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Original Article

The implications of a transitional Reception Unit for drug users*

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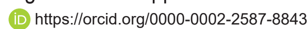 https://orcid.org/0000-0002-2587-8843
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Objective: this study aimed to understand the meanings of the experience of transient residential care, in a Reception Unit, from the users' perspective. Method: to this end, a qualitative research was conducted using ethnography as a methodological strategy. The data collection procedure involved participant observation with a total of twelve users and open interviews with seven of these. The analysis was made through the triangulation of the data and, for the presentation, the Natural History of the Research was used. Results: the results showed that the unit represents a place of bond, with the possibility of self-care and freedom, in addition to the possibility of reducing drug use. Conclusion: it was concluded that this is a powerful space that can be used for both effective and only temporary exit from the streets.

Descriptors: Mental Health; Homeless People; Drug Users; Substance-Related Disorders; Cultural Anthropology.

* Paper extracted from master's thesis "Lançar as amarras ao cais ou viver à deriva? A experiência de uma unidade de acolhimento para usuários de álcool e outras drogas em situação de rua", presented to Universidade Federal de Santa Catarina, Florianópolis, SC, Brazil.

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Os significados de uma Unidade de Acolhimento transitória para usuários de drogas

Objetivo: este estudo teve como objetivo compreender os significados da experiência do acolhimento residencial transitório, em uma Unidade de Acolhimento, da perspectiva dos usuários. Método: para tanto, foi realizada uma pesquisa qualitativa utilizando-se da etnografia como estratégia metodológica. O procedimento de coleta de dados envolveu a observação participante com o total de doze usuários e entrevistas abertas com sete destes. A análise foi feita por meio da triangulação dos dados e, para a apresentação, utilizou-se da História Natural da Pesquisa. Resultados: os resultados apontaram que a unidade representa um local de vínculo, com possibilidade do cuidado de si e em liberdade, além da possibilidade da redução do uso de drogas. Conclusão: concluiu-se que se trata de um espaço potente que pode ser utilizado tanto para a saída efetiva quanto apenas temporária das ruas.

Descritores: Saúde Mental; Pessoas em Situação de Rua; Usuários de Drogas; Transtornos Relacionados ao Uso de Substâncias; Antropologia Cultural.

Los significados de una Unidad de Acogida de transitoria para los consumidores de drogas

Objectivo: este estudio tuvo como objetivo comprender los significados de la experiencia de acogida residencial tansitoria em una Unidad de Acogida, desde la perspectiva de los usuarios. Método: para ello, se realizó una investigación cualitativa utilizando la etnografía como estrategia metodológica. El procedimiento de recolección de datos involucró la observación participante con el total de doce usuarios y entrevistas abiertas con siete de ellos. El análisis se hizo por la triangulación de los datos y para la presentación se utilizó la *Historia Natural de la Investigación*. Resultados: los resultados mostraron que la unidad es un espacio de vínculo, com la posibilidad de cuidado de si mismo, en libertad y, además, con la posibilidad de reducir el uso de drogas. Conclusión: se concluyó que esa unidad es un espacio de gran alcance que se puede utilizar tanto para una salida efectiva o como una salida pasajera de la calle.

Descriptores: Salud Mental; Personas sin Hogar; Consumidores de Drogas; Transtornos Relacionados con Substancias; Antropología Cultural.

Introduction

The relationship between drug use and homelessness is a phenomenon that has been studied in so-called contemporary complex societies since the last century. In recent years, in Brazil, this theme has gained notoriety as it has been widely explored by the mainstream media as one of the main concerns related to the fact that the country hosts two major world sporting events: the soccer World Cup in 2014 and the Olympics, in 2016.

What is invariably observed in these major repercussions on drug use by the homeless population is the lack of depth with which the phenomenon is addressed and the neglect of the discussion about conditioning and determining factors. In general, it is pointed to the user as solely and exclusively responsible for their condition and / or the drug itself as the great evil to be combated for having taken this user to the street situation. This explanatory model is known as the medical / legal-moral prohibitionist paradigm[1].

Recent studies aimed at understanding drug use in the context of homelessness have pointed to the need to overcome these reductionisms that place drugs at the center of the problem. A nationwide study, conducted by the Oswaldo Cruz Foundation (FIOCRUZ), funded by the National Secretariat of Drug Policy of the Ministry of Justice (SENAD / MJ), with the intention of elucidating responses so that the State knows more about regular users of crack in the country brought some revealing data. What drew the most attention were the numerous markers of social exclusion present among users. The hypothesis formulated with the results was that social exclusion aggravates the consequences of use, but, moreover, exclusion and use form a vicious cycle that feeds back[2].

In the qualitative part of the research, a study with those who live on the streets revealed a curious continuity relationship between the house and the street. Many report that they were literally born on the streets or from extremely poor families with stories of deprivation and violence, and had the street as their main space for daily living, even while still living in a house[3].

In the research of evaluation of the program "Of Open Arms", of the city of São Paulo[4], The most varied notes of homeless people appeared about the factors that led them and keep them in this situation. Family conflicts, separation, unexpected pregnancy, professional failures and unemployment are some examples that mark the trajectory of these people. Drug use is not always mentioned, although this is often the case. There are a multitude of challenges faced by those who live on the streets, with crack cocaine and other drug use being just one of them.

These large studies also show that "housing", "residence" and "having a roof" often appear among the main demands of this population regarding public policies as a basic condition for producing significant changes in their lives.

The demands of the problems arising from the use of drugs in the health area are addressed by the field of knowledge of Mental Health and, specifically, in Brazil, they are dealt with in the scope of Psychosocial Care. With the Brazilian Psychiatric Reform (BPR), regulated by Law 10.216[5], substitute services to psychiatric hospitals, especially CAPS, have multiplied as a free care proposal for both people with so-called mental disorders and those with drug problems.

The issue of drugs and problems related to their use has gained prominence within this new way of approaching Mental Health and a privileged space of care: the specific CAPS in the Alcohol and Drugs modality, known as CAPS AD. If previously these demands were dealt with by Psychiatry, within the asylum logic in psychiatric hospitals or in mainly religious communities of therapeutic nature, in both cases, from the single perspective of abstinence, with the BPR, it was possible to expand the possibilities of attention.

In the ten years following the publication of this law, after numerous experiences, the actors involved with these policies identified the need to enhance and expand technologies in Psychosocial Care, proposing new practices and strategies to overcome problems that the BPR could not fully overcome. To this end, in 2011, a Psychosocial Care Network (PSCN) was established)[6]. This network included existing services and laid the foundation for the creation of other.

With this new configuration, in 2012, a new service called Reception Unit (RU) emerges as a point of attention for the RAPS Transitional Character Residential component. For the Ministry of Health, the RU is a residential care unit for people with needs arising from the use of crack, alcohol and other drugs for up to six months. It should function as a full-time, 24/7 residence, in conjunction with CAPS AD. Provides voluntary care and ongoing care for people in situations of social and / or family vulnerability, usually homeless, who require therapeutic and protective support[7].

The primary purpose of the RUs is to provide transient housing, but also to provide wider and more comprehensive attention to those most vulnerable. They seek to work fundamentally under the freedom of care paradigm, without the need for long-term removal and hospitalization. They are guided not by abstinence-based treatment as the only possibility, but by looking

at subjects' singularities and reducing harm as a guide to their practices.

The logic of mental health care in CAPS AD and RUs is based on the idea of displacing the treatment of the psychiatric hospital and closed institutions, places without social exchanges[8], to the flat territory of everyday life. "Disease" as a simple and concrete object is transformed into a complex object and linked to the multiple dimensions of life. This means necessarily acting in the transformation of subjectivity and ways of life[9].

The emergence of the RUs was the result of the sum between the need to respond to drug-related demands and a gap in health services for homeless people, with problems arising from use, which needed comprehensive care.

This article results from the master's dissertation of one of the authors, whose proposal was to address part of this phenomenon in the context of Public Policies of Mental Health and Psychosocial Care, more specifically from the RU as a device that proposes to offer a coping alternative. To this emerging issue in recent decades: drug use by the homeless.

The objective of this study was to start from an ethnographic study: to understand the meanings of the experience of transient residential care in a RU from the users' perspective.

Method

The methodological design built in this study was inspired by the formulations of Edward MacRae, from the Federal University of Bahia (UFBA)[10-11], on methodological aspects and qualitative approaches in the study of psychoactive substance use issues from a critical perspective to the biomedical health model. It is an ethnographic study, with participant observation. Such method falls within the field of qualitative and descriptive field research.

The research scenario was a RU of a large city in southern Brazil. The survey participants were residents of this RU, who were welcomed in the unit, and former residents, who had already had the experience of hosting. Nine residents who were or were in the host during the field research period and three former residents, in a total of twelve, participated in the study. The selection was made by invitation and free acceptance and the inclusion criterion was the key informants.

The main data collection procedure consisted of the participant observation itself. During a period of six months, from January to June 2018, a systematic daily immersion in the field was made, from Monday to Friday, from 12h to 18h. Such procedure had as record instrument the Field Diary. In addition, open interviews were conducted, conducted by a script indicating some items to explore, with which we sought to investigate in depth specific information. A total of seven interviews were conducted, four with residents and three with former residents. The saturation principle was used to delimit this sampling.

The analysis model, because it deals with subjects whose purpose is to describe and classify them into qualitative categories, was made by triangulating the data obtained by the different means of observation and registration. Discourses, practices and constitutive representations of a shared culture were sought, seeking not to create falsely homogeneous groups, but to apprehend units of operation, beginning with the analysis and understanding of interrelated details, which are identified in ever-changing broader patterns and processes, having as parameters, analysis categories.

The presentation of ethnographic data was made through the Natural History of Research[10]. It involves the explicit and systematic description of all elements and steps of the process, with historical and contextual narration.

The study is in line with that proposed in the guidelines established by Resolution No. 466 of 2012 of the National Health Council[12]. The provisions of Law 10.2016 were also observed. The project was submitted to the University's Research Ethics Committee, with favorable opinion No. 2,646,531. Participants who agreed to participate signed the Free and Informed Consent Term (FICT).

Results as Discussion

The universe of what is known as "homeless people" is not homogeneous, even though they share certain common features. Among them, there are those who directly access public services and those that do not. Those who access are divided between those who do it eventually, or emergently, as a way to meet some basic need for survival, and those who do so often and seek to be linked mainly with services especially geared to this population.

Such a link may have two distinct functions, not necessarily mutually exclusive. The first is the maintenance of nomadic life through access to baths, clean clothes, blankets, food, document making, among others. The second is helping to settle in and out of the homeless by rescuing family ties, relocating to the job market, professional qualification, health care and reducing drug use.

Homeless people arriving in the RU are almost exclusively those who make up the latter group, who are more or less regulars in public services. This is due to the specificity of the unit, which is to provide transitional

residential support for those undergoing treatment at CAPS AD, ie, who voluntarily sought assistance.

Those who arrive and those who stay

From the speeches of the key informants interviewed, it was possible to identify categories of "types" of RU residents. It is, at first, how the residents themselves identify each other within their value judgments and compare them to themselves. They are: 1 - those who wish to settle. This implies a process of changing lifestyles, including decreasing drug use, seeking formal employment, rescuing and sharing social norms that have been partly abandoned; 2 - those who just want to temporarily get off the streets. In general, they do not articulate movements of change either to address their mental health issues, seek to rescue affective bonds, qualify professionally, access intersectoral networks or generate some kind of income; 3 - the third "type" are those who, in general, express desire and perform some actions towards change, but have some specific characteristic: they have major limitations on the execution of their personal projects, either by the significant dependence on some substance, severe associated mental distress, cognitive deficits and the difficulty of adapting to a model of residence.

The decision whether to settle in a home or continue to drift on the streets usually involves a cost-benefit assessment. In general, jobs that are the flagship for effectively getting off the streets, to which this population has access (when they have), are poorly paid, require strict discipline and above-average physical effort. Users often find it more advantageous to maintain the nomadic life in which one can do the least to survive despite all the suffering than to work exhaustively for small comforts in a home.

There are examples of residents who began formal work in large industries, the so-called "factory floor", and ended up not realizing that they could not meet the hard hours, easily frustrated in the face of numerous challenges and, especially, in relation to to low pay. By contrast, life on the street seems less costly under the judgment of many: *There are people who can get things very easy on the street, people who have lip service, get one and get food, money, everything, get it easy, and there are people who adapt on the street, there are people who fall anywhere and sleep, in my case, I couldn't sleep on the street (...) there are those who like this life, most restaurants give the food, so the guy has the lip and thinks: Why am I going to work?.* (E3)

Upon entering the RU, the senses are produced and transformed as situations are experienced. This cost-benefit ratio is also constantly reevaluated. The difficulty of the process of transition from the free-flowing, low-street universe to an environment where relationships generate conflict and frustration, but which, on the other hand, offers a series of positive transformations, comes into play.

Self-care

Regardless of the desire for major changes and to settle on a lifestyle permeated by family and labor ties, the RU enables caring for you. As basic needs such as food, sleep, safety and hygiene begin to be met, different degrees of self-care are evident. Caring for one's own body, returning to formal study or seeking professional qualification and rescuing bonds are the most observed self-care movements among residents.

In the first weeks of reception in the unit, changes in visual appearance are noticeable. They lose the slender appearance characteristic of heavy drug users, care is taken more often about bathing, shaving and cutting hair, washing clothes and overall image. A point that draws attention is the great demand of residents for dental care. Such concern is more for aesthetic reasons than for health itself. It reveals a symbolic point of transition from the abandonment of one's own care in the streets to a look towards oneself, even with aesthetics issues once neglected.

Health care is mediated by the team, mainly with primary care. This is very little accessed by this population, and this approach has been narrowed, showing fruitful results. It is a population that, due to living conditions, presents high levels of health problems and little attention received. It is not uncommon when entering the RU to start a true marathon of consultations, exams, surgeries and various other health procedures.

The investment made by the service and a keen eye for health issues are often remembered when asked directly to residents what marks them most when they think of their trajectories in the RU. One of the residents emphasizes the health care itinerary that began after the welcoming process in the unit *Although I haven't got a job yet, thank God, I've gotten a lot of things here at the house, I'm taking care of my health, I've been taking my medication, I'm doing a lot of tests to see if now I finally find out what have. Before, I almost did not go to the doctor, now, I have a busy schedule, the girls from PAM already know me so much that I go there.* (E5)

Another way of taking care of yourself, which emerges from the lines and is observed in the residents' movements, is the reentry into formal education. When it comes to acting on one's own destiny, education is seen as one of the "life-changing" possibilities. One of them attributes to the RU the role of mediator in its process of leaving the streets and states that during their stay in the unit, they saw in return to study the

best way to give a new direction to their life *(...) At that time, the first time I was here, I was very "depressed" and I think they understood that, they didn't charge me so much to look for a job, they said it was good for me to finish high school, that it would help me. And really, if I got a job, it was because I was finished with the study, not because I had the desire for a technical (course) and even a college. But high school is a good start.* (E1)

A resident who had been in the house for just over four months had already taken three vocational courses: one for electrical, one for hydraulics and one for NR35, which enables him to work at heights. The first two are part of joint projects with the Secretariat of Social Assistance; the last one was courtesy of one of his teachers who also teaches at another school.

Over time, after joining the RU, there is a movement towards narrowing or rescuing contact with people with whom the now resident still has some affectionate bond, usually family. The bonds with the family nucleus, that is, with those with whom the house was shared, such as the spouse, children, father and mother, in general, were broken or very worn out, being this rupture, in several situations, the main trigger to the streets. Family members, even those who do not wish to resume ties as they once were, have generally responded positively to rapprochement, as they express expectations that the family member will abandon drifting life and drug use.

In addition to the family, other bonds are established in this process. Churches, especially evangelical churches, play an active role in establishing affective and supportive relationships with this most vulnerable public. The example of the course Moreno received courtesy of the professor who taught him hydraulics, who was also a "brother of the church," illustrates this relationship. The teacher sponsored the user and inserted him in his community relations, since Moreno no longer had contact with the family.

The care in freedom

The life itineraries of homeless people are marked by numerous contacts with services and institutions that offer some support for them to "abandon the drug world". These institutions have the function of trying to propose a new norm of life for these subjects, removing them from the homeless situation and imposing the total abstinence of any drug as a means to change their condition[13]. Among therapeutic communities, psychiatric hospitals and treatment clinics, there are many services dedicated to this mission.

Among the existing variations, the isolation of the subject from his social context and abstinence are the imperatives that guide the practices of such services, starting from different paradigms from the RUs. Comparisons with other treatment models have appeared in numerous situations by different users, reflecting the innovative and counter-hegemonic character of residential care with open doors, *Man, I've lost count of how many clinics I've been to; you stay there nine months, is it good ?; It is sometimes on the farm, which, on the one hand, it is good that the guy is isolated there, has animal to take care of, but also has to work hard and pray a lot too, something I no longer liked. So far so good, the guy can handle it. But so when do you leave? The follies of the guy go out with him, the society has not changed and the desire to use comes great. What's the first thing the guy does when he gets out there? Will use!* (E3)

In the RU, the movement is constant, residents go to CAPS AD, to school, look for a job, take a walk, visit friends, family, access health services, eventually go out to use some kind of drugs and a multitude of other daily tasks, without substantially affecting what is meant by treatment. On the contrary, it works as a kind of laboratory so that when something destabilizing happens, whether by drug use or not, the user has support to deal with what is happening right now.

In some situations, it was observed how the team worked, in daily relationships, exposure to drug use. This is part of an intervention of the social worker with one of the residents, who had the opportunity to witness, illustrating the view from the user's point of view on care in freedom *(...)I'll tell you something: that time, at the beginning, when I came in here, that I couldn't control myself and had used it, I came straight to pick up my things and leave because I thought: "I left without warning, it filled my face damn it, the guys will send me away!" Then I was surprised when I arrived and you said that I was supposed to come in, take a shower and rest. In the other places I've stayed, "it's goodbye", hesitated, there is no turning back. I thought to myself, "I shit and the guys still treat me well." Then I began to understand what was behind it, what is your plan, and today I can say it works.* (E4)

Care in freedom arouses a certain strangeness, but at the same time an increase in the sense of responsibility. There is no control by the team about what is done from the door out, however, there is a greater self-surveillance to maintain what is contracted between the group. There is a charge among the residents themselves for responsibility and commitment to departure and arrival times, which are generally discussed collectively. This kind of commitment to one's own peers ends up with a number of self-regulatory functions: not spending the night without warning, not coming under the influence of drugs, and preserving the safety of the place.

The function of drugs

The theme of drugs not only permeates reception in the RU, but, above all, is structuring in the raison d'être of this device. From the perspective of Psychosocial Care, health services are not intended to offer treatment that focuses exclusively on total and immediate cessation of drug use, but rather to provide tools for users to create or expand their skills to manage their own lives with minimal possible harm caused by drug use, whether or not it is interrupted.

What was found with the study is that, in general, there is an effort to abandon the use, especially crack and alcohol. However, there is a specificity regarding marijuana and a tendency to maintain its use in many cases because it is not considered a hazardous or harmful substance.

There are minor particularities linked to the use of each specific substance. The use of crack is closely related to the context of the streets by users and is referred to in the following statements *(...) Here, I feel protected* (E7); *I don't feel like using it anymore because here I have something to occupy myself with, to talk to (...)* (E1); This use has to do with the routes and itineraries that the users traveled *(...) this was the time (at dusk) that I would start running, going around maneuvering to get as much change as possible to get into the stone* (E3)

Exclusive users of alcohol showed greater difficulty in stopping use for longer periods compared to exclusive crack users. Attempts to explain the greater difficulty in reducing or stopping alcohol use compared to other drugs revolve around its legality and socializing role in different contexts and social strata, as, for example, in this speech brought after an intense use right after you receive your first salary. *(...) I was happy, had received (...), I wonder why everyone can have a beer, fraternize, and I do not? I sat at the bar to talk, have one, and when I saw it, it was, you already know the rest of the story.* (E2)

It has been identified that the specificity of maintaining marijuana use is linked to two central issues: first, because it is a drug that is generally evaluated with a low potential for harm, it is widely used for recreational purposes without the concern that its use destabilize the rest of your projects. Second, marijuana is seen as a "harm reducer". It is commonly used to relieve craving and symptoms of anxiety, insomnia and poor appetite due to crack or alcohol withdrawal.

In general, residential care produces a significant reduction in harm and consumption per se, probably supported by the basic needs supplied, such as adequate food, warm bath, adequate and adequate sleep and human interaction. Many of those functions that drugs had on the streets, such as sociability, protection from fear and cold, and disinhibition, no longer make sense when you are welcomed.

The house ends up playing a protective place. It is not necessarily, or only, the physical space that "protects" residents, as many of them were already making heavy use before going to the streets when residing in homes. But much more a desire to fulfill the expectation of the other, whether professionals or fellow residents, ie also the symbolic space of protection, care and commitment.

Bonding

The bond ends up being the main tool to work the most diverse demands that arise in the daily life of the unit. Notably, the difficulties in dealing with frustrations appear to be the biggest impediment to advancing their unique projects, and the team constantly faces the need to address such a demand.

Some residents see how the dynamics work differently in the relationship with the team compared to the family relationship. *Both at my mother's house and on the street I couldn't handle frustration, I ran into crack, sank me. Here, there was frustration too, of course, but then I had someone to turn to, had you, talked to one, talked to another, people helped me a lot here, you, I say. I was looking straight.* (E2); *(...)I managed to learn a little how to control my frustration, how to deal with it. In my house, you know, it's different, no one understood when I was pissed off, I was upset (...) it's not for lack of love, I think it was actually too much, but it didn't work. Here, they would listen to me and give me back speaking the real, politely, of course, but they would talk about the situation.* (E5)

Health studies show the positive role that the bond between health professional and patient plays in the treatment process and even in the cure of diseases[14-15]. In Mental Health, where care technologies are fundamentally light technologies based on human relationships, the role of bonding is even more decisive. The RU is a place where it exists par excellence due to its residential characteristics and the deep social contacts it offers, besides the concrete possibility of establishing lasting bonds and, thus, transforming the reality of the users.

Final considerations

An ethnographic immersion in the unit's daily life allowed us to understand the device as a potential to produce changes in life histories, mainly due to the bond as a care technology. It was also observed that the welcoming also contributed as a conditioning factor in the decision on how to guide and organize their life paths from then on. The meanings attributed to the host are multiple, and the research showed *self-care*, the possibility of *care in freedom* and *decrease or discontinuation of drug use*,

the RU as a space for *protection and safety,* that provides the *expansion of networks and social relations and the exit from the streets and fixation*.

Survey participants have their own rhythm in the way they lead their lives, most of the time refusing to follow social codes dictated by society and replicated in the micro-politics of health services. In the case of the RU, the goal that the service be a means for users to leave the wander was often subverted and other meanings were being constructed. In service, it is also seen a possibility of just "taking a break" from life on the streets.

The RU is a powerful point of care and care device within PSCN, in line with and consistent with the assumptions of the BRP and the Psychosocial Care Policy. It is presented as an alternative of care to the asylum and asylum model. Working with the perspective of harm reduction and the logic of health care, it presupposes respect for the uniqueness of the subjects, human rights and citizenship.

Nevertheless, there are different obstacles that need to be overcome for the proper implementation and strengthening of this point of care model to consolidate itself as the first choice in the choice of transitional residential services by municipalities, managers and the users themselves. In the municipality surveyed, the RU is a rich network enhancer, with latent possibilities that demand improvements and investments to flourish.

The results and notes raised by this research were taken to municipal managers, teams and users of the service as feedback.

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Authors' Contributions

Study design and planning: Diogo Fiorello Foppa, Tânia Maris Grigolo. Data collection: Diogo Fiorello Foppa. Data analysis and interpretation: Diogo Fiorello Foppa, Tânia Maris Grigolo. Preparation and writing of the manuscript: Diogo Fiorello Foppa. Critical revision of the manuscript: Tânia Maris Grigolo.

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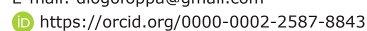 https://orcid.org/0000-0002-2587-8843

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