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Original Article

Reflection on the policy of the Brazilian Ministry of Health for the care of alcohol and other drugs users under the view of the Sociology of Absences and Emergencies

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In 2003, the National Policy of the Brazilian Ministry of Health was implemented to care for users of alcohol and other drugs. This is a interpretative and documental research with the objective of reflecting on the refereed Policy, under the theoretical reference of the Sociology of Absences and Emergencies. The Policy came from the social movements that for more than two decades have demanded inclusive forms of care, since the centric-hospital model was exclusion. The against-hegemonic origins give the Policy legitimacy, which proposes the psychosocial rehabilitation and the social emancipation of people with existence-suffering. The action practiced by the mental healthcare teams in the territories is what will ensure its success.

Descriptors: Public Policies; Alcoholism; Toxicology; Health Management; Social Sciences; Nursing.

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Reflexão acerca da política do ministério da saúde brasileiro para a atenção aos usuários de álcool e outras drogas sob a óptica da Sociologia das ausências e das emergências

Em 2003 foi implantada a Política Nacional do Ministério da Saúde do Brasil para a atenção aos usuários de álcool e outras drogas. Estudo interpretativo e documental que objetivou refletir acerca da referida Política, sob o referencial teórico da Sociologia das ausências e das emergências. A Política emergiu dos movimentos sociais que, por mais de duas décadas, reivindicaram formas inclusivas de cuidado, pois o modelo hospitalocêntrico era o de exclusão. As origens contra-hegemônicas conferem legitimidade à Política, que se propõe à reabilitação psicossocial e à emancipação social das pessoas com existência-sofrimento. As ações praticadas pelas equipes de saúde mental nos territórios é que garantirão o seu sucesso.

Descritores: Políticas Públicas; Alcoolismo; Toxicologia; Gestão em Saúde; Ciências Sociais; Enfermagem.

Ponderación acerca de la política del ministerio de la salud brasileño para la atención a los usuarios de alcohol y otras drogas bajo la óptica de la Sociología de las ausencias y de las emergencias

En 2003 fue implantada la Política Nacional del Ministerio de la Salud de Brasil para la atención a los usuarios de alcohol y otras drogas. Estudio interpretativo y basado en documentos que objetivó reflejar acerca de la referida Política, bajo la referencia teorética de la Sociología de las ausencias y de las emergencias. La Política emergió de los movimientos sociales que, por más de dos décadas, reivindicaron maneras inclusivas de cuidado, pues el modelo hospitalocéntrico era lo de exclusión. Los orígenes contra-hegemónicos confieren legitimidad a la Política, que se propone a la rehabilitación psicosocial y a la emancipación social de las personas con existencia-sufrimiento. Las acciones practicadas por los equipos de salud mental en los territorios es que garantizarán su éxito.

Descriptores: Políticas Públicas; Alcoholismo; Toxicología; Gestión en Salud; Ciencias Sociale; Enfemería.

Introduction

The harmful use of alcohol and other drugs is considered a multi-factorial disorder. Unfortunately, in many societies, it is still not considered a public healthcare problem and many people suffer, because they are stigmatized and do not have access to treatment and psychosocial rehabilitation[1].

Alcohol is a substance present in the daily life of practically everyone. Its use is considered common in our society, been related to parties and celebrations, and to socially valued questions, like pleasure, freedom and leisure. Drinking is socially approved in several social groups, which makes it difficult to establish limits between

recreational consumption and dependency[2].

It estimated that 205 million people use illegal drugs, including the 25 million that are dependants. This consists in a public healthcare problem; affects the social-economic development and generates demands related to safety, in industrialized and developing countries[1]. Therefore, the negative consequences of this condition has repercussions in the family, social, on the health, besides the significant economic impact[3].

The continuous use of psychoactive drugs can impact epidemiological indicators like: consumer market of alcoholic beverages, traffic accidents, violence and criminality and hospital admissions, besides anti-social behaviors, inefficiencies in jobs that require strength and difficulties for family members and users[4-5].

The harmful consumption of alcohol generates a significantly higher cost than the one caused by tobacco and other drugs. It is estimated that Brazil spends, annually, 7.3% of the Gross National Product (GNP) with treatments and social assistance related to its use[4-6].

The amplitude and seriousness of the problems mentioned above require that the governmental offices of all the countries adopt policies and strategies that decrease the use of drugs by the population in general, as well as avoid consequences of the harmful use of these substances. However, a policy cannot be traced with only one objective: abstinence, since working this way, in healthcare, means working with a very narrow understanding of this issue[7].

The healthcare policies for issues related to harmful consumption of alcohol and other drugs presented different conformations and objectives, and this article has the objective of analyzing the National Policy of the Brazilian Ministry of Health for the integral care for users of alcohol and other drugs[8], in the perspective of a theoretical sociological referential, since there are no similar studies published.

The issue raised here is if the Policy in question meets the demands of the alcohol and other drugs users. Furthermore, the authors wanted to verify if the policy is consistent with the demands of the users of psychoactive substances.

Methods

The qualitative, interpretative and documental study consists in part of the theoretical basis of the doctoral thesis of one of the authors.

The documental research enables the exam of materials that were not submitted to an analytical treatment yet, or that can be reexamined for new interpretation or complementation. It can serve as basis for other qualitative studies, besides enabling that the researcher's creativity guides the investigation under different perspectives[8].

For the analysis of the Brazilian National Policy of the Ministry of Health, in caring for users of alcohol and other drugs, in order to verify if this Policy meets the demands of the users; the theoretical referential of the Sociology of Absences and Emergencies will be used, built from a critical theory called Emerging Paradigm, which preconizes "a prudent knowledge for a decent life"[10]. The theoretical construction is opposed to the modern rationality, and that is why is called critical.

In the view of the Sociology of Absences, the knowledge in order to be useful, must allow to be applied in the social field and promote transformations in people's life, so they can have a decent life.

The Sociology of Absences is proposed as a procedure for the widening of the world and dilation of the present. It is about logic "that seeks to show that what does not exist is , actually, actively producing as non-existent, that is, like a non credible alternative to what does exist"[10].

The objective of Sociology of Absences is to transform impossible objects into possible and based on them transform absences in presences, centering in the fragments of non-socialized social experiences by the rationality of metonymic totality. In this sense, all of the efforts must be placed in the sense widening the life experiences of the present, of alcohol and other drugs users, in order to contract the future, bringing it closer[10].

The theoretical construction defends the thesis that a cosmopolitan rationality proposes to expand the present and contract the future, only that way we can create a space-time necessary to know and value the inexhaustible social experience that happens in the world today, avoiding the huge waste from these experiences. To expand the present, the Sociology of Absences is proposed, and to contract the future, the Sociology of Emergencies[10].

The role of the Sociology of Emergencies is to replace the void of the future, accord to linear time (a void that is everything is also nothing), for a future of plural and possible possibilities, therefore, concrete. This is with the care activities we have in the present[10].

Results

The current National Policy of the Brazilian Ministry of Health for integral attention to users of alcohol and other drugs, that is going to be analyzed, was instituted by means of Bill nº2,197/GM, in October 14th of 2004. The analysis of the Policy enables the verification of what it consists, with the demands of psychoactive substance users.

In Brazil, the social exclusion and absence of care mark the existence of carriers of mental disorders, users and dependants of alcohol and other drugs, since the interventions to the health of the users and dependants of alcohol and other drugs in the country, throughout history, resumed in are initiatives of total character, having abstinence as the only objective to be reached[8].

Law 10,216, from April 6th of 2001, which was a historical Mark for the Brazilian Psychiatric Reform, rectified Law 8080/90, which establishes that directive of the Universal Healthcare System, ensuring all users and dependants of alcohol and other drugs, the universality of Access to integral assistance, prioritizing the decentralization of healthcare services, determining that they should be structured within the community, close to the social environment of the users. Therefore, the

assistance networks must center themselves in the existing inequalities, adjusting their actions to the demands of the population, to meet the demands in a equal and democratic way[8,11].

Based in the conceptions of the Psychiatric Reforms, the construction of the assistant network began based in extra-hospital devices of psychosocial care, located in the territory and articulated with other social sectors. This network that has the objective of social reinsertion of the subjects who experienced a existence-suffering or that have already developed psychic problems from the abusive use of alcohol and other drugs[12].

In the realm of the Universal Healthcare System, Bill GM/816, from April 30th of 2002, instituted the National Program of Integrated Community Action to Users of Alcohol and Other Drugs, taking into consideration the multiplicity of organizational levels of the assistance networks located in the States and Federal District, the different population profiles existent in the country and the variability of incidence of disorders from the abusive use and/or dependency of alcohol and other drugs.

With this, it is proposed the implementation of the Centers of Psychosocial Attention Alcohol and Drugs - CAPSad, with the objective of improving the assistance in mental healthcare and shelter, in therapeutic projects, care practices that contemplate flexibility and comprehensiveness possible to the demands of the attended population, under the strategic perspective of reduction of social damages and health[8].

Considering the advances in accessibility, coverage and quality in mental healthcare treatment, the Ministry of Health instituted, by means of Bill GM 678, of 2006, the National Strategy of Assessment, Monitoring, Supervision and Technical Support to CAPS and other services of the public network of mental healthcare of SUS. The coordination of Mental Healthcare of the Brazilian Ministry of Health divulged, in June of 2010, that Brazil counts on 242 CAPSad in the national territory[8].

We noticed that the use of alcohol and other drugs is an issue that transcends to other healthcare areas, since it involves justice, education, social well-being and development. Therefore, a series of inter-sectional articulations are necessary with several sectors of civil society, like union movements, universities and community organizations. These articulations are essential to elaborate the strategic plans of States and municipalities, in order to increase the actions directed towards hard-to-reach populations, besides been essential instruments for the promotion of social rights and control[8].

In 2005, through Bill GM 1612, mechanisms for financing beds for alcohol and other drugs in general hospitals - GH were regulated, with the objective that users of chemical substances were admitted in beds of general hospitals and no longer in psychiatric hospitals. However, the number of beds in GH is still insufficient to meet the demand[11].

According to the data from the Ministry of Health, of June 2010, Brazil has 2,568 available beds in 415 GH. With this, many users in situations that demand admission, are still admitted in beds for detoxification of alcohol and other drugs in psychiatric hospitals, private clinics or in therapeutic communities, which at many times have inadequate hospitality conditions.

In 2005, the National Pact for the Reduction of Accidents and Violence Associated to the Prejudicial Consumption of Alcohol was implemented, under the coordination of the Ministry of Health and Justice, National Office on Drug Policies – Senad and National Mayoral Front. In that same year, Bill 1,059, of 2005, regulated the financial incentives for the CAPSad that would develop actions of harm reduction. For cities that had only CAPS I, it was authorized for them to charge SUS for the treatments to people with disorders that resulted from the use of alcohol and other drugs, by means of Bill SAS 384, of 2005[11].

In the Program, the control of narcotics and substance that cause physical or psychic dependency is regulated by ANVISA – National Agency of Sanitary Safety, according to Bill SVS/MS nº344/98, competency executed by the Ministry of Health, under shelter from article 6th of Law nº6368/76[6]. Just the same, the residential therapeutic services, instituted to enable psychosocial rehabilitation of people with alcohol and other drugs dependency, are regulated by means of the Resolution of the Collegiate Board of nº101/2001, from May 2001. With these attributions, Anvisa is included amongst the agents that accepted the challenge of facing issues regarding alcohol and other drugs, with their psychic, social and economic consequences – one of the major problems of modern society[8].

The Ministry of Health, is currently investing efforts in the incorporation of actions of harm reduction by other programs from SUS like the Programs of Community Agents and Family Healthcare. However for the Ministry, the harm reduction must be the logic applied as referential for political, educational, therapeutic and preventive actions, in all levels. Bill GM 1028 of 2005, regulates the actions that seek the reduction of social and health harms, removing from been an institutional clandestine, this valuable strategy of approaching problems associated to alcohol and other drugs[8].

Actions like the restriction of cigarettes and other tobacco-derived products, in collective locations, are harm reduction strategies, which respects the individual choice of who consumes this substance, but also stopping the harmful and unpleasant effects to non-consumers, preserving and protecting public health. In the same manner, classes are given that include issues of sexuality, drug use and STD/AIDS in the course curriculum. These strategies work for the prevention and also promoting the health of the population[8,13].

In June of 2009, the Ministry launched the Emergency Plan of Increasing Access to Treatment and Prevention of Alcohol and Other Drugs (PEAD), directed to the 100 largest Brazilian cities, more than 250 thousand inhabitants, all of the capitals and seven border cities were selected, totaling 108 cities. These cities add 77.6 million citizens, corresponding to 41.2% of the national population[14].

PEAD has the goal of reaching, as a priority, children, teenagers and young adults in a situation of serious social vulnerability, by means of preventive actions, promotion and treatment of the risks and harms associated to the prejudicial consumption of psychoactive substances. To reach these objectives, four action axes were predicted: increase of access, qualification of the professionals, intra/intersectional articulation, as well as health and rights promotion, besides facing the stigma[14].

In December of 2009, the Ministry of Health launched the National Campaign of Warning and Prevention of Crack Use, considered a never seen before action to prevent drug use, crack is derived from cocaine and has a high degree of dependency, with the slogan "never try crack"[14].

Associated to the National Campaign of Warning and Prevention of Crack Use, the Ministry of Health released the financial incentive for projects called Street Clinics, in 50 cities, with approximately 500 thousand inhabitants, to offer actions of health promotion, basic care and harm reduction to people living or in the streets, and are users or dependants of alcohol and drugs[14].

Since 2006, the Ministry has been developing, in partnership with researcher of the Medical School of Riberão Preto, the Program of integrated actions for the prevention and care to the alcohol and other drugs users in the community - PAI-PAD, which seeks the capacitating of professionals of Basic Care for the tracking of alcohol consumption and the use of brief intervention strategies - BIs[14].

Two other measures of the Ministry of Health consist in the implementation of 60 Halfway Houses, structures designed to shelter alcohol and drugs users in situation of risk, and 70 Reception Points to users of crack and other drugs, action already adopted in several countries. The Reception Points are open spaces, in urban centers with more than 400 thousand inhabitants, that receive the people for food, shower and rest[14].

Discussion

The movement of psychiatric reform initiated with the process of Sanitary Reform in Brazil was, later, headed by the Movement of Mental Healthcare Workers, of against-hegemonic character, considered as a political device in the project of the Brazilian Psychiatric Reform. Therefore, proposals of reformulation emerged from the assistance system that consolidated the critical thinking in the psychiatric knowledge[15].

In western culture, will is associated to objective conditions, since there are two social distinctions of subjectivities: rebels and conformists. The rebel subjectivities are those that are always seeking changes, do not conform to the present situation[15-16]. These transgressive subjectivities do not articulate through a political path, in a conformist action, but by promoting the rebel action.

Rebel subjectivities are capable of producing an alternative to conservative and neoconservative hegemony and their deeds in increasing human-social barbarism[16-17].

In the historical scenario of the Psychiatric Reform, the mental healthcare workers – the rebel subjectivities – seek in the hegemonic power, represented by the Ministry of Health, the access path so that their demands and proposals are legitimized.

In this sense, the manifestations of workers and scholars in the scenario of acting/study in alcohol and other drugs sensitized the Ministry of health to change many of these services from, level II to III, which will minimize the difficulties faced in the intervention of health problems, associated to the consumption of psychoactive substances, that are befallen on the users and at many times brief admissions are required[14,18].

The deconstruction of the exclusion paradigm of the person that has an existence-suffering and the construction of a new one, is what brings the perspective of living with differences, it is a process; still when these human figures excluded from society do not participate in the process of production and represent onus to the productive parcel of the population.

Although the reform in health, education or social services announced in the post-modern world are, at most times, to worsen the lives of their citizens, it must be consider that theoretically, the National Policy for the care of users of alcohol and other drugs, the Brazilian Ministry of Health, tries for the social emancipation of these people[17], because it proposes strategies that promote care, autonomy, the psychosocial rehabilitation and the social inclusion by working, once that these people recognizes themselves as citizens, by working.

The authors use the expression "theoretically" because, although they are prescribed in the strategic policies that focus on a triad of psychosocial rehabilitation: housing, work and social network, at many times these do not materialize in the daily life of the CAPSad, given the complexity of these issues and the difficulties of intersectional articulation.

Regardless the heavier association of violence with drug trafficking, studies show that the rates for domestic and urban violence, among people that consume psychoactive substances, are more elevated than the ones that do not use them, besides the higher involvement in traffic accidents, been under the effect of these substances[19-22]. Therefore, the strategies proposed by the National Policy of the Ministry of Health fight for the autonomy and emancipation of the social subject, once it proposes decreasing the participation of users in this epidemiological census.

Here, the authors understand the emancipation of the user has been their psychosocial rehabilitation. The emancipation of the subject is process of regaining dignity, of the condition of citizenship. To think about emancipation is to think about promoting freedom, equality and solidarity.

The space where it will happen is in the community, because the role of the State is social regulation, which counterpoises to the principle of emancipation. However, "the community lies on the horizontal politics obligation between individuals or social groups and in the solidarity

it occurs from it, solidarity concrete and participative, that is, socially contextualized". Therefore, under the point of view of emancipation, it is possible to think about other forms of citizenship, more comfortable with participation than rights and duties, non liberal and non nationalizing, but enable a more balanced relation with subjectivity[23].

The Sociology of Absences is a transgressive process, an insurgent Sociology to try to show, what does not exit is produced as non-existent, as a not believable alternative, as a disposable alternative, invisible to the hegemonic reality of the world[10]. There are ways to produce absences and the referential develops in opposition to the following rationales: monoculture of knowledge and the rigor of knowing, monoculture of linear time, the logic of social classification, dominant scale and logic of non-existence – productivist logic[22].

Until some time ago, the only public policy that existed for the abusive use of alcohol and other drugs was coercive and did not approach the issues related to health and the subjectivity of the human being. Compulsive drinking was associated to a deviation of moral conduct and it was a justice matter. Not that this perception was inexistent in society, but today we see discussions surrounding these social vulnerabilities related to heavy drinking and drug use, considered illegal, and how much it leads the person to the condition of falling ill and existence-suffering.

There are nowadays, two public policies for matters related to the consumption of alcohol and other drugs: one elaborated by the Ministry of Health of care to users of alcohol and other drugs, in analysis by this article, and another, approved by the National Antidrug Council of the National Office on Drug Policies – Senad.

The authors admit that the National Policy of the Ministry of Health has been constructed with the help of the users, family members and workers, that expressed themselves in the collective, as seen in the IV Conference of Mental Healthcare, taking place in June/July of 2010, in Brasilia. It is exactly the "participation" of interest segments of society that gives a against-hegemonic character of producing realities where the empty would rule, the inexistence.

In the mental healthcare services, of community character, many workers act as rebel subjectivities and with greater understanding of the users' demands, they manage to develop a model of care in health, which involves sheltering, humanization, bonding and integral attention to health. These practices are opposing to the medical and hospital-centered model.

In this perspective, in the area of user attention, other against-hegemonic strategies may emerge that are not known in society, because it is still a non-existent knowledge, not recognized. "The Sociology of absences and the Sociology of emergencies will produce a quantity of realities that did not exist before"[17]. From the knowledge path that comes from day-to-day life, strategies can be created that will answer the needs of those who live realities considered inexistent.

The logic of harm reduction, which has started to be applied in Brazil in the 80's, goes against the hegemonic model of existence. This logic that associates with the absence of consumption, without considering the needs, dependency and the rights of subject-citizen.

The harm reduction does not exclude abstinence as objective for the dependents, but realistically it allows the people to make more pragmatic choices to limit their consumption. On the hand, it helps the people to engage, motivating them to contact the services, when they feel ready to. Harm reduction operated under the logic of Sociology of Emergencies that defends the idea of working with the possibilities of people.

In this perspective, the succession of horizons lead to a final state and approach three modal characteristics of existence: reality, need and possibility, the last one been despised by modern science[10].

The Sociology of emergencies is the investigation of the alternatives that fit in the horizon of concrete possibilities. This Sociology widens the present, incorporating as the possibilities and expectations it carries. Widening the present implies in contracting the future, since the "not yet", far from an infinite and empty future, it is a concrete future, even if uncertain and always at peril[10].

Under the rationality of a Sociology of emergencies, care for users of alcohol and other drugs is to proceed with a symbolic widening of the practices, knowledge and agents, in order to identify the tendencies of the future, that is, the "not yet", under which one can act to maximize the possibility of hope and in relation to the probability of frustration. This symbolic widening is, actually, a sociological and political imagination that has two objectives: two know better the conditions of possibility of hope and define the actions that will promote the actualization of these conditions[10]. Therefore, these practices of harm reduction are placed in the "not yet" of the users, it becomes a possibility, a hope of still been able to quit. The conception of abstinence, on the other hand, most of the users' live through the raining frustration of a number of unsuccessful attempts.

In the same manner, the campaigns of the Ministry of Health, faces head on the increasing consumption of crack in Brazil, they launch new strategies, like the street clinics and halfway houses; thus investing in possibilities that coincide with the users' way of life, which with frequency, already have become social pariahs, no job, housing and social relations. These strategies mean, to these users, a possibility for social emancipation in an individual plain.

In sum, preventive campaigns for the consumption of alcohol and other drugs, with emphasis in crack, have been broadcasted in the media.

This article fulfill its mission, to expose the National Policy of the Ministry of Health for the integral care of users of alcohol and other drugs was elaborated after great mobilization by the workers, users and family members, around the demands of a more dignified and socially-rehabilitative treatment, for those that experience existence-suffering from the dependency of psychoactive substances.

Final Considerations

The current National Policy of the Brazilian Ministry of Health for the integral care of users of alcohol and other drugs abide to the prescriptions of the Conferences of Mental Healthcare and Law nº 10,216 that redirected the model of care, seeking the psychosocial rehabilitation of people that suffer from mental disorders and users of alcohol and other drugs.

The National Policy meets the demands of the users, as it was implementing services of a community base, and currently, investing resources in new service models and program, like the street clinics, halfway houses, PAI-PAD and PEAD, with the expectation to rehabilitate the most number of people and prevent that other people become dependents.

In the perspective of Emerging Paradigm, we understand that psychosocial rehabilitation and social emancipation is produced from the Sociology of absences and emergencies, in the perspective of social inclusion by means of strategies and possibilities that are considered by society as inexistent, for not been expressive in the value scale.

We understand, under this view, that the mental healthcare professionals has the challenge of realizing the gift of life of the users as something ephemeral, and they should not disregard these strategies; today, the users won't have what to gather in the future, maintaining the retro-feeding of the dependency.

Therefore, if the Policy is conceived from the social demands, giving it legitimacy, the Ministry of Health and the mental healthcare professionals must invest a lot, in order to offer, in the future, the desired assistance for the users and dependent of alcohol and other drugs. For that to occur, it is necessary that we prioritize a more humane assistance, characterized with more sensitivity to listen, without prejudices. This assistance can be possible by changing the attitudes; search of knowledge, perfecting the skills and recognitions of the existence of others, from what is considered inexistent.

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