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What is the emphasis of Brazilian drug policy: resocialization or internment?

Qual é a tônica da política de drogas brasileira: ressocialização ou internamento?

Cuál es la tónica de la política de drogas brasileña: ¿rehabilitación o reclusión?

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Abstract

Objective: To analyze the discourses of public managers, at the municipal and state levels of the city of São Paulo - Brazil and of community services that serve users dependent on drugs with mental disorders, in order to confront them with the current public policies of the Brazilian Ministry of Health and Check whether they have advanced or receded. **Methods:** Cross-sectional, interpretive qualitative study was carried out with four public managers and community service providers who attend drug users. Data were collected through semi-structured interviews. **Results:** The speeches indicated that despite the fact that despite participant health managers indicate which direction should be given the care to drug users, under some aspects, public policies in the last six years have receded. **Conclusion:** The Policy advanced with the structuring of the psychosocial care network and articulation with a single network of social assistance, among others, but fell back when it introduced the therapeutic communities in the health network and promoted hospitalizations with public funding.

Keywords: Disorders Related to Substance Use; Mental Health Services; Public Health Policies; Drug Users; Nursing.

Resumo

Objetivo: Analisar os discursos de gestoras públicas, nos âmbitos municipal e estadual do Município de São Paulo - Brasil e de serviços comunitários que atendem usuários dependentes de drogas com transtornos mentais, para confrontá-los com as atuais políticas públicas do Ministério da Saúde brasileiro e verificar se as mesmas avançaram ou retrocederam. **Métodos:** Pesquisa transversal, interpretativa e de natureza qualitativa, realizada com quatro gestores públicos e de serviços comunitários que atendem usuários de drogas. Os dados foram coletados por meio de entrevistas semiestruturadas. **Resultados:** Os discursos sinalizaram que apesar dos gestores de saúde participantes indicarem qual direção deveria seguir o cuidado aos usuários de drogas, sob alguns aspectos, as políticas públicas retrocederam nos últimos seis anos. **Conclusão:** A Política avançou com a estruturação da rede de atenção psicossocial e articulação com a Rede única de assistência social, entre outras, mas retrocedeu quando introduziu as comunidades terapêuticas na Rede de saúde e promoveu as internações com financiamento público.

Palavras-chave: Transtornos Relacionados ao Uso de Substâncias; Serviços de Saúde Mental; Políticas Públicas de Saúde; Usuários de Drogas; Enfermagem.

Resumen

Objetivo: Analizar los discursos de los gestores públicos municipales y estaduales de São Paulo, Brasil, y los servicios comunitarios que asisten a los usuarios de drogas con trastornos mentales, para confrontarlos con las políticas actuales del Ministerio de Salud de Brasil y verificar si hubo avanzo o retroceso. **Métodos:** Investigación trasversal, interpretativa, cualitativa, realizada con cuatro gestores públicos y de servicios comunitarios. Los datos fueron recolectados por medio de entrevistas semiestructuradas. **Resultados:** A pesar de los gestores de salud participantes indicaren cuál dirección debe seguir la atención de los consumidores de drogas, las políticas públicas retrocedieron en los últimos seis años. **Conclusión:** La política ha avanzado con la estructuración de la red de atención psicosocial y la coordinación con la red única de asistencia social, entre otras, mas ha retrocedido cuando se introdujeron las comunidades terapéuticas en la Red de salud y promovieron las rehabilitaciones a la financiación pública.

Palabras clave: Trastornos Relacionados con Sustancias de Uso; Servicios de Salud Mental; Política de Salud Pública; Los usuarios de drogas; Enfermería.

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INTRODUCTION

The use of drugs is a growing problem from the point of view of public policies in education, health, social care and work, both in developed and developing countries. Of course, this situation results in a wide range of health problems, family and social repercussions, in addition to the significant economic impact.

The world report on drugs (2015) pointed out that approximately 243 million people, representing just over 5% of the world population aged 15-64, have used illicit psychoactive substances (IPAS) in 2013. About 27 million people have had harmful use of those substances - just under half were injecting drug users and about 200 thousand people died in 2012 due to drugs. The number of new drugs doubled between 2009 and 2013.[1]

The world report on drugs of 2016 revealed that the number of dependents with some type of drug jumped to 29 million in 2014 and that about 250 million people aged 15-64 used at least one drug in 2014.[2]

Indicators such as traffic accidents, criminality, urban violence and hospitalizations are strongly related to abusive use of licit psychoactive substances (LPAS), such as alcohol and illicit drugs (IPAS), such as cannabis and cocaine, among others, in addition to generating high costs for society and to the state in all continents.

The clinical consequences of the use of LPAS are intoxication, harmful use, dependence and psychic disorders; being the psychiatric comorbidities prevalent in people who abuse the use of LPAS for long periods.[3]

Brief bibliographic review

Historically, in Brazil, the treatment of IPAS dependents occurred in psychiatric hospitals and specialized clinics, in a repressive and segregating logic. It was only in 2004 that the Brazilian Ministry of Health formulated a national policy of comprehensive health care for these people, including them in the field of public mental health policies. Thus, the construction of a network of community services, denominated Center of Psychosocial Attention to Alcohol and Drugs - CPSA ad.[4]

In 2008, there was a higher prevalence of users of smoked cocaine-crack in the CPSA ad, which resulted in the implantation of other health devices and the establishment of the Psychosocial Attention Network (PSAN).[5]

The Brazilian Psychiatric Reform is a process of overcoming the psychiatric structure and practice, which can be recognized in the attention promoted to users with mental disorders and users of psychoactive substances, in the Psychosocial Care Centers and in other services of the Psychosocial Care Network.

It is known that the expansion of care coverage and the improvement of the treatment offer in the PSAN services are important for the advancement of care in this area. However, it is essential to be clear that only the expansion of the service network is not enough for the integral attention of users, since it is necessary mobilization and articulation of actors in different sectors of society, in order to be effective.[6]

The above considerations justify the urgency of research on public policies on alcohol and other drugs, which are very scarce, pointing out that abusive consumption of IPAS is a serious and multi-causal problem in Brazil and in the world, and therefore it has repercussions on more diverse segments of society, due to the social aggravations resulting from it or reinforced by it.

In this sense, this work aimed to analyze the discourses of public managers, at the municipal and state levels of the city of São Paulo, Brazil, and of community services that attend users dependent on IPAS with mental disorders, due to abusive use, to confront them with the current public policies of the Brazilian Ministry of Health and verify if they have advanced or fallen back.

METHODS

The empirical, transversal and interpretative study was carried out with the state and municipal coordination of mental health in São Paulo and with two coordinators of CPSA ad, also at the municipal and state level.

The choice of the CPSA ad was intentional, because the authors considered it important that the services were the best evaluated from the perspective of municipal and state management. Thus, in both instances, managers indicated the services that served the largest number of users and with features that best approximated the determinations of Administrative Rule no 336 of 2002, which regulated the CPSA.[4]

The participants of the study were two public managers of mental health (municipal and state), in the area of alcohol and other drugs and two coordinators of CPSA ad.

Semi-structured instruments were used for the individual interviews, since the authors considered that it would not induce to predetermined answers, allowing the freedom and spontaneity necessary for the enrichment of the investigation, as well as focus on the specific subject to be investigated.[7]

In fact, interviewing is the most usual resource in fieldwork, and it is especially appropriate to have information about what people know, think, believe, expect, feel, and aim to do, as well as their justifications and representations.[7]

The data of this article were derived from a doctoral thesis titled: "Analysis of the Policy of the Brazilian Ministry of Health for the Integral Care of Users of Alcohol and Other Drugs". The data were collected between January and May 2009. The interviews were recorded to ensure the reliability of the participants' responses and the results were processed, resulting in five categories: Policy guidelines; Potentialities; Weaknesses; Factors that prevented the advance of the Policy; Strategies that should be adopted and implemented in the Policy, from the perspective of the participants.[8]

This article originated from two categories of the referred thesis, being: the fragilities of the National Policy of integral attention to the users of alcohol and other drugs and of the strategies that should be implemented in the Policy. The authors considered them relevant to the understanding of what has or has not been in the Policy since 2009.[8]

The operationalization of the data consisted of: transcription of texts; data ordering; classification and analysis of data.[7]

The interview texts were categorized and identified by letters (interview) and numbers 1, 2, 3 and 4, referring to the four participants. To the extent that the words of one participant were being presented, they were named by letters of the alphabet, with sequential entries: A, B, C, and so on. In this way, the results will appear in this text as follows: AI1, AI2, successively.

The discourses of the participants were analyzed by Dialectical Hermeneutics - HD.[7] The authors understand that in the field of health, hermeneutics addresses the existential problems, which are interpreted in human actions. Thus, taking into account the object of the present study "abusive consumption of IPAS", the problem should not only be analyzed from a clinical point of view, but a process of reflection is necessary on the existence of the person who establishes a dependency relationship with one or more drugs. Thus, hermeneutics poses critically against the biomedical way of approaching problems, as in the issue of alcoholism.[7]

In this sense, through the "HD", authors analyzed the speeches of the participants in light of the public policies of the Brazilian Ministry of Health, which were implemented as of 2009 and by the dialectic with some sociological constructions of Boaventura de Sousa Santos.[9]

All the ethical determinations of Resolution 196/1996 were observed, and the research project was approved by the Ethics Committee of the Nursing School of the University of São Paulo under the number 656/2007.

RESULTS AND DISCUSSION

Although the objective of this study was to analyze the discourses of public managers and community services that assist users dependent on IPAS with mental disorders, to confront them with the current public policies of the Brazilian Ministry of Health and verify if they have advanced or retreated, the authors visualized the possibility of highlighting the credibility of qualitative research, because although the research was in the "case study" modality, which in theory would not allow generalization, it was verified that the "participants' discourses" were completely aligned with the national scenario of that moment.

In addition, the participants' speeches indicated the paths that should or should not be taken by the formulators of the public policies for the area. Six years after the conclusion of the research, the content of its lines remains valid and up-to-date, and because it is in line with the context of the current Brazilian public policy in the area.

The authors believe that it is inherent in every emerging paradigm, expressed in this work as a public policy, to overcome the logic of its predecessor, because it is expected to express what the population demands. This is recognized in social practice, because through this it expresses itself, is transformed by self-knowledge and self-recognition. This reading refers to a knowledge or policy that goes to social reality and takes shape there and adapts to local conditions.[9] That is why health policies and services do not and cannot all operate in the same perspective, Since they must adapt to the social, cultural and economic differences of the populations they serve.

The authors highlight the following, advances and setbacks in the National Policy, based on the speech of the participants:

Full reception in the CPSA ad

The increase in the number of CPSA ad beds was extremely relevant for the care of IPAS users, as one of the participants pointed out:

> *[...] In my opinion, the National Policy and Ordinance No. 336 greatly reduce the work of the CPSA, assigning many functions, but providing few conditions so that the team can do what is proposed, as in the case of the number of beds for detoxification and stabilization of abstinent users [...] (AI3).*

The Decree to which the participant referred was No. 336, dated February 19, 2002, which mandated CPSA to provide two to four beds for the detoxification of users of alcohol and other drugs.[10] However, when these services were accredited as CPSA ad II there was not a 24-hour attendance, as stated below:

> *[...] The team and I are against the issue of lasting psychiatric hospitalization, but one of the great points that I would need to improve and which seems to me to be incoherent is that because we are CPSA II we have care from 7am to 6pm. When the user arrives in a very complicated condition, we put him in the detox and at the end of the day if the doctor evaluates that he needs a hospitalization, there is no support from a general hospital for brief hospitalization [...] (AI4).*

Attending until 6:00 pm or having an extended period until 9:00 pm did not meet the needs of users and workers, for a service that has beds for detoxification and/or stabilization. So, the question was: *What to do with the user in bed care for detox or stabilization after the service closing time?*

In this sense, the participant completed:

> *[...] secondly, it is necessary to increase the number of observation beds in the CPSA ad, at least one bed is*

what it says in the Policy. At least one, no please! It is necessary to have more beds, especially when you are in distant municipalities that you can not direct them to general hospitals [...] (BI3).

With the introduction of the PSAN in 2011, through Ordinance No. 130, dated January 26, 2012, the Ministry of Health redefined that the CPSA ad passed from modality II to III and that from that date, all others were implemented in modality III. In addition, it determined that this mode of service offered 24-hour service, seven days a week, uninterruptedly, offering overnight accommodation to intoxicated users or with withdrawal syndrome.[11]

When prescribing "beds for night care", the Ordinance states that they are for clinical stabilization of intoxication, but not for attention to withdrawal, as explicitly stated in article VI: "regulate access to night-care beds based on clinical criteria, especially detoxification, and/or in psychosocial criteria, such as the need for observation, rest and protection, conflict management, among others". Therefore, it would be at the discretion of the unit manager whether or not to allocate beds for attention to acute slight/moderate intoxication and withdrawal symptoms.

The authors raise this questioning, based on previous experience, in which municipal public manager, when questioned, defended himself by saying that the beds of night reception were not for the stabilization of users. The question that the authors ask is: for what conditions do hospitalizations of IPAS users prevail? If CPSA ad III does not stabilize clinical manifestations of mild and moderate intoxication or withdrawal syndrome, what does this mode of service differ from CPSA II for mental health? Of course, the severe conditions of the clinical conditions described above should be met in the emergency services of general hospitals.

Work overload and unpreparedness for interdisciplinary action

It is understood that a team with many assignments and small numbers of people to perform them, should prioritize the daily actions of the service, since it will not have self-sufficiency to meet all the demands that come to them, as expressed the participant:

[...] I think that the professional staff established for the CPSA ad should be reviewed, because among the attributions that Decree 336 establishes are those of the team. With that team determined by the Ordinance it's not possible, either you stay inside the CPSA ad or you go to the street. You have to choose what you are going to do: if you go to the street with the external actions or if you will stay inside the service working with the team. Otherwise nothing is done completely. So it gets complicated! (BI3).

Another participant complemented:

[...] as to the methodologies that should be used, these are at the discretion of the team, which is not always capable and qualified, and that is why a little is lost [...] (DI3).

It is expected that the CPSA technical team carry out activities with families and the local community. According to Ordinance 130 of 2012, professionals in this type of service should also be responsible for the elaboration of the unique therapeutic plans of users voluntarily received in the Temporary Reception Units - TRU, when these are implemented by local management. However, since the implementation of the CPSA, regulated by Administrative Rule 336, of 2002, the number of professionals of the technical staff of CPSA ad II did not increase.

In addition to the many functions that the technical teams of CPSA ad have, the number of services is less than necessary. According to data from the Ministry of Health, in October 2015, Brazil has 378 CPSA ad, 309 units in modality II and only 69 in modality III, which does not guarantee care for the entire population of IPAS users who need care.[12]

It is important to emphasize that a technical team is composed of different professional backgrounds and, therefore, is called a multidisciplinary team, assuming that the work takes place in the logic of interdisciplinarity. Therefore, a team of health professionals, in which each professional attends the individual patient/user does not act in an interdisciplinary perspective, since this implies shared work, so that the collective demands of the people who need care are solved in the collective, making the work process more resolute and expanded.

As of 2009, the Ministry of Health, in conjunction with the National Drug Policy Secretariat ("SENAD"), began implementing multiprofessional residency courses and training courses for professionals working in different PSAN contexts, with emphasis on CPSA ad and in the services of the Basic Attention. Thus, the Regional Centers of Reference in Crack and other Drugs (RCR), which are components of the prevention axis of the Crack Program it is possible to win, instituted in 2010, in an interministerial action and that is training professionals of the points of care of PSAN, in order to offer unrestricted support to at-risk groups in all their needs, contributing to the reduction of drug use rates.[13]

Actions between sectors for full attention to drug users

Regarding fissures contained in a policy that apparently was not carefully planned, the participant expressed:

[...] This Policy had to be between sectors, it could not be just health, and the legal framework had to be well sewn.

The whole social apparatus had to be well built at the time of the launch of the Policy and it was not [...] (EI2).

As a result of the lack of this framework, in 2010 several segments of society met in the capital of the federation, Brasília, for the IV National Conference on Mental Health, in order to discuss strategies amid sectors that would render more effective to the production of care in existing health services. Thus, the theme of the Conference was the collaboration between sectors.[14]

It is known that the multiple facets of the phenomenon "abusive consumption of IPAS" are revealed in the psychosocial field. Therefore, it would not be a single health device - the CPSA, to account for such complexity. It was necessary to have a network of actors and services that would meet the demands for the integral care of those who lost their autonomy along the consumption trajectory.

The social apparatus to which the participant referred was the existence of a Network of Psychosocial Attention, of the Unified Health System - "SUS", acting in articulation with that of the Unified Social Assistance System - SUAS,[5,15,16] which at that time were not articulated, in addition to other initiatives that would guarantee citizenship and the human rights of this population. The proposed changes are contained in the final report of the IV Conference.[14]

Regarding the legal apparatus mentioned by the participant, the authors understand that it is related to the alignment of health legislation with that of justice, since Law 11,343 of 2006 did not discriminate the amount of IPAS that a person must carry to characterize it as a user or trafficker. In addition, the process of making it judicial matter the compulsory hospitalization of people with mental disorders and dependents of IPAS in Brazil is recurrent and prevalent.[17,18]

The hospitalization and segregation of IPAS users

In general, hospitalization is one of the biggest problems that CPSA teams face when it becomes necessary.

[...] I believe that the Service Network could make CPSA service ad more effective. When I say that the Network works I am referring to this logic [...] (BI4).

The participants' statements, reproduced below, reinforce the difficulty that the CPSA ad team has in articulating with the general hospital, for the hospitalization of users:

[...] We have a general hospital of reference, but we already had the situation of the nurse entering with the user in the ambulance and me follwing in my car, to look for a vacancy for the hospitalization of people who, sometimes, come to die due to the lack of assistance, because the referral hospital claimed no vacancy [...] (CI4).

The participant continued:

[...] We do not know what to do, because we have a life there, and when we get to another service, in the general hospital, they say, for example: "we will not attend because it is alcohol and other drugs." [...] I think that psychiatry as a specialty should work better for these emergencies and not for long-term hospitalization [...] (DI4).

Another participant complemented:

[...] The general hospitals still have strong resistance to the adoption of the new model and there is still the existence of the old model [...] (BI2).

Hospital administrators and municipal managers are resistant to bed implantation in general hospitals, since the IPAS patient's clinical condition, hospitalized in the general hospital, most often does not require imaging and procedures that generate profitability for the hospital institution. Even the Ministry of Health having increased the value of the daily hospitalization in the general hospital, the scenario has not changed, which reinforces the ideological aspect that surrounds the issue.[19,20]

The main reasoning of professionals and those interested in hospitalization in psychiatric hospitals, whether of people with psychic disorders or users of chemical substances, is that the costs of the care offered in the CPSA are higher than that of the bed in a psychiatric hospital and those of the general hospital and private clinics, which in Brazil are commonly called therapeutic communities. This term originates from a conceptual and operational error regarding the understanding of the attention model conceived by Maxweel Jones in England.[20]

One of the participants expressed:

[...] We always stand in the hardest clashes with the people who defend the other way of working, because they contend that this Policy is unfeasible because the costs are absurd. I ask: - And the possible hospitalization and the cost of the house keeping? What is it? Will you not treat? [...] (EI3).

There is no coherence in the way in which funding for Mental Health is given, as expressed by the participant:

[...] I think there is a lack of clarity regarding the financing [...] (AI1).

Each one defends the paradigm adopted to treat the SPA user, based on their training, conceptions and beliefs. Thus, the participant goes on:

> *[...] For every argument you may have, questioning the extra-hospital model, you will have 20 to prove that it is better, including the costs [...] (E3F).*

It can be safely affirmed that psychiatric hospitalization in a psychiatric hospital and in the therapeutic community does not presuppose the effectiveness of care, where, in most cases, the conditions of hospitality and care are deficient,[5,6] as the following discourse revealed:

> *[...] Because hospitalization is not treatment, that's my opinion! It is not internment, because you do not fully address the human being. [...] (BI1).*

The Resoluteness of care offered at CPSA ad

In contrast to hospital care, the participants' speeches emphasized the resolving of care within CPSA ad.

> *[...] You have to do the extra-hospital work yourself, to take care of the integrity of that person, in the biopsychosocial, inserting socially, articulating with other institutions. This the CPSA ad does magnificently. In fact, I am a great defender of this model, so much that I do not believe in the other [...] (GI3).*

Another participant complemented:

> *[...] I think people are looking more for the extra-hospital environment, and I can intervene in a much more comprehensive way, since a lot more people are looking for us. This is completely different from hospitalization, because we are here, and they have access to us, so much that we have already seen this. In the State Department of Health, we observed that the number of drug users increased significantly, but why? Has the number of users increased? No! Increased demand because the service is affordable and access to treatment is so fast ... [...] (HI3).*

The existence of a service close to the residence of the user of chemical substances facilitates their treatment, since in CPSA ad he participates in individual or group psychotherapy sessions, receives daily doses of medications, participates in workshops and therapeutic groups, in short, has the possibility to go to daily service, depending on the periodicity established by your individual therapeutic project, and to return home at the end of the treatment period.[21] In addition, you may participate in activities in other community spaces.

In relation to this the participant stated:

> *[...] So you offer a service that you did not have before, so it was said: "- Ah! You just have to intern!" Now the person passes the door, enters and sees that there are others inside being attended to and does not need all that confusion and restrictions that involve hospitalization [...] (CI1).*

One of the participants drew an analogy between the decrease in hospitalizations and the relationship with the care users receive in CPSA ad, as shown in the following speech:

> *[...] What is our hospitalization rate? It is very low! And look, the Service only runs Monday through Friday and closes at 6 or 7 pm, depending on the clinical condition of the user who is here. Because I solve it! Get it? This I show and prove here in the Service, we show this all the time, because, in fact, I think CPSA ad is resolute [...] (II3).*

The authors agree with the participant regarding the resolution capacity of the care provided in CPSA ad, which results in a lower incidence of psychiatric hospitalization. They also point out that, in general, this event is observed in the daily services, with workers, users and family being reported.[22]

Still on the resolution of comprehensive care offered in CPSA ad, one of the participants stated that:

> *[...] Inclusive treatment is one that is offered in the territory where the person lives, with the possibility of spending part of the day or even stay in the service full time, for a few days or every day of the week. Inclusive treatment is one that enables the person to receive the necessary care, remaining for approximately a week in full-time care in community service, at a time when he/she has used excessive IPAS and is therefore intoxicated or because he/she stopped using IPAS and, consequently, went into withdrawal syndrome [...] (DI1).*

Inclusion of the therapeutic community in PSAN

Although the participants' discourses, which were also workers in the area, were in defense of CPSA ad, the number of units implemented in Brazil between 2009 and 2015, that is, in six years were only 86 units, totaling 309 services, in 2015.

In contrast, the number of therapeutic communities in Brazil, which are included in the PSAN, therefore, agreed with the Unified Health System, sums up to 336 units, totaling 7541 beds. Despite this, it is known that in Brazil, the number of those who are not accredited is much higher.

The therapeutic communities are hospitalization services, in the residence modality for IPAS users. Most of the time,

they are located in areas far from urban centers, promoting the isolation and social segregation of the IPAS user. Those that do not have multiprofessional technical teams prevail and act in a prohibitionist, mystical-religious and disciplinary logic, in which the treatment methodology prevails.[20,23]

The current scenario reinforces the idea of a reversal of the financing logic in the PSAN context. Therefore, the Ministry of Health Policy and the National Policy on Drugs does not prioritize the short hospitalizations offered in the CPSA ad (14 days, on average), but the long duration, on average, nine months, offered by this type of service. This is corroborated by the financial investment of R$ 92 million in therapeutic communities contracted with the Ministry of Health in 2014, compared to the R$ 63 million invested in the same year, for all mental health actions in the country.[24]

Dialectic with sociological constructions of Boaventura de Souza Santos

Reflecting the participants' statements about the strengths of the National Policy for attention to users of alcohol and other drugs, the authors cite the sociologist,[25] who proposes the Critique of Indolent Reason. According to the author, this one is expressed in the impotent, arrogant and metonymic rationality, that will be presented next.

The impotent reason to the one that does not or does not exercise, because it considers that it can do nothing against a necessity conceived in the space outside her, in its exterior.

This allusion is to better explain the indolent rationality which is considered unique, exclusive, and which is not exercised sufficiently to see the inexhaustible wealth of the universe. This has an inexhaustible epistemological diversity, but this lazy reason is reductionist.[8] The authors understand that impotent reason dominates those that impose abstinence and social segregation as a form of treatment to the users of IPAS.

Arrogant reason sees no need to exercise itself, because it sees itself unconditionally free, and therefore free from the imposition of its own freedom. Thus, if a Health Policy is elaborated by the hegemonic class, respecting only the "rights and interests" of the dominant classes, it is under an indolent, or arrogant, rationality.

If the psychiatric hospital was responsible for the moral, psychological and physical damages of millions of Brazilians, why does it still exist? Are the state and municipal health secretaries not civil servants? Why is the number of CPSA III still insufficient to contain the psychiatric crisis? So, why are CPSA III ad not implanted to integrate the substitutive Network to the psychiatric hospital?[8]

Soon after the conclusion of the study that originated this work, the CPSA ad III began to be implanted in the middle of 2010, but still are insufficient to meet the demands of the users.

Nowadays, in Brazil, it is seen that indolent rationality is expressed in the political field, since in the National Congress prevail the party interests and hegemonic segments that privilege their own interests and not of the population that, in this case, the users of IPAS.

Metonymic Reason: Metonymy is a figure of literary theory and rhetoric which means taking the part for the whole. This rationality easily takes the part for the whole, because it thinks that the whole is constituted by homogeneous parts, and that which is outside this whole does not interest them. It is responsible for contracting and subtracting the present and, thus, wasting social experiences. This rationality does not work like the possibilities that users present to them.[25]

It is well known that an expressive religious group of federal deputies defends hospitalization and abstinence as a model of treatment, expressing the metonymic reason. This has resulted in the inclusion of therapeutic communities in the PSAN, and the needs of users, family members and workers, who live or coexist with the difficulties imposed by the abusive use and dependence of IPAS do not prevail, but the interest of those who finance such devices, which are in fact promoters of segregation and exclusion. The authors infer that PSAN was instituted as a political maneuver for the inclusion of therapeutic communities in the mental health network that in practice already existed.

The conditions of treatment and hospitality offered at these institutions are, in most cases, very bad, violating the human rights of those who are hospitalized there.[26]

The contributions of this study turn to the formulators of public policies of the Ministry of Health, provoking them to reflect on the direction given to the public policies of attention to the users of IPAS, since at present these do not fully correspond with the resocialization and inclusion of the same ones in society, on the contrary, promote stigma, violations of human rights and social segregation. It is still possible to resume the direction of Brazilian public policies to care for drug users, that these be settled in the territory, where they live, circulate and work.

In addition, this work contributes to the praxis of the CPSA ad workers, with emphasis of the nurse's, reinforcing that these should be fosters of caring, bonding and autonomy. Let them be technically and subjectively empowered to contain the crises of abstinence and intoxication in the beds of the CPSA, which are preferably destined for this purpose.

CONCLUSIONS

Participants' discourses showed that although public health administrators and the health services of the largest Brazilian municipality signaled the direction that the health care of substance users should continue to guarantee the principles of the "Brazilian Single System", public policies in the last six years have regressed, yielding to hegemonic interests.

Based on the statements of the participants of this study, the authors conclude that the National Policy has advanced since 2009, regarding the constitution of the street offices, social centers and CPSA III and ad III; Financing the training of health service workers and professionals with the creation of multiprofessional residences in alcohol and drugs and promoting intersectoral actions and articulation of "SUS" and SUAS networks.

The Policy fell back when it implemented the PSAN, which actually existed, but in its formal institution introduced the therapeutic communities in the same way and promoted their funding, through agreements, drastically increasing the number of hospitalizations in these devices, including those of compulsory modality, with public funding, as if this *modus operandi*, in fact, brought the solution for overcoming to the dependency of IPAS. Thus, it stopped investing in the expansion of the community service modality "CPSA ad III" that allows the resocialization of users in integral care and returned to the financing of hospitalizations.

Implications for clinical practice: This article reinforces the imperative that comprehensive care, in the perspective of psychiatric reform, be offered in community services, which are, in fact, promoting the resocialization of IPAS users in society.

In the different components of the PSAN, the nurse must develop actions that promote the resosocialization and psychosocial rehabilitation of the IPAS users. This professional needs to understand that his role in the interdisciplinary team is beyond medication and nursing protocols, since he must turn to subjective and psychosocial interventions, appropriating communication, therapeutic relationship and brief interventions.

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