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Dilemmas and Impasses in Public Health Policies Directed at People Who Make Use of Alcohol and Other Drugs in Brazil

Maria Cristina Gonçalves Vicentin,
Jacqueline Isaac Machado Brigagão and
Pedro Paulo Freire Piani

Additional information is available at the end of the chapter

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Abstract

The first Brazilian public policies directed at people who make use of alcohol and other drugs focused on criminalization and punishment. In 1932, medicine and its strategies of governmentality began to work within this field. The Penal Code of 1941 brought the ideal of abstinence to the Brazilian public arena, which was then broadly disseminated by the legislation up until 2006, when a new mental health policy began to be implemented for this population. In this chapter, we analyze the tensions between models that focus on care and those that have a safety perspective in programs for users of alcohol and other drugs in the central region of the city of São Paulo. We analyzed public domain documents: documentary material on the legal landmarks of policies; revision of literature; and news in Brazilian media about governmental actions in this area. Results of the analysis indicate that the tension between harm reduction models and the abstinence model persisted in governmental actions over the years. Regarding the central region, there was a diversification in the offer of treatment models and approaches. But these models took form as a market dispute: for sellable goods, employability of professionals, and the interests of the pharmaceutical industry.

Keywords: Brazilian public health, alcohol and other drug policies, harm reduction, abstinence, mental health

1. Introduction

Brazil is a South American country with continental dimensions and a population of over 208 million inhabitants, in a territory of 8,516,000 km² divided into 5 regions, 26 states, and 1 federal district where the capital is located. Its population of young people between 14 and 29 years of age is of approximately 51 million. This vast territory is made up of big cities and 5570 municipalities [1].

Portuguese colonization began in 1500, and although independence took place in 1822, the country did not become a republic until 1889. Throughout history, democracy in the country suffered many ruptures, with the last military government lasting over 20 years; the Federal Constitution of 1988 was a landmark for the country's new political organization. Portuguese is the official language, and completely hegemonic, spoken in all regions, but there is a vast ethnic and cultural diversity. Within the last decade, Brazil has rated among the biggest world economies, ranging between seventh and ninth place. With commodities sought by the international market, besides biodiversity reserves and large cities, Brazil can be considered an economic powerhouse, although one with structural difficulties and international interests that block development. Minerals, oil, agriculture, livestock farming, the energy sector, the automobile industry, aviation, and other goods make up the large internal and external offer of the Brazilian economy, with bilateral trade on all continents.

In a country marked by deep social inequality, with a heritage of traits that trace back to colonialism, slavery, and authoritarianism, the 1988 Federal Constitution—a result of a number of social movements—was a milestone for the new democratic political order of the nation, instituting an increase of processes that guarantee and give access to rights, especially in regard to social policies, such as in the case of the Brazilian Unified Health System (Sistema Único de Saúde—SUS). The movements known as sanitary reform and psychiatric reform soon became an international reference [2] and their establishment took place amid disputes between segments defending State actions in health and segments defending private sector health care.

In the field of policies relating to the use of alcohol and other drugs in Brazil, it is possible to observe two lines of state actions. One, punitive, which focuses its actions in the public safety arena, and another, in public health, which prescribes treatment and health-care actions for those who make problematic use of alcohol and other drugs. In this chapter, our aim is to discuss the tensions and polarizations between different health-care models, both those guided by the perspective of reducing harm and those guided by an ideal of abstinence and safety, using as a basis health-care actions aimed at people who make use of alcohol and other drugs. We present as an *analyzing event*¹ the actions undertaken over the past 4 years in the Luz neighborhood in the center of São Paulo, an area known as Crackland (“Cracolândia”), when different intervention programs were set up “competing” for the local population and drug users. Two programs are the focus of this analysis: the Open Arms Program (Programa de

¹Analyzing events: critical events that allow a clarification of the forces at play in a determined situation, as well as arguing for certain naturalizations [3].

Braços Abertos), implemented in 2013, developed by the municipal government, and the Fresh Start Program (Programa Recomeço), also implemented in 2013 and developed by the state government.

From a methodological point of view, we used the following strategies: (1) revision of legal regulations that refer to mental health policies and drug policies, aiming at understanding the Brazilian panorama. These are public domain documents available in the databases of the ministries of Health and Justice. We focused on documents from the period between 2006 and 2013, when the country underwent changes in drug legislation, as well as outlining care relating to alcohol and other drugs within mental health policies (2) revision of literature on governmental actions carried out in the city of São Paulo, in particular the research conducted by public agencies on the impact of service programs and media news on the actions developed by the territory's government. In this manner, the chapter was developed with basis on a revision of literature with the introduction of an analytical angle derived from this institutional analysis—the analysis of critical events that allows for a clarification of the power plays at work in a determined situation, as well as arguing for certain naturalizations [3].

We shall begin by presenting a brief historical overview of policies and laws that relate to drug use in order to situate within history how actions of welfare, health care, and safety became part of the governmental agenda. Next, we shall present the perspective of the prevailing Brazilian health policies so as to demonstrate the ramifications of this perspective within the programs developed in the municipality of São Paulo. We present a contextualization of the area where the programs are developed, and of how the public powers intervened with the neighborhood's population by means of government strategies over the past decades, producing disputes and tension between the models that guide these actions.

2. Brief historical overview of the laws and public policies that relate to the use of alcohol and other drugs

The first policies and laws that relate to drug use in Brazil were guided by the punitive model and configured within the field of public safety. In 1830, the Municipal Chamber of Rio de Janeiro established a court fine for the "*vagrant blacks*" that were caught smoking marijuana, and in 1890 the Brazilian penal code expressed, in an explicit manner, the prohibition of the use of substances considered poisonous, stating the need to create complementary guidelines [4]. In 1932, the sphere of health was incorporated in the Brazilian legal framework relating to drug use. From then on, as medicine and its sanitary model for society began to influence and guide Brazilian legislation in a number of sectors, it is possible to observe a link between those health policies that prescribed treatments, often guided by the ideal of abstinence and social isolation by means of hospitalization, and legal mechanisms of repression and prohibition of drug use in many of the laws and public policies relating to the use of drugs [4, 5].

The policies that derived from international conventions and American politics, denominated "war on drugs", which started in the 1970s and were broadened in the following decades, also had a lot of influence upon the legislation, policies, and programs proposed by the Brazilian

government. It is worth pointing out that, between 1964 and 1985, Brazil was under a military dictatorship marked by governmental actions that repressed individual and collective rights. Within this context, Law 6.368/1976 was approved, which talked of *the measures for prevention and repression of illegal traffic and the improper use of intoxicating substances or those that create physical or psychic dependence, and other provisions*. The principles that guide this law in its different articles are guided by the idea of repression, criminalization, and social exclusion, since the treatments it advocates are centered upon incarceration and isolation, as demonstrated by article 9 of the aforementioned law: *The health care networks of the States, Territories and Federal District will count on, whenever necessary and possible, suitable establishments for treating those dependent on the substances referred to by the present Law. §1 While the establishments referred to in this article are not created, the existing network will adapt units for this purpose* [6]. This law made possible the proliferation of so-called *therapeutic communities* in Brazil, which are private services managed by civil society entities, generally linked to religious institutions, that adopt hospitalization, social isolation, and abstinence as their main treatment strategies for drug users [5].

In 2002, a new law comes into effect, Law 10.409, but due to a number of unconstitutional aspects and technical deficiencies, it was vetoed in many aspects, with only its procedural part put into action. Thus, Law 6.368/1976 was still valid in regard to its penal aspects. In this manner, this law remained in place for over 30 years, or in other words, it guided both governmental and civil society actions and programs, as well as the development of a mentality about treatments and health issues relating to people who make use of drugs, until in August 2006 Law 11.343 was set in place, revoking both previous laws. This law introduced the novelty of non-incarceration sentencing in cases of drug possession for own use, and included the availability of health treatment for users.

Over the last 30 years, Brazil went through many transformations, especially in the field of health. Since the 1970s, different civil society groups, such as health care professionals, women's groups, academics, and social movements fighting for housing rights gathered under a banner of *sanitary reform* that fought for changes in how health care was organized in the country. This movement was responsible for elaborating and discussing proposals during the 8th National Health Conference in 1986, which established the principals and guidelines for health care that would be included in the 1988 Constitution, as well as the basis for the Brazilian Unified Health System (SUS).

Thus, during the country's re-democratization process, health care was acknowledged as a right of all citizens and a duty of the State, and SUS, created in 1990, has as its principles universal access, integrality, and equity, which means it is a system where processes of health and sickness are understood to be a result of social determinants of health such as poverty, housing, and others. Within SUS, everyone has access to public health services, and these services seek to guarantee that different people have their needs attended to [2, 7]. This has meant a profound reorganization of health services and the supply of health care in Brazil, reaching all levels of care, a diversity of professionals, and public and private institutions, and moving an immense productive chain within national development, while employing an economically active population in Brazil. With all this repercussion, it is not hard to interpret that the construction of this system is proving to be durable and extensive.

In the field of mental health, the anti-mental institution movement and the fight for a society without mental asylums that took place in the 1980s and 1990s were crucial for the reorganization of services and approval of Law 10.216 in 2001. This law established new parameters for mental health care, investing in structuring a public network of mental health care services, including the establishment of the Psychosocial Care Centers (Centros de Atenção Psicossocial –CAPS). Following on from the new law, the Ministry of Health created the National Policy for integral care for users of alcohol and other drugs [8]. This policy is clearly guided by the harm reduction model, and allows for the implementation of a specific care network for those who make use of alcohol and other drugs, named CAPS-AD [5]. These centers basically perform outpatient care and group activities, taking treatment possibilities beyond psychiatric care, since they include other health-care professionals and focus on social reinsertion. This policy breaks with exclusionist hospitalization strategies and highlights the importance of the following principle in public health: *The offer of care for people who present problems due to the use of alcohol and other drugs should be based on mechanisms for specialized psychosocial attention taking place outside hospitals, duly connected to the mental health care network and to the rest of the health network. These mechanisms must make deliberate and efficient use of the concepts of territory and network, as well as a broader logic of harm reduction, carrying out an active and systematic search for the needs to be attended to, in a manner that is integrated with the cultural environment and community within which they are inserted, and according to the principles of the Psychiatric Reform* [8].

But, as in Brazil, the matter of use of alcohol and other drugs has always been on the agenda for health-care and public safety organizations, in 2005 the National Office for Policies About Drugs (Secretaria Nacional de Políticas Sobre Drogas—SENAD), connected to the Ministry of Justice, established the National Drug Policy (Política Nacional sobre Drogas—PND), which—despite including the strategy of harm reduction—brings back the possibility of hospitalization as treatment, whether in therapeutic communities or psychiatric hospitals: *Promote and guarantee the coordination and integration, in a national network, of interventions for treatment, recovery, harm reduction, and social and occupational reinsertion (primary care centers, outpatient centers, CAPS, CAPS-AD, therapeutic communities, groups for self-help and mutual aid, general and psychiatric hospitals, day hospitals, emergency services, fire department, specialized clinics, support and community centers, and assisted living) within the Brazilian Unified Health System and the Unified System of Social Care, for the user and their family, by means of decentralized distribution and the monitoring of technical and financial resources* [9].

The Ministry of Health was responsible for the introduction of a public health policy and a code of ethics for care when dealing with drug users. As a guardian of sanitary reform, the Ministry implemented the first support programs in mental health for users who had difficulty with social insertion; program benefits included payment of one minimum wage, and support for families and users in order to help them return home. As from 2010, with the elaboration and implementation of the project *Crack Plan, it's possible to win (Plano Crack, é possível vencer)*, the funding for hospitalization has grown in all Brazilian capitals. The triad of prevention, care, and authority, despite the proposal of integration, emphasized funding for a return to psychiatric hospitalization and security measures. Coming from a different perspective, the Oswaldo Cruz Foundation (FIOCRUZ) created in 2014 a program for alcohol, crack, and other drugs, taking actions beyond crack, which had been chosen by the federal government as the

banner of the fight, though not without criticism from sectors already working with integral care for users. This institution, besides working on training network professionals, carried out a large survey project in Brazil, the *National Survey on Use of Crack—Pesquisa Nacional sobre o Uso do Crack* [10] which brought a new dimension to crack addiction, indicating less use than had been propagated in the media and presenting a user profile according to aspects such as gender, age, education level, occupation, and patterns of usage.

Implementing the principles and administrative directives that guide SUS, in other words, decentralization, regionalization, hierarchy, and community participation, is a complex task, due to multiple factors such as the country's territorial extension, regional differences, and political, social, and economic issues

Decentralization of actions in health is one of the administrative directives that, in the day-to-day application of measures, seeks to involve all three levels of government: federal, state, and municipal. According to [11]: *The Federal Constitution of 1988 made it so that Brazil became a peculiar case of a Federation with three entities considered primary parties within the pact: Union, states and municipalities—only Belgium and India give local power a similar status. Indeed, one could observe a greater political, administrative, and financial autonomy of municipalities in regard to the previous period, followed by a decentralization of resources and attributions.*

Thus, responsibility fell to the federal government to formulate and follow up on the execution of national health policies, while the states were responsible for more complex services, besides the management, formulation, and coordination of some policies, and the municipalities took responsibility for executing actions and offering direct services. In this manner, the three public spheres participate in the national policy and its execution with distinct responsibilities, either set out by the legal system or pressured into it by the law.

As from 2006, the construction of the new policy within the national plan brought, on one hand, directives that indicated a need for a new posture in regard to user care; on the other hand, setting the programs in place highlighted that there were still indicatives and financing issues that allowed for a questioning of actions and the resurgence of religious and philanthropic institutions that turned to user care, choosing to trust in confinement and isolation, with little social insertion, and that competed for public resources.

The new policy presented prevention, care, and authority as lines of action, taking into consideration an approach centered upon construction of the person as a subject of rights, upon humanization, and upon the establishment of links within the service network, the family, and the community. The introduction of public programs and statutes for professional training took place all over Brazil, with regional reference centers implemented in the states supported by the vast network of public federal universities that worked with professional training for intersectoral services. The reach of this policy was initially extensive. The mental health care network was widened by psychosocial care centers, therapeutic residential units, street clinics, and specialized reference centers, strengthening deinstitutionalization as a movement for the creation of new mechanisms and therapeutic spaces.

However, the service network could not cope with user monitoring and care. There were also a growing number of religious therapeutic communities that still had no direct support from the

public powers. This phenomenon was strengthened by a rise in parliamentary representatives linked to religious institutions. This context provoked a change in how drug policies were carried out. The Ministry of Health had established guidelines from a human rights perspective, adopting criteria and regulations for the implementation of health care services that respected access and integrality in their actions. The Ministry of Justice took on drug policies in 2011 by means of the National Office for Policies About Drugs (Secretaria Nacional de Políticas sobre Drogas—SENAD). The guidelines continued, but a growth was observed in programs that came under the responsibility of religious institutions. In 2015, with presidential changes due to impeachment, new managers took over the ministries of Health and Justice, promoting the implementation of a new policy that focused on treatment of chemical dependency, compulsory hospitalization, and religious therapeutic communities.

On an international level, a debate was gaining ground, especially after the creation of the *Global Commission on Drug Policy* in 2011, made up of former Heads of State and specialists, and which contested the war on drugs as an efficient combat policy, indicating by means of studies and statements a different path to tackle the drug problem. In the Commission's first report, with the title *War on Drugs*, released in June 2011, the organization proposed 11 recommendations to substitute the criminalization and punishment of drug users for an offer of health services, support, and treatment of users, besides highlighting the need to advance in regulating psychoactive substances. Commissions linked to the UN, such as the *Expert Committee in Drug Dependence* and the *International Narcotics Control Board*, were still focusing on the classification of narcotics as forbidden and ignoring research and the cumulative knowledge of the World Health Organization (WHO).

3. Tensions between health-care models within the same territory: the Cracolândia case

The arrival of crack in the urban landscape of São Paulo² dates back to the 1990s, and the establishment of public sales and usage zones gradually turned the so-called cracklands into symbols of immorality, abandonment, and demonization; this legitimized, as from 2010, the compulsory rounding up of the street population, making social and urban exclusion invisible and becoming a historical process connected to the aggravation of the social inequality that resulted from urban expulsion and economic and social segregation.

In the 1960s, before the central region of São Paulo became infamous for the commerce and use of drugs and crack, prostitution was the main target for police actions in the area. Initially protected by territorial confinement, the neighborhood engaged in an ever-changing game between the tolerated, the permitted, and the repressed [11]. As from the 1950s, however, with the city's growth and urban development, the grouping of licit and illicit activities surrounding this practice would migrate to other nearby territories [12], and this area would become a constant target for police and urban interventions aimed at "re-qualifying" the region, besides

²For this contextualization about territory and the "Operação Sufoco" we based ourselves on the text [34].

the “mega operations” that often occurred, gathering different public departments to combat irregularities and illegalities in the neighborhood.

Following this track, the 2000s brought the Nova Luz project, predicting a radical transformation of the neighborhood, declaring the region as a public-use area³ and attracting investments, by means of fiscal incentives. By proposing the demolition of existing buildings for the reconstruction of the neighborhood [13], the “New Luz” went from social blight to highly valued real estate. Based on the idea of “urban rebirth”, this legitimized the expulsion of certain social groups from decadent regions of the city, especially the poor and homeless population, often by violent and repressive means⁴—a process that took place in a number of metropolises and is known as *gentrification* [14]—and with the State and businesses as the main agents, in public-private partnerships. However, this process incurs disputes [15], offering resistance to the logic of urban segregation, whether this takes the shape of social movements and neighborhood associations⁵, or whether simply due to the determination of those who frequent the region to remain, despite repressive measures.

Thus, as signaled by different scholars [16, 17], it is a case of considering the so-called crackland less as a specific geographic location within the city and more as an “itinerant territoriality”: a dynamic constantly instituted within the relationships established with the city by those who are marginalized and living with illegality, determined by the force applied by repressive mechanisms of the public powers and the resistance strategies of the users.

The year of 2012 began with “Operation Suffocation” (“Operação Sufoco”), “an integrated action involving State and Municipality to rescue people in vulnerable conditions, fight drug traffic and create a suitable environment for social areas”, with three phases: “consolidation of the area”, predicting actions by the Military Police of the State of São Paulo and the Metropolitan Civil Police to control and occupy the area, promoting arrests of drug dealers, users, and fugitives from the law; “social action”, that, at a second moment, would initiate welfare and health care; and “area maintenance”⁶.

The state coordinator of Drug Policies from the State Department of Justice and Defense of Citizenship (Secretaria de Estado da Justiça e Defesa da Cidadania) justified these actions:

³The conflicts surrounding Nova Luz and the resistance organized around the actions were vividly reported in the documentary *Luz*, part of the project Museo de Los Desplazados, of the artistic collective LeftHandRotation. Available at: <<http://vimeo.com/32848727>>. Accessed on: 19/January/2014.

⁴The dossier published by the Centro Vivo Forum (2007) denounces a number of rights violations that indicate social hygiene as the predominant policy of government actions, especially under mayors José Serra and Gilberto Kassab (2005–2012). This points to a lack of housing policies in the center of the city and, consequently, the relocation of the poor population to the outskirts, including at times forced removal with collusion of the government and supported by police violence. Regarding the street population, the dossier mentions anti-homeless ramps; the closure of shelters in the center and their relocation to the outskirts; coercive measures with children; recurring expulsion actions with regards to street dwellers and “urban cleansing”, the famous “*rapa*” [35, 36].

⁵One result of the resistance that emerged was suspension of the Nova Luz project, by court order, in January 2012, and re-elaboration of the project by mayor Fernando Haddad (PT), in 2013. (“Haddad shelves Kassab’s plan for Luz”. *Folha de São Paulo*, 24/January/2013).

⁶Military Police of the State of São Paulo. *Operação Integrada Centro Legal*. Available at: <<http://www.policiamilitar.sp.gov.br/hotsites/centrolegal/index.html>>. Accessed on: 15/December/2012.

The lack of drugs and the difficulty caused by attachment to them will make people seek treatment. How can you lead users to treatment? Not by reason, but by suffering. Those seeking help are those who cannot stand that situation any longer. Pain and suffering make people reach out for help [18].

As soon as the operation began, accusations of police abuse, aggression, and violation of rights began to multiply. In addition, the practice of involuntary or legally mandated hospitalization of users intensified. The right to life started being used as a justification for the suppression of the capacity of users to determine their own lives. Such is the interpretation published by the Brazilian Psychiatry Association (Associação Brasileira de Psiquiatria), defending the need for hospitalization without patient consent:

Freedom has limits. What has no limits and is unquestionable is the right to life. Even if, to fully exercise this right, the citizen must relinquish freedom for a period of time.⁷

Within medical knowledge, there is evidence of different prescriptions and ethical positions on the issue:

There is no scientific support signaling that dependency treatment should be preferably carried out by means of hospitalization. Paradoxically, hospitalization that has been badly conducted or erroneously recommended tends to generate negative consequences. In the case of compulsory hospitalization, relapse rates reach 95%! In general, the best results are those obtained by means of outpatient treatment [19].

You have to care for those people who are always on the streets (due to abusive use of crack). This [involuntary/compulsory hospitalization] is an act of solidarity and not private imprisonment [20].

It is important to underline that what was being debated was not the possibility of involuntary and compulsory hospitalization, since these approaches are listed in the Psychiatric Reform law [21] as therapeutic tools to be recommended as exceptions, being popular practices in mental health. The controversy was focused on mass involuntary hospitalization as a form of treatment. Thus, Operação Sufoco was already marked by heterogeneous discourses and practices set in motion by governmental actions, with homeless chemical dependents described either as undesirable segments or the subjects of rights [17]. In addition, if these hospitalizations were proving a failure in terms of connection to hospitalization services, the offer of street side care—by both social welfare and health care teams—was also impaired by the operation. The professionals working in the region reported that, with the migration, they lost contact with many users and that these became more reactive and resistant to their efforts, identifying them with the repression carried out by the government.

⁷“Internação compulsória e direito à vida”. *Correio Braziliense*, 06/March/2012. Available at: <www.correiobraziliense.com.br>. Accessed on: 12/December/2014.

At the end of 2012, when Operação Sufoco was completing a year and showing signs of failure, since it was clear that Cracolândia had survived and the use and sale of drugs in the Luz neighborhood persisted, a new intervention was created, focusing on making more beds available for treatment of this population. The year of 2013 began with a cooperation agreement signed by the State Government, in partnership with the Ministry of Public Prosecution and the Brazilian Bar Association (as well as the Public Defender's Office, which joined the effort despite not being mentioned in the agreement), looking at setting up a legal office at the Reference Center for Tobacco, Alcohol and Other Drugs (Centro de Referência Tabaco, Álcool e Outras Drogas—CRATOD), a health care unit in the Luz region, bringing together doctors, judges, and lawyers in order to “accelerate procedures for the process of compulsory hospitalization (predicted by law), in order to protect the lives of those who need it most”⁸.

Reigniting conflicting interfaces with mental health, the Judiciary, by inaugurating a sort of “special court”, added tension to the divergences on the compulsory nature of these hospitalizations occurring with the justice system itself, bolstered by an alignment of the networks regarding the cases. By operating as an administrator for hospital beds, this sets up hospitalization as a primary response that is often fundamentally repressive-punitive in character. In this manner, the scene is set for complex relationships between distinct ethical-political concepts relating to the street population, where hospitalization is lauded as the answer to social misery and to the threat posed by certain segments, contrasting with the viewpoint that defends life and rights. The acts of social expulsion and taking people off the streets are backed by the use of logics by health care services that back repression and incarceration, such as penal-sanitary logics [22], even if these are in constant tension with practices that seek to establish care within the territory and in networks of protection.

Two cases in Brazil's largest city highlight these tensions in care models. The years of 2013 and 2014 would bring new modulations. The Fresh Start Program (Programa Recomeço)⁹, launched by the São Paulo state government in 2013, leant on the integrated work of the Judiciary and Executive powers in order to facilitate medical treatment and hospitalization. Operating with the legal office created at the CRATOD, the program aimed at paying R\$ 1350 per user hospitalized at associated entities, most of which were therapeutic communities, with a total monthly investment of R\$ 4 million in what became known as the “bolsa-crack” (crack stipend)¹⁰. The program adopted the punitive perspective of a “world free from drugs” and a metaphysical-religious view of its subjects, as can be seen in a fragment of the “message” from the communications office of the State Department of Justice and Defense of Citizenship of São Paulo to its beneficiaries, available on the Programa Recomeço site: “May God preserve you in his image and likeness.

⁸“Entenda o que é internação compulsória de dependentes químicos”. *Portal do Governo do Estado de São Paulo* [online]. 29/January/2013. Available at: <<http://www.saopaulo.sp.gov.br/spnoticias/lenoticia.php?id=225,660>>. Accessed on: 29/April/2013.

⁹Joint action by the Department of Health, Department of Social Development, and Department of Justice and Defense of Citizenship.

¹⁰“Cartão para tratamento de usuário de crack custará R\$ 4 milhões mensais”. Tatiana Santiago. *Portal G1*, 09/May/2013. Available at: <<http://g1.globo.com/sao-paulo/noticia/2013/05/cartao-para-tratamento-de-usuario-de-crack-custara-r-4-milhoes-mensais.html>>. Accessed on: 12/December/2014.

This is our expectation for all who are working with us and for many others who depart this difficult path”.¹¹

In 2014, the new municipal government (Mayor Fernando Haddad, Partido dos Trabalhadores 2013–2016) “exchanges Sufoco for Open Arms”¹². The Open Arms Program (*De Braços Abertos* – DBA)¹³ introduced a “rights package” (housing, food, employment, and health), in the words of the national coordinator of mental health at the time, Roberto Tykanori Kinoshita. This placed focus not upon the drugs, but upon the subjectivities, the new groupalities, and the broadening of contractualities¹⁴ of users [23], bringing tension to the actions already implemented and that were based on police and legal “compulsion”.

The DBA, a name chosen by users and workers in assembly, was based on low-threshold treatment services¹⁵ and inspired by successful international experiences in treating those in high vulnerability situations who make use of alcohol and other drugs, such as Housing First, in New York and Vancouver¹⁶. The program aims for the social rehabilitation of beneficiaries by means of job offers—sweeping, gardening, building maintenance, cosmetics and beauty, painting and sculpture, furniture restoration—with an income of R\$ 15 for 4 hours per day of labor, paid weekly, as well as housing in hotels in the area and meal tickets for the Restaurante Popular program. Health treatment is encouraged, although not a condition for inclusion in the program, but on average 60% seek some form of health treatment. Over 450 people signed up and received benefits.

In fact, the complexity of care would be confirmed later by research carried out by the Oswaldo Cruz Foundation [6]: “The profile of crack users at scenes of usage is composed by 80% men, in the group of 20–30 years of age; 8 in 10 are black; 8 in 10 did not reach high school; 40% live on the streets; 49% came from the prison system.”

As pointed out by [23], “the money received weekly for labor creates a new duration, forcing a distinct temporality from the immediacy of crack”, and is used for personal hygiene products and

¹¹Link: <http://programarecomeco.sp.gov.br/noticias/selo-recomeco-vai-recolocar-dependentes-quimicos-no-mercado-de-trabalho/>

¹²“‘Cracolândia’ troca Sufoco por Braços Abertos”, Carta Capital, 16/January/2015.<http://www.cartacapital.com.br/sociedade/cracolandia-troca-sufoco-por-bracos-abertos-mas-ha-duvidas-sobre-novo-programa-6234.html>. Accessed on 21/August/2015.

¹³The De Braços Abertos program began in January 2014, with actions coordinated by the municipal departments of Health (SMS), Social Assistance and Development (SMADS), Development, Labor and Entrepreneurship (SDTE), Urban Safety (SMSU) And Human Rights and Citizenship (SMDHC). (“Programa ‘De Braços Abertos’ completa um ano com diminuição do fluxo de usuários e da criminalidade na região”, site of the Prefeitura de São Paulo, 16/January/2015).

¹⁴“Contractuality—The Contract with the Operation Work Program (Programa Operação Trabalho—POT) contributes to a rupture with the logic that is characteristic of drug use and addiction, lengthening the time between one moment of usage and the next. Work creates a new temporality in the life of program beneficiaries, who start to have new sources of satisfaction in their daily lives, besides perspectives for the future.” [38].

¹⁵“Low-Threshold: the principle of not imposing abstinence as a condition for remaining in care, or for accessing the offered benefits.” The expression literally means a low bar in terms of entry and triggers [27].

¹⁶“Housing First: intervention method already tested and evaluated in several countries of the world; proposes the offer of housing for people living on the streets and users who make intense use of alcohol and other drugs. Some international evaluations point to a reduction in consumption of alcohol and other drugs, of violence and, above all, of the supposed perception of urban disorder due to an excess of conflict on the streets [27].

clothing, injecting local businesses with over R\$ 30 mil each week. From the perspective of harm reduction, the DBA encourages self-care and the guarantee of rights, within a mindset that is not only individual but also collective, and taking into account the singularity of choices and possibilities.

Recomeço and *De Braços Abertos* have opposing perspectives regarding models of health and assistance, the concept of subject, and the concepts of rights and public space. The two programs are rivals in competing for the “users” of the Luz region, not only in an ideological sense but also in terms of the physical space where their hospitality “tents” are set up, one facing the other, close to the region’s flow of drug use and traffic¹⁷.

As pointed out by [24], based on ethnographic studies from the Cracolândia region, a close look at these disputes in terms of treatment and intervention models (involving both the internal quarrels of the public and private entities that offer care for drug users, and the external forces that question the efficiency of their actions) allows us to perceive the complexity of this region, and signalizes that “the State, seen from its tip, or from its margins, is something much more complicated”.

Indeed, if this antagonism aligns radically different destinies and lifestyles, especially for users, it must also be viewed in terms of urban space management. After all, even when recognizing the use of drugs as socially determined and integral to the concept of harm reduction, the national drug policy already demonstrated among its political and legal landmarks the “contradictory and veiled coexistence between two antagonistic perspectives” [24].

As put by [25]: “In each of these programs (and in the region of Cracolândia), there is a matter of the coordination of power mechanisms, guided by distinct logics, but which compose themselves and condition to a large degree the manners of circulation of these populations. These programs fix individuals and social groups to their places of implementation—the programs presume a territoriality, a fixing in place, of the populations classified as their target-audience and, at the same time, end up acting as gravitational poles for others arriving from other places. From one moment to another, they might find themselves obliged to set themselves in motion once again, in search of other hospitality points, due to the effects of repressive actions that operate from a logic of dispersion (liberation, “cleansing” of these spaces), often in the aftermath of the dismantling or deactivation of these programs by the acting governors”.

These logics of *dispersion* and *concentration*¹⁸ operate in a concerted manner, allowing comprehension of these places within a government rationality of urban populations and spaces, by

¹⁷Name given by users to define the area of use in the Luz region.

¹⁸There was a moment of inflection in the forms of state management of the Cracolândia space after Operation Sufoco: from a dispersion rationality, that aimed to prevent gatherings of crack users by means of force (mainly by policing and the resulting “crack processions”), to a government logic based on territorial establishment, on concentrated space, and the multiplication of programs and services offering social assistance, health, and care. In this manner, a field of gravitation around Cracolândia is formed; especially in regard to the extremely poor population with precarious access to housing and employment, and that these subjects that install themselves in the area are made to move on as soon as the local establishments close, going to new locations where they find a possibility of settling [16, 27, 37, 38].

means of traffic management. The State defines and limits where people can or cannot remain according to situational scenarios and interests. These are triage points, from which, according to certain criteria, it is decided who enters and leaves: who may remain, who must be sent on, and to where, following a logic for distribution of people within urban space [16, 26, 27].

The logics of the programs, however, “are far from agreeing on fixed identities that capture individuals. In the liminality between care and control, paths of escape emerge upon which the subjects glide (...)” [28]. Evaluative research on the DBA, qualitative-quantitative in nature, and conducted throughout the first semester of 2015, from the perspective of its beneficiaries, brings forth evidence that the program is “for the most part well evaluated by its participants and that, in fact, the public effort in offering employment, food, and housing has resulted in an improvement of objective and subjective conditions in these people’s lives and in the general diminishing of the problematic consumption of crack” [29] although “the truculence of the actions coordinated by the Municipal Department of Urban Safety, which is an integral part of the DBA, is a permanent threat to the beneficiaries and to the public visibility of the program”.

Despite the beneficiaries’ desire for continuity of the program, and although research indicated important effects from the program, the waves of resentment, destruction, and production of despair that swept the country after the presidential impeachment in 2016 also brought a promise from the new mayor, João Dória¹⁹, of ending the DBA and adopting in the municipality a program aligned with the already-existing Recomeço, named Redemption (Redenção).

By the end of the first year of the new administration, the manager of the Redenção program stated that they were not about to deny the advances and good ideas brought by the DBA, but let it slip, as pointed out by [25], that different mechanisms of power combine to create “governable spaces” — which also means spaces that are protected against the “undesirable behaviors” associated to these ineffable figures of all who are seen as risk carriers and threats to a certain regime of order and safety: in different manners according to circumstances, between use of coercion (and violence) and the policing of conducts, between punishment and “protection”, between incarceration and “care”.

4. Conclusions

This brief incursion into urban policies adopted under the urgency of “crack combat” indicates that policies aimed at the street population that were ushered in after 2010 exacerbated existing tensions between care and protection in policies for health care, welfare, and public safety. If,

¹⁹João Dória, affiliated to the PSDB, was elected with 3,085,187 votes, corresponding to 53.29% of valid votes. Doria is the first mayor of São Paulo elected in the first round of voting since 1992, when elections began to have two rounds. He had as his main campaign marketing strategy his self-attribution as an administrator and not a politician.

on one hand, they strengthen care practices relating to the use of alcohol and other drugs, consolidating the “chemical dependent” in public policies and the allocation of specific funding, on the other hand, they do not always allow visibility of the complexity that gives rise to these processes, resulting from the combination of a diversity of demands and needs, and belonging to several spheres of interpretation and intervention for which there is no single or definite institutional solution.

Even though sanitation and roundup operations are not new within urban policies, the drug issue is placed in the field of health as central to management of the street population, re-establishing the duty of medical policing. Painted as a continuum of the “politics of pain and suffering”, psychiatric hospitalizations as a primary response reinstall the mandates of protection of the social order and neutralization of the threat attributed to certain individuals. The idea of drug-related danger and the lack of capacity of users to overcome this become a motto to be disseminated in society. The epidemic was in the numbers presented and the discourse that supported them. Within this policy, medicalization as a strategy and process gains force among several social segments [30].

Heterogeneous, the health field tended toward, on one hand, the creation and investment in hospital beds for confinement, and on the other hand, itinerant care mechanisms (such as Community Health Agents, Harm Reducers, and Street Clinics), which widened the focus to include care strategies based on harm reduction and defending life [31]. Thus, the “itinerant” professionals reaffirmed the idea of health as a defense of dignity and social rights, counter to the assimilation of social control roles, such as “medical police” [23]. This tension still marks the policies created in Brazil in the last decades. If the homogeneity of the first decades of policies centered on abstinence and repression was a characteristic of the time, the novelty of the new policy brought a diversification of treatment models and mechanisms. These models persisted not as a planned offer based on the demands raised with users, but based on disputes such as market competition for sellable goods, professional employability, and the interests of the pharmaceutical industry.

Indeed, abandonment and vulnerability become dangerous when complexity stops being taken into account, working instead with single or fragmented institutional responses [32]. By pathologizing complex social demands, and defining them as risky, untreatable, and unrecoverable, we see a heightening of expulsion processes in the social field [33].

Author details

Maria Cristina Gonçalves Vicentin¹, Jacqueline Isaac Machado Brigagão^{2*} and Pedro Paulo Freire Piani³

*Address all correspondence to: jac@usp.br

1 Department of Social Psychology, Pontifical University of São Paulo, Brazil

2 University of São Paulo, Brazil

3 Federal University of Pará, Amazonia, Brazil

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