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Experiences of adolescent crack users and their relatives with psychosocial care and institucionalization

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Abstract *The Drug User Comprehensive Care Policy establishes that care practices should cover biopsychosocial realms. However, evidence reveals an institutionalized practice, in which families prioritize the subject's seclusion from its context of use. This study aimed to understand the implications of psychosocial care and institutionalization in meeting the needs of adolescent crack users and their families. Eleven teenagers and six relatives narrated their experiences through in-depth interviews, which were analyzed in the light of Paul Ricoeur's Phenomenological Hermeneutics. A flow was observed in which teenagers seeking care are initially institutionalized and then referred to replacement services. Thus, there is an urgent need to strengthen the psychosocial care network so that adolescent crack users' care is offered comprehensively, ensuring respect for their fundamental rights, such as the right to freedom and to experience family or community life.*

Key words *Crack cocaine, Adolescent, Family, Institutionalization, Social Vulnerability*

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Introduction

Adolescent crack use is the subject of much discussion in both society and media[1,2] and scientific literature. Regarding the latter, national and international studies highlight crack use risk factors in adolescence[3-5] and disorders related to the use of these substances[6], such as psychotic episodes, cognitive deficits, mood swings, change of behavior, respiratory problems and offences and violence[7,8].

Following this evidence, care actions aimed at this group usually occur through control and punishment practices, resorting to abstinence as the only form of treatment[9,10].

Within collective health, however, studies[10-12] emphasize the debate over adolescent crack users' care from the perspective of the Psychosocial Care Centers (CAPS). In Social Psychology, publications[8,12-16] place their subject matters in psychosocial care and institutionalization and problematize this issue.

In the political-institutional sphere, guidelines and legal documents aimed at providing care to drug users highlight the harm-reduction strategy as the line of actions in the Unified Health System (SUS) and emphasize the need for an intersectoral and multidisciplinary approach to care, as well as comprehensive care to the most vulnerable populations, such as children, adolescents and teenagers, with development of clinical actions and actions related to family, community, school, housing, work, culture, drug trafficking and violence[17,18].

However, evidence is an institutionalizing practice, since families seek primarily to distance the subject from its context of use and believe that replacement services do not offer this alternative of care[16,18].

Indeed, one can perceive the antinomic relationship in the challenge of providing care to adolescent and young crack users. On the one hand is the guiding line based on deinstitutionalization, reception, access, comprehensive care, autonomy and respect for human rights, territorial actions, with coordination between community and social and health devices, for the social inclusion of users and their families[19-22]. On the other, upheld practices of classical and moral-religious psychiatry based on moral and disciplinary treatment, with deprived freedom and incentive to abstinence of the Brazilian therapeutic communities[8,14,18,23-25].

Thus, children and adolescents are not understood based on subjectivity, in the very aspects of their current phase. This is coupled with the moral panic[26] disseminated by the media and spread throughout society[1,2], reproducing identity marks of criminalization of these groups and "pathologization", which justifies such hygienist stances.

In addition to compulsory hospitalization in therapeutic communities, the short institutional reception in shelters or nursing homes is also used by the Judiciary to assist adolescent drug users who may be homeless, in compliance with socio-educational measures or receiving death threats[27].

However, these settings, namely, therapeutic communities and shelters represent to adolescents and their families alternatives in the search for care, protection, "detoxification" and an attempt to "get rid of drugs"[8,15,28]. Thus, what is argued is how these services come about in meeting the needs of these subjects.

Even alcohol and other drugs psychosocial care centers (CAPSad) and children and adolescents psychosocial care centers (CAPSi) have ideological and socio-cultural developments that are involved in the hardships of treating adolescent crack and other drugs users. According to literature, difficulties arise as the supremacy of the clinical health model, using abstinence as the only treatment[5,9,10,29], emphasis on "medical mental control"[30,31] and unprepared professionals to deal with issues related to the user of these substances[32,33] and his family[9,10], as well as resistance to harm reduction[29], which evidences the centrality of care only in biological and psychic aspects.

However, while these challenges are part of the day-to-day care of these services, they represent advances in drug user care, since there is an attempt to overcome the drug use approach, once only seen by the legal sector, and the prohibitionist approach, for actions of prevention, health promotion, treatment and reduction of risks and damages associated with harmful consumption, with practices of reception, linkage and establishment of therapeutic groups[14,18,24,34].

Indeed, considering the scarce scientific production[10-12] in spite of the contributions of the experiences of these adolescents with the clinical-institutional plots of these settings, a knowledge gap is perceived, but other studies can provide scientific subsidies to the discussion on the consolidation of care in line with the needs of this population, focused on actions to reduce social and health harm. This study aimed to understand the implications of psychosocial care and institutionalization in meeting their needs.

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Field and methodology

In this study, we opted for qualitative research based on the Phenomenological Hermeneutic Theory by Paul Ricoeur[35]. Thus, we focused on understanding the narratives and sought to understand the plurality of senses and latent meanings in the speeches of the respondents. This is part of a wider research called "Clinical care in the production of care for crack users - health care and support social networks", which was submitted to and approved by the Ethics and Research Committee with Human Beings, State University of Ceará, Brazil.

It is understood that narrative results from the interrelationship of social forces and their socio-historical flows. Thus, shifting from dialogue to text is permeated by socio-historical characteristics that locate a context, which opens the narrative to interpretation[36].

In order to demonstrate these relationships in the studied phenomenon, we used the in-depth interview, with a triggering question of a concrete, factual character related to the daily experiences of adolescents and their families[37]. Systematic observations were also made at research sites.

After explaining the objective of the investigation and obtaining the permission of the respondents to record, the triggering question about adolescent crack users seeking care was launched.

Initially, CAPSad and CAPSi of the municipality were sought. All adolescent crack users followed-up by these services had been referred from the shelter. Therefore, it is important to highlight the fact that, parallel to CAPS follow-up, most adolescents were in institutional sheltering, providing temporary housing until the adolescent is able to return to own family.

Thus, research loci were located in Fortaleza, capital of Ceará, and corresponded to a type II Alcohol and Other Drugs Psychosocial Care Center which operates from 8am to 6pm, which follows-up on adolescents through individual and group care, among which was the "harm reduction" group; however, it should be noted that only the name referred to the harm reduction approach, since it was observed that group meetings were still focused on the achievement of abstinence, and this group name was used to identify the unique group targeting drug users at that service; a type II CAPSi operating from 8am to 6pm; and a reference shelter in the Municipality of Fortaleza-CE. It can be observed that, at the time of collection, Fortaleza did not have a 24/7 CAPS III service, which justifies the non-inclusion of this type of service in the investigation.

The narratives about the trajectories of adolescent crack users seeking care emerged from the experiences of 17 respondents, namely, eleven adolescents in the 10-19 age group who were followed-up or who attended CAPSad / CAPSi at least once due to crack use, and six relatives, not requiring consanguineous or marital ties. All were given fictional names. Thus, family is considered in an extended perspective, since the term "family" involves diverse organization forms, also encompassing the bonds of affinity or affectivity[38].

For the interpretive analysis, we opted for the analysis of narratives based on Ricoeur's Theory[35], which provides that the analytical process concerns detachment, appropriation, explanation and understanding of the experiences lived by adolescents and their families[39]. Based on the material built from the dialogue between researchers and their respondents, we proceeded with text approximation in order to establish senses and meanings units.

Results and discussion

Meanings attributed to institutional reception: from institutionalization as search for care and overcoming fragile linkages to the inefficiency of moral treatment

Family is thus unveiled as part of this resource, as it encourages the adolescent to seek help and accompanies him in this process, and institutionalization in shelters or in psychiatric hospitals as settings that foster a network of meanings built by the respondents seeking care.

Thus, we can see that, even after decades since the beginning of the Psychiatric Reform process, which seeks to shift the mental health care center from the institution to the community, there is still a belief that only user isolation-based treatment is effective. Such a model uses the most important principle of moral treatment of the subject in psychic suffering, the "isolation from the external world", which assumes that the causes of psychic suffering are found in the social environment, in such a way that the subject's isolation is necessary to remove him/her from the source of his/her problems[40].

Relatives also expect institutions to do what they can no longer do, that is, keeping adolescents

safe far from the streets and dangers that surround them. This can be seen from the account of Mrs. Larissa, the aunt of a 15 year-old user:

Drugs come to you, no matter how much you do not want to, they come, a friend comes by and calls you [...] *a friend comes and asks you to go for a walk, and there are many bad elements in the streets* [...] *The first thing I sought was the Council* (Guardianship Council) *to seek hospitalization.*

Mrs. Larissa's statement also reveals that hospitalization is generally carried out through the Guardianship Council, which according to families, indicates a full-time reception institution. The Guardianship Council is a permanent, autonomous, non-jurisdictional body consisting of representatives of society and charged with ensuring the rights of children and adolescents[41].

In turn, the shelter is considered an institutional reception and, in accordance with the Statute of the Child and Adolescent (ECA), is provisional, with a maximum of two years, and should be used in cases of serious violation of children's and adolescents' fundamental rights and is therefore considered a protective measure[41].

Families believe that shelters are a safe environment in which the adolescent is cared for and keeps away from the crack use context. Families that still have ties with users also receive the support of the shelter's staff, as shown in Mrs. Margarida's account: *I always say that only those angels here* [shelter professionals] *can help him* [the adolescent], *unlike the family* [referring to her family], *each one is more concerned in making money, with this and with that, and so forth* [...].

In the same way, adolescents find themselves protected in the shelter. This feeling is evident in the report of 16-year-old Abelardo, who was taken in the shelter: *That's it, everyone treats me well here. I feel safe.*

Thus, adolescents seek institutionalization to get out of the streets, as a way of avoiding penalties for committing offenses or fleeing from traffickers' death threats. As such, it is revealed that respondents construct a network of meanings for this institutionalization. In their experiences, they understand institutions as spaces of protection and care, made up of the possibility of setting important resources to cope with the biopsychosocial consequences of crack use, although – in part – they are not specialized facilities that offer actions geared to these needs.

The appropriation of the institution as a place of care and protection is related to the social vulnerability experienced by adolescents. As part of this experience, the street situation is marked by violence, drug abuse and difficult access to services that meet their demands and needs. However, as some studies[26,32] highlight, before experiencing the streets, these adolescents are already in socio-family contexts marked by exclusion, abandonment, physical or moral violence, child labor, family rejection, substance abuse and drug trafficking, which leads to breaking with the family and community core.

Thus, the lack of affection, dialogue and care in the socio-family environment encourages adolescents to seek professionals of institutions that can meet these needs[28].

Regarding hospitalization in a psychiatric hospital, narratives reveal a different context of the institutional reception in shelters, since it occurs compulsorily by judicial measure. Thus, the mother of Fabrício reports that the experience of the adolescent in that institution was marked by treatment directed only to the biological body, which was manifested by the physical restraint and use of drugs: [...] *Because in the mental hospital I was tied up, I got to pee on the bed, I got to defecate on the bed, they just cleaned me the next day, when the doctor's inspection visit time had ended, so that I remained tied up, got it? I took pills that I believe were not meant for me, such as Haldol, which is a very strong pill that I took and I became all crooked, my tongue rolled, the air lacked* [...].

This type of practice is based on Law No. 8.069, of July 13, 1990, which provides for the Statute of the Child and Adolescent (ECA)[42], which, despite being considered a milestone to guarantee the protection of children's and adolescents' rights - seeking to ensure the citizenship of these subjects - does not clearly state how care should be provided to this public in health institutions. In this same document, article 101, dealing with the Specific Protection Measures, establishes that child or adolescent drug users should "receive temporary guidance, support and follow-up; request for medical, psychological or psychiatric treatment in a hospital or outpatient setting or inclusion in an official or community program of care, guidance or treatment for alcoholics and drug addicts"[43,44].

In this regard, Vilarins[45] agrees with the idea that the ECA only signals to the fact that adolescents with drug abuse-related problems will receive individual and specialized treatment, in a place appropriate to their conditions, but does not point the locations for this kind of care and the guidelines for the treatment. Indeed, the ECA recommends that the competent authority may request medical, psychological or psychiatric

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treatment in a hospital and outpatient setting, provided there is a medical indication[43], in addition to allowing the request for compulsory hospitalization to be performed by the Public Prosecutor, seeking to ensure access to health.

There is a contradiction in the ECA, since the document provides for the fundamental rights of children and adolescents, including the right to freedom, respect and dignity, recognizing the autonomy of adolescents, ensuring freedom of expression, as well as the sanctity of physical, moral and psychic integrity[42]. However, it is also used to support judicial decisions that may clash with the interests of these developing subjects.

In addition to compulsory hospitalization, Fabrício reveals a treatment centered on the biomedical model and the "medical mental control" practice, which contributes to the hegemony of medical discourse and sets the user as a mere onlooker. Regarding health institutions geared to crack users, Silva et al.[5] and Medeiros[30] comment that therapeutic proposals aimed at drug users still follow bureaucratic and formal protocols, based on abstinence criteria.

Despite the fact that compulsory hospitalization was experienced in a way suffered by mother and child, both agree that it did not produce any change in the use of crack, because, as the young fellow's mother alleges, Fabrício was back on substance use the very day he left the hospital, as can be seen from the excerpt of her narrative: [...] *But he spent a month in the psychiatric hospital exactly to follow a treatment for his addiction, and left in the morning. In the afternoon, he was already on drugs again, so it was not worth much, because it did not get any results.*

However, this situation of resuming crack use upon leaving the institution, can also be noticed when adolescents leave the shelter. This is somehow associated with the fact that these institutions find it hard to consider the multiple realms and complexities that permeate drug use, which is revealed by actions focused only on biological and other aspects that criminalize and stigmatize those involved in this phenomenon.

By reducing the return of crack use to the "pathologizing" vision, understanding it only as part of a "chemical dependency or addiction clinic", this phenomenon is objectified and disregards the social contexts of adolescents who are from institutions as part of a set of meanings that also strengthen close relationships with crack, possible crimes and drug trafficking.

Stories narrated by Scisleski and Maraschin[46] reveal adolescents' disbelief vis-à-vis institutions to help them find their way out of drug involvement. The hospitalizations they experience are not an alternative to rethink their participation in trafficking, nor to show them ways to re-signify life.

However, as a possibility to seek a way out of marginalization and for this resignification, adolescents participating in the study by Ferreira et al.[47] see the transformation of their social reality, such as family experience, housing acquisition, upward mobility through access to study and professional training, in other words, they seek the realization of their demands and needs and to obtain answers to the social inequalities to which they are subjected.

It is understood that, even in cases where adolescents report a positive experience, characterized by a possible resocialization through various referrals made by staff, it is still common for adolescents to experience problems again due to drug abuse at school when leaving the institution, and they often return to the shelter for the same reason. In the analyzed narratives, it is observed that most adolescents were at least in the second institutional admission, as pointed out in Fabrício's account: [...] *so, when I went to the shelter for the first time, I only spent a few days. The second time around, João* [shelter coordinator] *did not want me to stay there, because I fought with another boy.*

This difficulty in sustaining abstinence achieved during hospitalization may also be related to hurdles faced by institutions seeking to strengthen family ties. This concern was noticed in observations made at the shelter, as families often alleged lack of time to visit adolescents or participate in some family-focused activity. However, the shelter also pointed to hardships in working with families, since the institution has a very small team that cannot even work with adolescents.

However, in order to be able to offer support to users, these families also require a network that grants them the necessary support. In the meantime, in this study, throughout the narrative of relatives, it was clear that they have few resources to help them, as reported by Larissa, a teenager's aunt: *No support whatsoever is offered to us where I live. We already had none there, and now that we actually have none, we have no support for anything, and he needs it.*

We understand, therefore, that the social context of these families is one in dire need of social support. Therefore, relatives are helpless and sometimes powerless, since when family cares, it does not do it alone, but is backed by a network

of social relations that provide assistance in times of need and crisis[48].

Thus, it can been seen that families cannot be blamed for adolescents' drug problems, since their empowerment depends on an efficient social support network, considering that families require a network of social relations mobilizing resources to exercise care[49].

Overcoming hardships to reestablish social bonds between users and families, institutions are also inefficient because they still offer, as observed in the shelter and from narratives of participants about psychiatric hospitals, a moral and curative treatment based on discipline and social control, on the assumption that crack users evidence a deviant behavior due to lack of limits and rules, as observed by a professional report recorded in the field diary: [...] *They* [adolescents] *like it here and learn to behave because they have limits, which they do not have at home.*

Thus, it is observed that the corrective-repressive and welfare-like approach still overlaps the socio-educational alternative, although socio-educational aspects can be found, mainly in shelters. Therefore, adolescent care is still focused on the punishment of deviant behavior and seeks the "cure" from this type of conduct[50].

This moral treatment invalidates escape from the marginalization process[8] and fails to recognize subjective, sociocultural or contextual factors, disregarding uniqueness and life experiences associated with drugs by adolescents[23].

Leadership of the institutional reception and psychosocial care deviations

In an environment of scarce community resources that could help adolescents and families cope with crack use, full-time adolescent care institutions operate as support because, although they do not show long-term effectiveness, some of them, such as shelters, provide, albeit circumstantially, adolescents with periods of abstinence and some possibilities of social reintegration, as can be seen through the narrative of Aluízio: *People here* [shelter] *who help me, sometimes scold me and all that, but it's for my own sake, they help me a lot here, they want to see me well, they help me with work, my studies, there's no better place than this, I do not even feel like using anything at all.*

Thus, it is perceived that shelters, as long as adolescents agree, refer to schools, medical consultations, sports activities and CAPS.

Therefore, adolescent access to CAPSad usually occurs through referrals from institutions such as shelters, psychiatric hospitals and therapeutic communities. So it is very common for young people to access community services only when they have undergone some experience of institutionalization, as can be seen in the following reports:

[...] *so, this was the place* [shelter], *this is where they talked to him and saw his agitation due to lack of drugs, and they decided to take him to CAPS* [...]. *Before the shelter, I did not know the CAPS* (Mrs. Sonia).

Thus, it is observed that adolescents seeking care are initially institutionalized and then sent to replacement services. According to the Comprehensive Drug User Care Policy[51], subjects who abuse drugs should preferably receive care in services available in the community, which have CAPS as main articulators of this territorial base, supported by psychiatric beds in general hospitals.

CAPSi is also a destination for which institutional staff tends to refer adolescents, since CAPSad serves only adolescents from the age of 16 onwards. Thus, boys and girls up to the age of 15 are usually referred to CAPSi. Among these two community-based services, it was observed that adolescents establish a greater bond with the CAPSi, as some weekly activities aimed at adolescent drug users were noted. On the other hand, in the CAPSad, according to field records, no activity was observed for adolescents.

Thus, although CAPSi focuses on severe and persistent mental disorders[44], it is well known in practice that this service also provides care to adolescent drug abusers of up to 15 years of age. However, the service did show some constraints with regard to working with this public, since in situ observations revealed that only one professional was responsible for the care of this population.

For adolescents and their families, CAPS appear to play a secondary role in drug user care, since treatment based on inpatient isolation, especially in shelters, seems to be the main strategy. Thus, relatives know the service only through information received from staff of hospitalization institutions, as advocated in the testimony of Mrs. Margarida: *I do not know how it is there, because I was never went there* [...] *When I come to visit Adriano, I have to come running because I work. People here told him to go there* [...].

Likewise, adolescents accept referrals requested by staff of the full-time host institutions and begin to attend CAPS. However, through observations made in the institutions, when they leave

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institutionalization, adolescents also give up attending CAPS. It is noticed that young people's acceptance to attend CAPS can be understood more as an attempt not to displease the shelter team, than to believe that the service provides some improvement.

The preferential search for institutionalization to the detriment of community services may be related to the ongoing difficulties in the replacement network, since, according to Junqueira and Duarte[52], Brazil does not yet have a sufficiently installed extra-hospital network that prioritizes people's health promotion without removing individuals from their environment.

Much in the same way, services sought by adolescents are not perceived as referring to the harm reduction approach, which focuses on health and the minimization of drug use-associated harm. This model of care is not only about abstinence; in this case, care can also be provided to those subjects who do not want or cannot interrupt drug use[54]. Thus, the leading role of institutionalization, mainly of shelters, in the search for adolescent drug users' care is observed; on the other hand, CAPS, considered as replacement services, are seen as supporting isolation, which may work, if associated with the main strategy, as seclusion from the drug use context.

Final considerations

Narratives evidence that, initially, adolescents go to full-time host institutions, which are gateways for further access to replacement services considered by them and their families as services with a secondary role in drug user care.

Replacement services are somewhat fragile, since they face many hardships in dealing with drug users, especially when they are adolescents. Thus, it was noticed that community services denoted lack of material and human resources to deal with the demand, often reproducing the hospital-centered model of care.

It is also important to emphasize that the difficulties of families to address the issues of adolescent drug abusers are mainly related to scarce community support network, hampering family members shared responsibility for adolescent care, which causes the search for institutionalization.

Indeed, it is necessary to strengthen the psychosocial care network so that adolescent crack users' care is offered comprehensively, guaranteeing respect for the adolescents' fundamental rights established by the ECA, such as the right to freedom and experiencing family and community life.

Collaborations

ML Paula participated in the paper's design, bibliographic research, data collection and analysis and final text writing. MSB Jorge participated in the final text wording. LL Lima participated in the bibliographic research, data analysis and final text writing. IC Bezerra participated in the paper's design, bibliographic research and text drafting and editing.

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