

## The discourse change in drugs users or addicts care: critical discourse analysis of a federal Act

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**Abstract** *Brazilian drug policies have undergone changes over time, bearing marks for each historical period and experienced sanitary-political interests. Nowadays, an anti-reformist character was perceived in changes concentrated on Law no. 13,840, of June 5, 2019. The aim of this study is to analyze the key elements of a normative document on drugs based on the Critical Discourse Analysis. We analyzed the Law no. 13,840 using Fairclough's method for three-dimensional analysis and then discussed it with Foucault's notions of Biopower and Biopolitics. We consider that the emphasis on involuntary hospitalization, therapeutic communities and abstinence opposes the Brazilian psychiatric reform movement. The development of oppressive care practices are hidden by the so-called ideological neutrality and scientific evidence.*

**Key words** *Public policy, Substance-related disorders, Mental health*

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## Introduction

This paper aims to analyze the relational and ideational identity functions of the discourse of the Law No. 13.840/2019, which amended Law No. 11.343 of August 23, 2006 to refer to the National System of Public Policies on Drugs.

Until today, the ideological tensions, contradictions and power disputes that marked the normative documents which govern public policies on drugs have brought them closer to the paradigm of disciplinary control<sup>1-6</sup>. The association between legal and psychiatric knowledge in policy documents, for example, reveals the influence of Brazil's adherence to the International Opium Conference in the early 20th century, which culminated in the standardization of compulsory treatment in mental asylums<sup>3,7</sup>. The documents mentioned are the Decree No. 14.969 of September 3, 1921, which approved the creation of a sanatorium for "drug addicts", and the Decree No. 891 of November 25, 1938, which characterized "drug addiction" as a disease of compulsory notification, restricting the treatment to the inpatient regime<sup>3</sup>.

The gaps in care for people with needs by the use of alcohol and other drugs were filled by medical associations guided by a hygienist paradigm<sup>8</sup>, which replicated treatments based on hospitalization, social isolation and therapeutic work<sup>9</sup>. The derogatory representation of alcohol and drug users as degenerate or deviant permeated Brazilian psychiatry in the first decades of the 20th century and remained as a socially hegemonic imagery in the 21st century<sup>10</sup>.

The asylum is understood as a locus of power and psychiatric knowledge<sup>11</sup>. However, the body is relegated to the background in the history of psychiatry due to the difficulty in justifying "mental illness" based on organic causes<sup>12</sup>. Thus, psychiatry takes as its object of power elements of everyday life and subjectivity - such as will, insomnia, passions, sadness, conflicts and behaviors - demarcating borders between normality and deviation, legitimizing pathologization under the premise of scientific knowledge<sup>12-14</sup>.

When this conception is combined with the theory of degeneracy<sup>11,14</sup>, understanding deviation as a hereditary threat, the deviant subject is segregated from the subjects and their rights, with the objective of restricting the dissemination of the so-called degenerates. Therefore, psychiatric knowledge does not focus only on the individual, but on populations, in view of the survival of some at the expense of others. It thus assumes contours of biopower and biopolitics<sup>14-16</sup>.

The ideological reorganization contextualized in the period of redemocratization culminated in the questioning of the hygienist paradigm and in the leverage of the Psychiatric Reform Movement in Brazil (PRMB). The change in the way of conceiving mental health care in Brazil is reflected in legislation at the beginning of the 20th century under the Law No. 10.216/2001<sup>17</sup>, a milestone in the achievement of the PRMB and the Anti-Asylum Movement (AAM)<sup>18</sup>. It then occurs the transition from the asylum model to the psychosocial model<sup>19</sup> with the successive expansion and capillarization of substitute services, such as the Psychosocial Care Centers (CAPS), succeeded by the reduction in the number of hospital admissions<sup>18,20,21</sup>.

Regarding drug policies, the changes in the federal government in 2002 made room for the Harm Reduction<sup>22</sup> (HR) perspective, included in normative documents from 2004 to 2011<sup>23-29</sup>. However, the pressure for changes in drug policy also mobilized sectors aligned with the biomedical and legal-criminal models, culminating in paradoxes found in normative documents from 2000 to 2016<sup>4,30</sup>. In this context, the anti-reform movement gets stronger from 2010 onwards and becomes more explicit from 2017 onwards, culminating in the pre-eminence of sectors aligned with the remanicomialization of mental health in Brazil at the federal level in the current situation<sup>2</sup>.

In face of this scenario, this study aims to analyze the key elements evidenced from the study of the Law No. 13.840/2019 from the perspective of the Critical Discourse Analysis.

## Methodology

This is a documentary research<sup>31</sup> with a qualitative approach, which starts from the premise that the discourse presents a dialectical relationship with the social structure<sup>32</sup>. In this way, the discourse is influenced by the social structure as it also builds it, being able to reproduce or transform it<sup>33,34</sup>. Thus, it can be understood that drug policies and conceptions about drug use are constructed from discourses that encompass complex mechanisms of power relations and ideological clashes, from which emerges the hegemony of certain discourses on other positions of resistance.

Drug use itself can be considered a socio-historical phenomenon, with implications for politics, the economy and health, as well as the different aspects of prohibitionism<sup>35-37</sup>. Similarly, the therapeutic perspectives for people with needs by

the use of alcohol and other drugs are also historical-social constructions, permeated by moralistic, judicializing, medicalizing, asylum-related, prohibitionist, anti-prohibitionist and psychosocial conceptions<sup>3,8-10,22,30,38-43</sup>.

We have chosen to analyze Law No. 13.840 because it changes several provisions of other drug policies in a context of change in the national political scenario. Furthermore, it inserts provisions that express a discontinuity in the scope of drug policies after the PRMB and AAM. The legal provisions analyzed in this article refer to the treatment of people with needs by the abusive use of alcohol and other drugs.

We start from Fairclough's three-dimensional framework<sup>33</sup>, which belongs to the field of social science and critical research<sup>44</sup> and complies with the Critical Discourse Analysis (CDA) from the understanding of the constructive effect of the discourse, which is shaped by the relations of power and ideologies<sup>45</sup>. For this reason, the discourse is able to build: a) social identities and the position of subjects (identity function); b) social relationships between people (relational function); and c) belief and knowledge systems (ideational function). The dimensions analyzed are the following: text (vocabulary, grammar, cohesion and textual structure); discourse practice (force, coherence and intertextuality); and social practice (ideology and hegemony). There is no fixed procedure for carrying out the analysis, and it is possible that one of the dimensions or categories will be highlighted depending on the discourse genre.

In this study, the Law No. 13.840/2019 was read and the most relevant legal provisions were transcribed for the study of the discourse change incited by the document, namely: clauses 23-A, 23-B and 26-A. The text referring to the legal provisions was transcribed and read exhaustively. The statements were highlighted with different colors, whether they represented a discourse change or not, having as reference the drug policies after the PRMB and MAA. Relevant expressions were also highlighted when representing a discourse change.

The text analysis took into account the meaning of the words and the textual structure, that is, the way the legal provisions were grouped. As noted, several legal provisions analyzed are gathered in the same chapter, whose theme encompasses prevention, care and social reintegration of drug users and dependents.

As for the analysis of the meaning of the words, their use in other drug policies or norma-

tive health documents was taken into account. This continuity in normative documents concerns a characteristic of the discourse practice. We chose to use quotation marks to highlight words and/or expressions cited *ipsi litteris* in the document analyzed, since this is a relevant element for the method of analysis used.

The dimension of the discourse practice involves the production, distribution and consumption mechanisms of the texts, which vary according to the discourse genre of the material analyzed. The categories included in this dimension are force, coherence and intertextuality<sup>33</sup>. We took into consideration the compliance of the Law No. 13.840 with other normative documents that are part of the drug policy, including continuities and ruptures (manifest intertextuality). However, we also sought to identify the veiled relationship between the discourse produced in the document and other discursive orders (interdiscursivity). Thus, it becomes necessary to analyze for whom the devices make sense, with their continuities and ruptures (coherence). Furthermore, the Law No. 13.840 was taken into account as it is a normative document, calls for compliance with its provisions as a rule, and is therefore essentially imperative (force).

The analysis of social practice encompasses the broader dimension of the discourse. We started from the premise that every discourse is ideological, as it produces a way to conceive reality. In this sense, discourses are produced through the negotiation of alliances (hegemony). Thus, the context in which the Law No. 13,840 emerged was taken into account. As it is a normative document, it is subject to approval at different levels, in this case, in the Legislative (Chamber and Senate) and Executive powers (Federal Government). This process takes place in a specific context, including alliances and modifications in view of the approval of the document.

This study does not require approval by the Research Ethics Committee, according to the Resolution CNS/MS No. 466/12, since it does not involve human beings and because the documents used are available in the public domain.

## Results

The textual structure of the Law No. 13,840 gathers the legal provisions which refer to the involuntary hospitalization of "drug addicts", the Individual Care Plan and the "welcoming" in the "Reception Therapeutic Community", re-

spectively, in Sections IV, V and VI of Chapter II of Title III, which addresses the prevention, care and social reintegration of drug users and dependents.

Another element of the text that stands out is the vocabulary. The words used can generate insecurity in the execution of the policy, as they give rise to different interpretations by the players who are in the assistance services, be they managers or professionals.

Item II of paragraph no. 5, Section 23-A, for example, states that involuntary hospitalization “will be indicated after the evaluation of the type of drug used, the pattern of use and in the proven hypothesis of the impossibility of using other therapeutic alternatives provided for in the health care system”. It is stated in the paragraph six of the same section, that “Admission, in any of its modalities, will only be indicated when extra hospital resources prove to be insufficient”. However, how to define precisely what is a “proven hypothesis” that other strategies in the psychosocial care system can be used, or that “extra hospital resources” are insufficient?

It can be considered that the document itself offers an answer to the previous question in item II of Section 23-A by stating that the treatment should “be guided by predefined technical protocols, based on scientific evidence, offering individualized care to the user or dependent of drugs through a preventive approach and, whenever indicated, through ambulatory care”. However, it can be said that this is a rhetorical appropriation of scientific evidence, considering that the document, in general, is opposed to community mental health care practices and acknowledgement of harm reduction strategies.

Section 23-B provides for the Individual Service Plan (ISP), which must be prepared based on a “prior evaluation by a multidisciplinary and multisectoral technical team”. The ISP shall consider “the objectives stated by the patient”; provide for “social integration or professional training activities”; “contemplate the participation of family members or guardians”, through “integration activities and family support” and “forms of family participation for effective compliance with the individual plan”; and establish “specific measures for the patient’s health care”. It is possible to observe successive references to an “individual plan”, “individualized therapeutic project”, “individualized care” or “individualized follow-up”, throughout the sections chosen for this analysis. Thus, it is possible to call into question whether such nomenclature is timely for

the field of health care that advocates territorially-based network care<sup>46</sup>.

The characterization of the ISP, throughout the Law no. 13.840, shows similarities to what is conceived as a Singular Therapeutic Project (STP). A semantic shift can be observed as it seeks to establish a relationship of similarity between the two concepts whereas they are not similar. For this reason, it is necessary to critically ponder on the implicit intention when choosing a term different from the usual one in the literature and in the construction of policies within the scope of the UHS. Therefore, it becomes mandatory to highlight the distinction between a singular care proposition built collectively with the participation of users, professionals and family members, from another that proposes to be individual or individualized<sup>47</sup>.

Still within the scope of vocabulary analysis, Section 26-A, which legislates in relation to “welcoming” in the “Reception Therapeutic Community”, is characterized by a euphemism by using several words to soften the treatment in the Therapeutic Community (TC). Thus, the TC is described as “welcoming”, in which any form of “hospitalization” and “physical isolation” is prohibited, and it is stated that “adherence and permanence” must be voluntary, only with “prior medical evaluation” in a “residential environment” of “welcoming” and “conducive to the formation of bonds” as a “transitory stage”, aiming at “social reintegration”.

The construction of the TC identity is observed as a welcoming environment whose type of assistance provided is different from hospitalization. However, there is a great deal of evidence that refute this representation.<sup>9,48</sup> The care provided by the TC is anchored in a prohibitionist paradigm with emphasis on a moral approach, which reproduces elements of treatment combined with spirituality and individual and/or group psychotherapeutic approaches<sup>9,48</sup>. Many question the effects of TC on the subjectivity of hospitalized people and their ability to achieve their objective: abstinence<sup>49,50</sup>. It is also pointed out the violation of human rights within the TC<sup>51</sup>.

The need for greater inspection, professionalization and scientific research in the TC is acknowledged even in studies that claim that this treatment model is not irreconcilable with public health policies and the assumptions of the PRMB and AAM<sup>41,52</sup>. The literature points out that the expansion of the TCs occurred due to the insufficiency of equipment bound for the UHS to deal with the care of people with needs by the use of

alcohol and other drugs<sup>53,54</sup>. However, it is necessary to analyze this problem from the point of view of power disputes within the scope of drug policies. The investment in TC is already higher than that destined to the expansion of Psychosocial Care Centers for Alcohol and Other Drugs (CAPSad), reversing a recent trend of greater financing of territorial services instead of hospitals focused on mental health<sup>6</sup>.

Although the operational logics of the CAPSad and TCs are different, the characteristics of temporary residential service for people with needs due to use of alcohol and other drugs assigned by Law No. 13.840/2019 to “reception therapeutic communities” are similar to those of the Reception Units proposition<sup>55</sup>. Hence, the division of public resources between similar equipment is a complete nonsense. The practical repercussion of the emphasis on the TC in the document studied is that this still controversial modality will be privileged over a public policy built in line with the PRMB achievements.

As for the discourse practice, considering that the Law No. 13.840 is a normative document that guides the assistance to people with needs by the use of alcohol and other drugs, its provisions have an imperative character which, in turn, generates insecurities regarding its practical effects since it contradicts other documents that are part of the drug policy. Thus, it is convenient to explore the intertextuality of that law with other documents that are part of the drug policy.

The provisions referring to the involuntary hospitalization of “drug addicts”, the Individual Care Plan and the “welcoming” in the “Reception Therapeutic Community” are made up of elements from other drug policies and portray consensus and dissensus. Thus, the description of voluntary and involuntary hospitalization of “drug addicts” is similar to that used in the Psychiatric Reform Law, which provides for the rights of people with mental disorders and modifies the model of mental health care<sup>17</sup>.

However, when compared with the Ordinance No. 2,197<sup>24</sup>, which establishes the *Comprehensive Care Policy for users of alcohol and other drugs* (CCPUAD), it is noted that the maximum length of hospital stay for detoxification increased from 15 days to 90 days in the new document. The interchangeable use between the terms “drug user” and “drug dependent” in the article referring to the reception in TC contrasts with the principle of treating users, abusers, addicts and drug dealers<sup>23</sup> in a different way<sup>23</sup>, which was maintained in a subsequent document<sup>56</sup>.

Furthermore, the STP, previously understood as the central axis of the logic of care<sup>29</sup>, was replaced by the ISP, similarly to what happens between the Reception Units<sup>29,55</sup> as a transitory residential service for people with needs by the use of alcohol and other drugs, and by “welcoming” TCs, and, eventually, abstinence is highlighted as a therapeutic objective over harm reduction<sup>23-29</sup>.

Contradictions in drug policies are not exclusive to the Law No. 13,840. The dispute between the prohibitionist and anti-prohibitionist paradigms had already permeated the construction of drug policies between 2000 and 2016<sup>4</sup>. In addition, there are tensions, for example, between actions taken by the Ministry of Health and the National Department for Drug Policies at the time of the CCPUAD implementation<sup>1</sup>. Thus, the contradictions of the Law 13.840 manifested in its provisions make sense to the opponents of the PRMB and AAM<sup>2</sup> achievements, which reinforce the prohibitionist and asylum paradigm. The discourse constructed in the Law No. 13,840 is aimed at groups that benefit from the emphasis on an outpatient, hospital or TC treatment guided by a prohibitionist paradigm, since the document discourse is coherent for that audience.

The social practice of the studied document consists of a reproduction of forms of domination and control, as it echoes ideological elements aligned with those practices to the detriment of the psychosocial logic, such as involuntary hospitalization and the encouragement of having TCs as an instrument of control and domination<sup>19</sup>. Such resonance only became possible considering the current national political situation since the document was filed with the Chamber as the Bill of Law (BL) No. 7663 in 2010 and sent to the Senate as the House Bill (HB) No. 37 in 2013. Hence, it is understood that the emergence of the Law No. 13.840/2019 became possible in an anti-reform scenario that gained strength from 2010 onwards<sup>2</sup>.

The discursive change as noted in the Law No. 13.840/2019 can be represented as the strengthening of the asylum and prohibitionist paradigm to the detriment of the PRMB and MAA achievements made positive in mental health and drug policies from 2001 onwards<sup>57</sup>. The opening to the logic of HR, especially after the change in the political scenario in 2002<sup>22</sup> and to the psychosocial care model has been constantly sabotaged by the counter-reformist opposition. We can highlight the gradual inclusion of TCs in public policies, the creation of moderate complexity outpatient care teams unrelated to territorial care, the ex-

pansion of funding for TCs and inpatient beds, including in psychiatric hospitals, the registration reduction in Psychosocial Care Centers – Alcohol and Drugs (CAPSad) and the disapproval regarding the HR<sup>2,4-6</sup>. The emphasis on pathologizing and moralizing models to the detriment of the psychosocial one is remarkable.

The Law No. 13.840/2019 emphasizes the treatment of alcohol and drug users in institutions such as hospitals or TCs in order to achieve abstinence at the expense of the CAPSad's community and territorial treatment, the welcoming in Reception Units and the harm reduction under the premise of adopting measures based on scientific evidence instead of ideological and philosophical positions.

### Comments as from Foucault

Considering the identity, relational and ideational functions of discourse<sup>33</sup>, we would like to discuss how power is manifested in the analyzed document, as well as its contribution to the production of knowledge and subjects. Therefore, we start from Foucault's work, which describes different technologies of power that affect the production of knowledge, the disciplining of bodies (disciplinary power), the production of subjectivities (normalization) and life management and population control (biopower)<sup>15,58-60</sup>.

The Law No. 13,840 emphasizes the role of hospitals, through hospitalization, and of TCs, in the treatment of people with needs by the use of alcohol and other drugs. Both institutions are recognized as favorable places for the action of power over the bodies and subjectivity of individuals<sup>11,49,61</sup>. However, the reproduction of psychiatric knowledge is also observed in substitute services after the psychiatric reform<sup>12,62</sup>. In this context, power takes on broader contours and acts on a population which, according to the Foucaultian understanding on the matter, here refers to users of alcohol and other drugs, dependents or non-dependents. It acts, for example, in the pathologization of behaviors categorized as deviant<sup>13,14</sup>, in the removal of homeless people, in the bureaucratization of care and in the segregation of care for people with needs by the use of alcohol and other drugs in specific facilities of the health care network, which contributes to their institutionalization<sup>63</sup>.

The impact of biopower on the population is based on the premise of survival. Hence, life management occurs through the State security devices in view of making live, which entails

a dark side: letting die<sup>15</sup>. This means that some subjects are stripped of their rights and, consequently, excluded because they represent a threat to the survival of others. Thus, from the articulation of biopower with the theory of degeneration<sup>14</sup>, which is relevant to the constitution of psychiatric hospitals as a *locus* of psychiatric knowledge and an instrument of exclusion<sup>11</sup>, it is possible to understand how the Law No. 13.840 favors the discrimination of people with needs by the use of alcohol and other drugs. It is somehow possible to consider that there is discrimination among the people with needs by the use of alcohol and other drugs themselves, making live those who desire and achieve abstinence and letting die those who would benefit from HR.

The provisions of the Law No. 13,840 analyzed here show a discursive shift in opposition to the PRMB. Thus, they interrupt a path constructed in view of the recognition of new subjects, their citizenship and autonomy, instead of being confined to disciplinary institutions or excluded from social life in favor of others<sup>64</sup>. Such shift becomes even more sensitive because the clashes in the execution of public policies did not allow for a consolidation of the psychiatric reform. Consider, for example, decision-making based on stereotypes produced from the conjunction of legal and psychiatric knowledge, associating treatment with disciplinary institutions and total abstinence even after the psychiatric reform<sup>65</sup>.

It can be observed how the discursive change has already been present in social practices from initiatives aimed at the hospitalization of people with needs by drug use without their consent<sup>66-68</sup>. Therefore, it is worth considering that the opening to the involuntary hospitalization of "drug addicts" strengthens practices that deprive these people of making decisions about their own life, under the justification that "they lost control over themselves", in order to make another population live.

### Final considerations

The results show how the discourses of the Law No. 13.840/2019 are in line with the hygienist paradigm and reproduce paradigmatic disputes within the scope of drug policies and normalizing the trend towards re-institutionalization of mental health care. It is noteworthy that the provisions related to involuntary hospitalization and reception in therapeutic communities threaten

the achievements of the PRMB, such as the consideration for human rights and citizenship of the population assisted in the context of mental health policies.

It should be noted that this study does not intend to analyze the Law No. 13.840 in its entirety, nor to condemn the document itself. The analysis of devices that point to social control in limiting social participation in the structure of the drug council, for example, will be carried out at another time.

### **Collaborations**

YFL Montenegro, AKR Paixão and NC Martins worked on the conception, design, analysis and data interpretation, wording of the paper and approval of the version to be published. AKR Paixão and NC Martins worked on the design, data interpretation and approval of the version to be published. AVM Brilhante worked on data interpretation, critical review of the article and approval of the version to be published and CCP Brasil worked on the critical review of the article and approval of the version to be published.

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