, but still can not cover all the nuances and complexity of crack users or other drugs.

**Descriptors:** Public policy; Cocaine crack; Nursing.

#### RESUMEN

**Objetivo:** Comprender si las políticas actuales están de acuerdo con las demandas y necesidades de los consumidores de crack. **Método:** Se trata de un estudio cualitativo de carácter explicativo. La investigación se llevó a cabo en un anuncio de CAPS II y la muestra fue de conveniencia. Entrevistas semi-estructuradas se llevaron a cabo con la aplicación de análisis de contenido. **Resultados:** El usuario de crack es un individuo con exigencias de reinserción social, tratamiento, ansiedades y deseos que no encuentran en la mayoría de veces lugar o persona, ya sea un profesional de la salud o de la familia que les dan la bienvenida. **Conclusión:** Las políticas públicas actuales sobre drogas tienen avances significativos, pero todavía no pueden cubrir todos los matices y la complejidad de la grieta u otras drogas usuario.

**Descritores:** Políticas públicas; Cocaína crack; Enfermería.

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## INTRODUCTION

It is known that the use of drugs has been inserted in the history of humanity since its beginnings<sup>(1)</sup>. The connection of the human being with the drug changes according to the historical moment experienced. In its early days, it was used as a form of connection between humans and mystical entities. Currently, drug consumption is seen as more of a market good, following the current capitalist logic<sup>(4)</sup>. Public policies focused on this subject are also created and implemented according to the historical-cultural context<sup>(2)</sup>.

It is understood that public policies are a set of collective actions aimed at ensuring the rights of individuals. They must be planned by the public power with the purpose of building society, codifying its norms and rules, dictating how the behavior of a particular people will be<sup>(1)</sup>.

The expansion of drug use is among the various problems faced by the countries in recent years, causing great concern for the society, the media, and the executive branch, and the intervention of the State is necessary<sup>(1)</sup>.

The public policies directed at drug users in the country are recently. Until the 20s, there was no legislation on the subject, beginning in that time, the regularization of drug use with restrictive laws and punishments to users. In 1938, Decree-Law Nº 891 was issued classifying drug use as a compulsory notifiable disease that should be treated in specialized places, such as psychiatric hospitals. Until the 1980s, there were no actions to reduce the supply, prevention or reinsertion of this user. Only in the second half of this decade, with the bankruptcy of the "war on drugs" strategy, the creation of public policies emerged serving drug users and the problem began to be perceived as a public health problem<sup>(2)</sup>.

At the end of the 1980s, a harm reduction movement was started in Santos/SP, initially aimed at the prevention of HIV, STD and hepatitis, with a focus on health promotion, and also extended to other at-risk groups, such as drug users, seeking self-organization of the individual as a first step towards recovery. Thus, this recovery would be characterized by voluntary control of substance use, general improvement of health care and social involvement of the

individual<sup>(7)</sup>, but it was only recognized as a public health strategy in 1994<sup>(2)</sup>.

In 2003, the Ministry of Health policy was launched for comprehensive care for alcohol and other drug users, based on SUS principles and the psychiatric reform. The guidelines for this policy are networking, user participation, the creation of alternative services to psychiatric hospitals, which are the psychosocial care centers (CAPS), bringing the specific CAPS to users of alcohol and other drugs (CAPS-AD), guided by the strategy of harm reduction, prevention, recovery and social reintegration<sup>(5)</sup>.

Even with the advances of public policies, there is still a discrepancy between what is written and what in practice occurs. CAPS are becoming centers focused on the biomedical model, and the gradual increase of therapeutic communities, which is a different treatment strategy than the adopted by CAPS<sup>(4)</sup>.

It is known that crack emerged in the late 1980s in Brazil and today it is the theme of awareness campaigns with specific programs of the government for its combat, being a theme of universal concern by being enigmatic, complex and multidimensional capable of mobilizing society, scholars, the media and even religious<sup>(4)</sup>.

Regarding specific policies on crack, the Ministry of Health launched the comprehensive plan to deal with crack and other drugs in 2010 with a focus on prevention of use, health promotion and risk and harm reduction<sup>(3)</sup>.

The media propagate crack and its users as destructive of social order, increasing stigma and social exclusion<sup>(4)</sup>, making it even more difficult to find treatment and social rehabilitation. The psychosocial care network is not articulated, the number of CAPS ad is insufficient and basic care professionals say they are unprepared for drug user care, having a lag between policy and the real.

Within this context, the user is voiceless and treated as a passive person of interventions imposed by third parties, and within the policies should be an active subject in the decisions of his treatment. This study questioned crack users about the reasons that led to their use, expectations regarding drugs, coping strategies used, and addiction management. With these data, it was intended to understand whether current policies are effective and in compliance

with the demands and needs of drug users, especially crack, the focus of this work.

## METHODS

This research has a qualitative approach focusing on the in-depth understanding of phenomena, whether by observation, description or analysis of the culture of a given context. This is an exploratory study, whose objective is the knowledge of the target population of the study, analyzing its characteristics, problems, and profiles<sup>(6)</sup>.

The theoretical references were Brazilian public policies and cognitive-behavioral therapy, providing relapse prevention, based on the compensatory model in which the individual is not blamed for the use of the drug, but is led to take responsibility for behavior changes. The authors divide the factors that influence the relapse between interpersonal and intrapersonal, analyzed during the interviews of this work<sup>(7)</sup>. The methodological reference used was the functionalism, derivation of social positivism that has the reproduction of the conditions of existence of a group and the capacity to describe this group in its complexity and integrative movements as one of its foundations<sup>(6)</sup>.

The research was carried out in a CAPS ad II of a city in the interior of the state of Minas Gerais, located in the Center-West region. It has 85 396 inhabitants, from December 2013 to February 2014.

As a way of collecting information, a sociocultural questionnaire was used, with closed questions related to the family situation, economic situation, frequency of use of other licit and illicit drugs to obtain the user profile of the place.

A semi-structured interview<sup>(8)</sup> was also conducted through a script composed of two modalities of questions, closed questions, previously standardized to allow the comparison of answers between the participants of the research and open questions allowing the deepening of the themes. During the interview process, other questions were inserted according to the need for greater clarification of the researcher. For the formulation of the questions, the intrapersonal and interpersonal determinants proposed by the theoretical reference were used. All interviews were recorded with the consent of the participant and had an average duration of 20 minutes.

The choice of participants was of convenience, and the inclusion criteria were subjects under treatment in CAPS ad, who report at least one episode of crack relapse, without severe cognitive impairment. The participant should be able to understand the proposed issues and be able to articulate their ideas in sentences and fit the diagnosis of addiction to psychoactive substances by ICD-10.

The number of participants was defined by the principle of data saturation, with 17 interviews conducted, of which 14 were male, with a mean of 36.9 years old. The predominant level of education was complete elementary school. Nine participants reported being single, and the same number claimed to be brown. As for religion, there were the same number of Protestants and Catholics, six each, and nine participants reported having some source of income, ranging from retirement, benefit or employment.

From the interview material, the transcription, reading, and application of the steps foreseen in the content analysis proposed by Bardin<sup>(11)</sup> were carried out. When completed, each interview received an alphanumeric code that ran in the following order: the initials of the respondent's name followed by his age. Each interview was listened to three times by the researcher and then transcribed in its entirety. Afterward, the material was compared to the original audio.

With the transcribed material the content analysis was started, following the steps of pre-analysis, material exploration, and data processing.

All participants read and signed the Informed Consent Term (TCLE). The project was approved by the Research Ethics Committee of the Nursing School of Ribeirão Preto, University of São Paulo (CAAE number 19403913.2.0000.5393).

## RESULTS AND DISCUSSION

The results showed users' expectations regarding crack, the reasons they claimed for the use and the difficulties they faced in controlling it. They also revealed the initiatives to seek treatment, the opinions on the treatment and their adherence. The study reveals the meanders experienced on the way toward abstinence, permeated by relapse and exposure to triggers that can lead to relapse or aid in abstinence.

### Reasons for its use

The reasons for the use of crack that will be presented are linked mainly to emotional states and situations experienced in everyday life. Current public policies are focused on social reintegration and harm reduction, and prevention should be strengthened, especially in basic health care, with family health strategies (ESFs) as the basis for primary prevention. It is necessary to recognize of individuals at risk of use or already in abusive use and the accomplishment of the appropriate referrals and follow-ups<sup>(10)</sup>.

Health-promoting schools are also great opportunities for young people to learn dealing with their feelings, frustrations, and dilemmas, and not to make drug use a way to resolve them<sup>(16)</sup>.

During the participants' reports, it was noticed that the beginning of the use occurred through other psychoactive substances, mainly of marijuana during the adolescence and only after some years the crack was introduced. Other substances previously used or concomitant with crack was not considered to be harmful.

"When I was 15, I used marijuana. Crack is already 20 years that I use. Now I do not know what made me do it." (WLM41)

"While I used only marijuana, I worked there as a technician, but after I had met the crack... it was over [...]" (MRAF33)

This corroborates with another study, showing the early initiation of the use of any psychoactive substance, especially licit ones, as a risk factor for the use of crack and cocaine in adulthood<sup>(17)</sup>. What is perceived in current public policies is the focus on the fight against the use of illicit substances through information campaigns for young people, and in the media and sports there are advertisements encouraging the use of licit substances, especially alcohol, which is counteracting, since the consumption of illicit substances starts with the legal ones<sup>(9)</sup>.

The crack was obtained through sale or attachment of personal property or family, and no participant cited the theft as a way of obtaining the substance. A national study indicates that only 6.4% of the interviewees reported involvement in illegal activities to obtain crack<sup>(12)</sup>. This also is opposite to what is being publicized in the media and by common sense, where crack users are blamed and stigmatized as individuals who should be treated either as a patient or as a criminal, reinforcing existing

prejudice and hindering to host them in the health network<sup>(13)</sup>.

"I did not steal; I bought through work, I never stole anything." (RAS31)

Prostitution appears in this study only linked to the female, reinforcing the vulnerability of this gender. The public policies are based on the needs of men, and it is extremely important that drug programs cover women's specifics, such as sex work, sexual abuse, child care, among others, reducing stigma and disapproval of use due to gender.

"I really prostituted myself." (CGL29)

After the beginning of the use, usually in adolescence, there are the motivators for the continuity, which in this research were pointed out as the situations experienced in the daily life, emotional states, moments of leisure and use of another psychoactive substance.

Since emotional states are the main cause of crack use, one study reports that 36% of people who use drugs are due to emotional problems, such as depression and shyness<sup>(9)</sup>.

"(...) when I was angry with something, I would drink, and when I drank, I wanted to use it too" (RAS31).

"I do not know, anxiety, a fissure! Such an inexplicable thing." (CAGL29)

Regarding the situations experienced, the participants reported the failures as the main triggers of crack use, followed by troubled marital relationships, and idleness (not having anything to do) was mentioned as a trigger for use. Research indicates that, for 29.15% of users, family problems or affective losses motivated them to use drugs, and dysfunctional relationships and constant couple fights<sup>(12)</sup>.

"The father of my children used it, then I went to try to help him and I could not, I felt like a failure. Then I started to use it too." (CAGL29)

"I use it because I had nothing to do." (VAG52)

Another motivator for the use of crack reported by the participants was related to moments of pleasure, is the companies and the moments of extroversion mentioned, as well as the use of alcoholic beverages.

"The drug was not the problem, I used it in small doses, but when I started to involve the drug with sex, party, binge and adrenaline, that was the problem." (HJM47)

"For me, the drink and the drug are a combination, when I drank I wanted to use the drug, and when I used the drug, it made me want

to drink. Then I drank too much and used drugs.” (RAS31)

These motivators could be more approached through drug prevention from the secretary of special projects of the Ministry of Education, focusing on affective education as a form of health promotion, with appropriate techniques developing self-esteem, the ability to deal with frustrations and anxieties, as well as resisting the pressures of friends and the community, encouraging care for health and well-being in general<sup>(9)</sup>.

### **Expectations regarding the use of psychoactive substances**

Adolescence is a time of discovery and many young people use the drug for curiosity or even for the expectation of new experiences and feelings, so public drug campaigns should not only address non-use but be informative, positive and negative effects of use in a critical and scientific way<sup>(20)</sup>.

How can one speak of life without drugs or in the improvement of the quality of life for individuals who often do not have minimal conditions for housing, education, basic sanitation or security? Individuals with no palpable goals can make drug use an alternative. Thus, the State must provide the minimum conditions of quality of life for individuals<sup>(20)</sup>.

When a person experiences the drug, they expect to achieve something, such as a state of pleasure or withdrawal or even a way of coping with situations considered unbearable<sup>(7)</sup>. The main expectation cited was being able to deal with events, such as loss and feeling of incapacity before uncontrollable events. This finding corroborates a study that points out the difficulties of drug users in dealing with frustrations, losses, and conflicts, so drugs become a means of dealing with unsupported reality<sup>(17)</sup>.

“Uai, I lost my fiancé, and I wanted to die. I went into the crack because I wanted to die.” (FAG35)

Hence the importance of governmental programs based on harm reduction aiming at the empowerment of this user about their health and choices, and when they feel welcomed and supported, consumption is reduced, and health production is generated<sup>(13)</sup>.

The idea of not being “addicted” and the use was just out of curiosity was also present in

the study, agreeing with another that indicates that on average 63% of drug users reported having started using by curiosity<sup>(18)</sup>.

“Curiosity to know how it is and such, but in fact, it was a false escape, for me, it is an escape, nowadays I see.” (MAL45)

Information on drugs is of extreme importance, but citing only the negative effects of use, denying its benefits, is not a productive approach, since many experiments for an act of affront to society or even to test their limits, so the importance of scientific information, without stigmata, that mainly lead young people to reflect on their choices, developing their critical thinking.

The specific use for leisure and facilitating the interpersonal contact was mentioned in the study, the drug as something that socializes making the person belong to some place<sup>(17)</sup>.

The use of drugs has always been linked to civilization as a form of socialization, treating the use only as judicial or medical is reducing the human being behind the use, promoting the loss of the individuality of this subject<sup>(14)</sup>.

“Pleasure. As said by the Dalai Lama that there are people who talk... confused saying that using drugs is incoherent, a lie! Using drugs is consistent with your goals if your goal is to have fleeting and inconsequential pleasures the drug is logical... if you want to improve your life, have a social life and build a solid family, no! It depends on your goals, my goals at the time was to have fleeting pleasures...” (HJM47)

One participant mentioned that drug use would be related to “Personality error” because of some patients' belief that drug use would be due to personality, being something related to character, also mentioned in another study<sup>(17)</sup>.

“We use the drug by personality error.” (WEN28)

This perspective also appears in some programs of recovery, mainly of a religious nature, such as those adopted in some therapeutic communities, which use the moral model of treatment, based on Christian morality that the individual can change if he has willpower and “moral fiber”; If he fails, “failure” would be due to an internal error<sup>(15)</sup>. This shows that the Brazilian model is antagonistic because, at the same time as the policy of harm reduction, with CAPS as a model, the therapeutic communities are based on the policy of total abstinence coexist<sup>(14)</sup>.

### **Dependency management (dealing with dependency)**

Regarding dependency management, the country has two coexisting treatment strategies, based on harm reduction and total abstinence. The strategy adopted by the therapeutic communities is of total abstinence, in which one sees the treatment of behavior, the focus on the medical model, centered on the case studies and the medicalization, often disregarding the social context of the individual and the meaning that he uses drugs<sup>(4)</sup>.

CAPS ad are out-of-hospital services with a harm reduction strategy and should be articulated to the rest of the psychosocial care network (RAPS). Primary healthcare (APS) should be the center of care, where the user must be welcomed and monitored, and should be referred to the CAPS ad only when APS care strategies are insufficient or ineffective<sup>(10)</sup>.

Regarding self-efficacy, that is, the individual's confidence in dealing with an event<sup>(7)</sup>, the participants mentioned the difficulties in remaining abstinent or controlled, and the fissure is seen as the biggest obstacle, connection of the fissure with something organic, which would be in the blood.

"I can not tell you, it is an inexplicable will... inexplicable... it is a will... it looks like it is in the blood. A terrible will to use." (FAG35)

The relapse was cited by participants as recurrent. The periods of seclusion in therapeutic communities were moments of abstinence, but shortly after leaving these sites relapse occurred, a fact corroborated by a study when reporting that, after long periods of seclusion, relapse is a predominant factor<sup>(17)</sup>.

"I held on for eight years when I stayed on a Catholic farm, then I went back and went to an evangelical farm and stayed there for about six months. Now I relapsed, from March to here I had a relapse, I came back in double." (RCR54)

The correct thing would be that, after this period of seclusion for treatment, these patients were reinserted in the community and welcomed by primary health care for continuity of follow-up, avoiding relapses occurring so recurrently and without the support of a team.

Ignorance of the problem also appeared in one participant's speech. Disinformation or even failure to acknowledge and accept the damages resulting from use hampers the control process<sup>(17)</sup>.

"As long as you do not recognize that you are a drug sufferer, that this is a disease, you have justification to use it, while I did not realize that I was a dependent drug, a dependent one, I could not stop." (MAL45)

The fear of the return to the use existed in the participants, also present in studies on the subject, referring that individuals who use drugs<sup>(7)</sup> have many uncertainties and fears when they are asked if they will be able to cross the barriers of the use<sup>(9)</sup>. Therefore, it is important to strengthen the psychosocial network so an integral care of the individual can occur, strengthening ties with society and giving it a social role<sup>(16)</sup>.

"No, I do not feel totally empowered, no. Because I can relapse." (CAGL29)

"I'm very afraid, but I'm going to be strong, I want to be strong." (FAG35)

On the expectation of control, one participant linked the fact of the control of the use of the change of perspective and goals of life, another one reported not feeling more will, being able to lead a life away from the drugs and a third spoke of the benefit of being attending a religion and to have plans.

"If your goal diverges with the drug, you're going to pull away. In fact, you have to treat the cause, which is the lack of goals... I have always had power; I just had no interest." (HJM47)

### **Coping Strategies**

The coping strategies include the resources used by the individual to overcome situations considered as high risk<sup>(7)</sup>. When trying not to use crack or when leaving long periods of hospitalization, the users need a re-signification of their social and individual role. For this, it is necessary that the family in which this person is inserted is in follow-up to help in this process of change, monitoring the individual for primary care and, if necessary, CAPS ad.

In this study, the most reported strategy was to seek an occupation, since abstinence causes a sense of emptiness related to the lack of significance and hope in the future<sup>(19)</sup>. The programs of income generation and reinsertion of the user in society are primordial in this sense. CAPS ad should be kept closer to the other sites of the psychosocial network to facilitate this user exchange, since otherwise the user may be chronicled in the CAPS ad at risk of manicomialization<sup>(16)</sup>.

"I have to sit around with my head all the time." (RAS31)

Another fact cited as a strategy was to want to change, to be ready for a change.

“Now, not before. Before I did not want to, so I had not stopped. The people was pushing me, forced me. The first time I stopped, I did not want to stop. When I joined the “half of the world,” the whole world came together and was inspired to admit me, I did not want to stop, it does not stop, and several people I know had motivation, they all came back...” (HJM47)

They also had the categories: Attending the group; The use of other psychoactive substances (SPA); Attachment to religious belief; Use of medication; and Stay at home.

In the category Attending the group, participants cited CAPS and anonymous narcotics.

“It's good here, the treatment is good. [...] I've been running around for about six months, and I came here.” (VAG52)

CAPS ad (quoted by only two participants) was expected to be more widely used as a means of coping and seen as a strategic location for those who attend it, which did not occur, and there are no indications there is the question of social stigma, since it is a specialized service in alcohol and drugs, with great visibility to society<sup>(4,17)</sup>. Coming to CAPS ad appeared less often in the participants' speeches as coping strategy than marijuana used as a tranquilizer. This substance was also mentioned for the same purpose in a study that highlights the use not only of marijuana but of alcohol as strategies used by users of crack<sup>(19)</sup>.

“When I want to smoke crack I smoke marijuana, then I stop and stay calm, I'm calm.” (RCR54)

Attending a religious group, “having Faith” in something, was also seen as a facilitator in the process of not using drugs. It should be noted that these religious groups have a similar role to those of self-help.

“I go to the church, I pray, to the Lord.” (GDR49)

Other studies corroborate this item by citing religion as a predominant coping strategy<sup>(17)</sup>. Religions, as well as self-help groups, often replace the gaps left by public agencies, with NGOs appearing more prominently in certain cities than government treatment places.

Diverting from SPA sale and friends of use also appeared as a strategy in this research. The withdrawal of the subject from the social and physical environment that can make him

remember the use or even cause him to consume is fundamental to the recovery process<sup>(19)</sup>.

“Before I came here on the farm and I would go there at the place to look for it, but there is already a month that I am going around, changing sides to avoid contact, not going there.” (FAG35).

The data presented demonstrate a fragility of the public policies regarding the integral follow-up of these users. Often, these users and their families seek CAPS-AD only in times of crisis and follow-up is not performed after discharge, so patients are left unattended in primary health care. Also, it would be necessary for the psychosocial care network to be able to absorb these users, effectively achieving their reintegration into society, but the network is still fragile and fragmented, based on isolated and individual actions of some professionals who work in it.

## CONCLUSION

When giving voice to the crack user, a wealth of information that Brazilian public policies can not cover are seen. The individual who uses crack should not be linked only to the use of the drug; it is of the utmost importance to be perceived in his entirety. The current public policies have already advanced a lot in perceiving the drug user as a political being, but there are still gaps in the care practice.

CAPS ad is still very isolated from the rest of the psychosocial network, mainly from primary care, and these places and therapeutic communities are considered to be the only places to treat drug addicts, and users do not achieve a social role different from that of “dependence”. As for the gender, specific public policies for women who use drugs are urgently needed and they were welcomed in their health units.

Health professionals, especially nurses who are at the forefront of care in primary care, need to appropriate more on the issue, not just refer patients to specialized centers. It is important that they prevent and promote health with their population by identifying families and individuals at risk or drug abuse.

Finally, public policies should be able to recognize crack users and other drugs as a being of rights and desires, which made drug use a way of expressing themselves. It is up to the public and professional policies involved in dealing with users to learn to understand what they wish to express.

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