Objective: to know experiences of non-voluntary hospitalization of drug users and their relatives. Method: ethnographic study. The sample comprised 20 relatives of the collaborating patients and eight people with problems related to the use of drugs for more than ten years, with or without diagnosis for chemical dependence and who had experience of involuntary or compulsory hospitalization. The interviews were recorded and later transcribed. The data were tabulated using the software of analysis of texts, videos, audios and Web images Qualitative Data Analysis (WebQDA), then analyzed through the technique of Content analysis. Results: three categories were identified: 1. Suffering, social and governmental helplessness; 2. Inpatient experiences and violation of rights; 3. Difficulties and possibilities after hospitalization. Conclusion: non-voluntary hospitalization calls into question the autonomy and rights of drug users; the relatives in front of him seek hospitalization as a way to save the life of the drug user. Research in the area is needed to assess the impact of this issue on the lives of the people, institutions and public policies involved. Descriptors: Commitment; Drug Users; Drug Abuse.

RESUMO
Objetivo: conhecer experiências de internação não voluntária de usuários de drogas e seus familiares. Método: estudo etnográfico. Compuseram a amostra 20 familiares dos pacientes colaboradores e oito pessoas com problemas relacionados ao uso de drogas há mais de dez anos, com ou sem diagnóstico para dependência química e que tivessem tido experiência de internação involuntária ou compulsória. As entrevistas foram gravadas e posteriormente transcritas. Os dados foram tabulados com o uso do software de análise de textos, vídeos, áudios e imagens Web Qualitative Data Analysis (WebQDA) e, em seguida, analisados por meio da técnica de Análise de Conteúdo. Resultados: foram identificadas três categorias: 1. Soffrimento, desamparo social e governamental; 2. Experiências de internação e violação de direitos; 3. Dificuldades e possibilidades após a internação. Conclusão: a internação não voluntária põe em questão a autonomia e os direitos do usuário de drogas; os familiares buscam a internação como um meio de ‘salvar a vida’ do usuário de drogas. São necessárias pesquisas na área para avaliar o impacto dessa questão na vida das pessoas, instituições e políticas públicas envolvidas. Descritores: Internação; Usuários de Drogas; Abuso de Drogas.

RESUMEN
Objetivo: conocer experiencias de internación no voluntaria de usuarios de drogas y sus familias. Método: estudio etnográfico. Compusieron para la investigación, 20 familiares de los pacientes colaboradores y ocho personas con problemas relacionados con el uso de drogas por más de diez años, con o sin diagnóstico de dependencia de sustancias químicas y que habían tenido experiencia de la hospitalización involuntaria o obligatoria. Las entrevistas fueron grabadas y transcritas más tarde. Los datos se tabularon utilizando el software de análisis de texto, videos, audios e imágenes Web análisis de datos cualitativos (WebQDA) y, a continuación, analizaron mediante la técnica de Análisis de Contenido. Resultados: se identificaron tres categorías: 1. dolor, desamparo social y gubernamental; 2. experiencias de persecución y violación de derechos; 3. dificultades y posibilidades después de la hospitalización. Conclusión: la hospitalización no voluntaria no pone en entredicho la autonomía y los derechos del usuario de drogas; los familiares antes de la admisión de búsqueda como una forma de salvar la vida del usuario de drogas. Se necesitan investigaciones para evaluar el impacto de esta cuestión en la vida de las personas, instituciones y políticas públicas involucradas. Descriptores: Hospitalización; Consumidores de Droga; Drogadicción.
INTRODUCTION

Hospitalization for non-voluntary treatment divides opinions and generates debate. Users of the health services network of psychosocial care alcohol and other drugs, their family members, health professionals and legislators are not always clear about the extent of this measure in the life of the person for treatment in situation of destitution of liberty.

In 2012, the joint declaration of United Nations agencies, including the United Nations Educational, Scientific and Cultural Organization (Unesco), the United Nations International Children's Emergency Fund (UNICEF) (UNODC), the World Health Organization (WHO) pointed out to UN participating States that they should close detention and rehabilitation centers related to the treatment of drug addicts, instead community health and on a voluntary basis, respecting the principles of human rights. The statement also points out that there is no evidence that the treatments against the patient's will are effective and constitute an obvious violation of human rights, as well as that hospitalizations are carried out without due process of law, which, in itself, damages these rights.1

Since 1975, non-voluntary hospitalizations in the United States of America are basically intended for drug users referred by the criminal system, who are on provisional release, however when they are interned, they lose their freedom as if they were in the prison system.2,3 This measure deals with a of the components of the country's 'war on drugs' policy, widely criticized for its discriminatory racial, economic and social bias. Despite these characteristics, this policy influences many countries, especially in Latin America, such as Brazil.

In the United States of America, drug users can be hospitalized non-voluntarily in several states and under different legal grounds, one of the concerns of researchers in the area is that the list of people seeking treatment voluntarily grows, but there are no vacancies in the on the other hand, those who do not find places in open services are systematically hospitalized in a non-voluntary way, which has increased the number of closed, mostly private, services. It starts from the premise that the drug user must be forced to undergo treatment for his own good, aiming for a greater good that would be the welfare of the family, society and the state. The focus of non-voluntary hospitalizations is drug users, especially those considered to be anti-social responsible for criminal acts and intravenous drug users, who may contract and transmit acquired immunodeficiency syndrome (AIDS) and who are not willing to go into treatment Voluntarily.5

A punitive policy of exclusion and internment has been questioned by the United Nations and characterized as actions that violate fundamental human rights for democratic systems.6 Especially when the application of legislation violates human rights in order to impose coercive and coercive treatment on the part of the most vulnerable population. Exclusion, which challenges the United Nations to curb abuses in Latin America in particular.7 International drug control and Brazil's adherence to drug conventions and human rights treaties are emerging issues, and international experiences point to changes in the current prohibitionist model to be discussed at the United Nations General Assembly Special Session (UNGASS), to be held in 2016, given the inefficiency of repressive policies that have led to increased violence, incarceration and violations of rights.8

Recent work criticizes the evidence base for the efficacy of treatment of chemical dependence through non-voluntary hospitalization. The development of sound policies and treatment practices has been hampered by a lack of awareness of the implications of this treatment modality, and evidence suggests that treatment based on this perspective can be detrimental in the long term.9

In Brazil there is a discussion regarding non-voluntary hospitalization, whether involuntary or compulsory, given its possibility of interpretation, even as unconstitutional. What has been used as a legal basis for this type of hospitalization is Law 10.216 / 01, which provides compulsory hospitalization for people with mental disorders, but does not report to chemical dependents.10 According to this Law there are three modalities of hospitalization Intended for a person with psychiatric disorder, namely: I - voluntary hospitalization: that which occurs with the consent of the user; II - involuntary hospitalization: that which occurs without the consent of the user and the loss of a third party; And III - compulsory hospitalization: that determined by Justice.11

Applying this law as a legal instrument that supports the judicial decisions of hospitalization highlights the trajectory of exclusion that minority and vulnerable groups in the history of health in Brazil, such as leprosy, tuberculosis, psychiatric patients.
Ordinance 3088 of the Ministry of Health that deals with the fundamental rights of the person imposes that the only possibility of hospitalization in host units, therapeutic communities or specialized hospitals would be on a voluntary basis.

The current model of what has been called the ‘drug war’, a belligerent nomenclature that refers to a war in the country against drugs and its ‘devastating power’ that can be analyzed in different ways, one of them being the incompatibility of a harm reduction policy coexisting with a model of abstinence that is in force in the therapeutic communities of the country with public funding, at times greater than that destined to the whole network and actions of Brazilian mental health. This logic of work generates clashes, dilemmas, and undermines fundamentally the official policy of harm reduction.12

Families, when they do not find support in health services and social assistance and are faced with delay in referral or care, sometimes choose to access the judicial system that by law, in some cases, determines involuntary hospitalization and not. They consider that the law that protects this hospitalization says that involuntary hospitalization should only be an option when no other extrahospital resources prove insufficient and if there is imminent risk of life for the user or for a third party.

In Brazil, the hospitalization of drug users under the justification that they are unable to cope freely with problems arising from the use of the drug has in some cases justified deprivation of liberty.11-3

It is understood that a phenomenon as complex as the use of drugs cannot be discussed in a homogeneous way and it is assumed that non-voluntary hospitalization as a therapeutic possibility damages the principles of the Psychiatric Reform, criminalizing the person who has problems with the use of drugs, characterizing what has been called therapeutic justice.14-5

For people who experience non-voluntary hospitalization, the issue is also complex and divides opinions, the question is whether non-voluntary hospitalization is effective in the treatment of chemical dependence and maintenance of abstinence and what the impact of this hospitalization modality on the life of the user and his family. The objective of the study was to know experiences of non-voluntary hospitalization of drug users and their relatives.

METHOD

This article is a clipping of the research project ‘Good practices in chemical dependency’, linked to the Regional Reference Center of the Nursing School of the Federal University of Minas Gerais, with resources from the National Secretariat for Policy on Drugs / Ministry of Justice.

Ethnographic study. Ethnography is a qualitative research strategy that aims to understand human behavior within its cultural context. Ethnography is a descriptive work of a group’s culture, including how people solve their problems, communicate, interact. It also includes understanding your actions and feelings in the face of adversity. All groups have a constant and complex way of behaving in the face of the events around them.17

The informants of the ethnographic study should be selected according to the degree of involvement with the phenomenon of interest of the researcher. The key informant is the one who, besides holding the knowledge about the phenomenon, also knows the people involved in the development of the phenomenon and its unfolding. Information collection was carried out at the home of the research collaborators, or at predefined sites between researcher and collaborator. The data collection instrument was a script of interviews where the collaborators talked about the subject in a free way for a time between 60 and 120 minutes.18-9

The interviews were recorded and later transcribed. The definition of the collaborators at first was through the technique of snowball, where one indicated the other and thus was composed the sample of the study. The sample consisted of eight people with drug-related problems for more than ten years, with or without a diagnosis of chemical dependence, and who had experienced involuntary or compulsory hospitalization; 20 family members of the study collaborators who lived directly or indirectly with him for at least five years.

The sample of ethnographic studies is formed by a clipping of reality, where we can observe events, activities, information, documents at different times, so the data collection was performed in more than one moment and in some cases in different scenarios (home, street, therapeutic community). All the interviewees signed the Informed Consent Term and the research was approved by the Research Ethics Committee of the home institution of the principal investigator (number 37574914.3.0000.5149).
The data were evaluated by means of content analysis comprising 1. Pre-analysis; 2. The exploitation of the material; And, finally, 3. The treatment of results.20

The data were tabulated using the software of analysis of texts, videos, audios and Web images Qualitative Data Analysis (WebQDA). The system is organized in three areas: 1. Sources - where the system is fed with the research data, organized according to the researcher's need; 2. Creation of codification or categories - interpretative or descriptive and 3. Questioning - the researcher creates dimensions, indicators or categories, whether interpretative or descriptive, which will be analyzed from agreements with analysis models previously elaborated for each of them. The categories of analysis identified were: 1. Suffering, social and governmental helplessness; 2. Inpatient experiences and violation of rights; 3. Difficulties and possibilities after hospitalization.21

**RESULTS**

♦ Suffering, social and governmental helplessness

The decision for non-voluntary hospitalization is based on the feeling of helplessness that family members describe in assessing that the drug user is at risk for themselves and those around them.

Reports of family violence, suffering, lack of perspective for the future, perception that society and government are not acting effectively, robberies, aggression, disappearance, arrests and fights permeate and to some extent authorize, the decision for non-voluntary hospitalization.

Relatives and users have stated that they feel helpless by society and public power under different aspects, such as: few available care services, lack of information, lack of places for treatment, use of which the drug user is a violent bandit. The use of drugs as something that can be controlled with hospitalization and medication, unemployment, lack of opportunities (education, access to health, housing, leisure), family and friends bias, shame for being and having a drug user in the family, police and trafficker violence due to user debts.

Users call themselves drug addicts, victims of drug power, patients and in need of treatment, but cannot be clear whether abstinence-based treatment, such as that occurring in some places of hospitalization, can be considered a predictor for the cure of disease. Most users (five contributors) claim that they could be treated in open services and not necessarily excluded from the environment in which they live is beneficial because they understand that after discharge they will return to the place where they live. For them non-voluntary hospitalization is a violence, but they understand the despair of relatives in the face of the situation.

The tension between drug users and their families is steady, family members believe the issue is linked to the fact that the drug user mobilizes the whole family in their addiction and everyone gets dragged into a well.

Family members could not delimit the exact moment someone decided or suggested hospitalization. For them over the years the situation is unsustainable and something needs to be done. In this sense they do not believe that a treatment where the drug user continues having access to the environment of use, the possibility of purchase and the environment in which he lives is effective.

For patients not to be consulted about hospitalization is the most serious point of the issue, they understand that at times they reject hospitalization vehemently, in others they arrive at the conclusion that there is nothing else to be done, but they bother to know that after do not have the right to choose after a certain time whether or not they want to stay in the hospital. When the decision is not to stay hospitalized and this right is denied them in general they run out of services.

The ability of the user to understand the situation in which he is at the time of hospitalization and decide whether or not it is complex generates doubts, another issue is when the family wants to hospitalize the user and both he and justice reject hospitalization.

A family member reports that he has applied three times to the court for authorization to internalize his child involuntarily and the requests have been systematically refused. In the end he chose to intern him by force in another state, where in theory he could not escape. The user in question fled and returned home five months after the escape, according to him for not having agreed to the hospitalization felt authorized to flee the place and accept the consequences of that act. This user was re-admitted with judicial authorization for a period of one year, after three years of abstinence he returned to use drugs, he said in a more controlled manner.

♦ Experiences of hospitalization and violation of rights
Relatives presented different opinions regarding hospitalization. Those who had positive experiences with the treatment of users in closed institutions and good results after discharge, affirm that hospitalization even contrary to the will of the person in some cases is the only resource to save and preserve life. In these cases the patients (three employees) after discharge were abstinent after one year, eight and six months respectively.

The hospitalization in the three cases was done with sedation without the knowledge of the individuals and the endorsement of justice according to the relatives. In the first attempts of non-voluntary hospitalization, two patients fled and the third after discharge, the family and the institution were arrested in custody for deprivation of liberty, a process that was withdrawn after the fourth hospitalization when the family reports that he was cured of chemical dependence. The hospitalization time of both was one year and eight months respectively.

For patients, non-voluntary hospitalization presents itself as a violation of a person's right to choose how they want to be treated, they report that in some places where the violation of rights has passed is clear. Patients are deprived of contact with the family, some places confiscate patients' personal belongings and they have to accept the religion that rules the place, which for them does not help in treatment. In contrast (four employees) believe that if they were not hospitalized they would not be alive and that after numerous hospitalizations they would be discredited before the family. In these cases they are grateful for family intervention and believe that there is now a possibility of curing addiction.

Relatives who oppose non-voluntary hospitalization even though they have used it, believe that this is not the best way to treat a person who is sick. The hospitalization in a closed institution in some cases was seen as the last resort for the relief of the suffering of the person and the family. The locations where these hospitalizations were performed were evaluated not by what they offer, but by the outcome at the end of treatment.

Relatives pointed out that they did not seek justice to validate the hospitalization, but pressured the users to stay in other ways, some cited threats of expulsion from the home, loss of the family bond with the rupture of the bonds, and in some cases the family blamed the mother's illness, mothers were often cited as suffering the most from chemical dependence.

Family members and users report violations of rights and coercion in some places of hospitalization, even if they are aware of these situations, it is still the best option in relation to the death of the user, something inevitable with the continuous use of the drug, whether by physical illness or by violence according to the collaborators interviewed.

For users during non-voluntary hospitalization the question that remains is: I did not make that choice, so why am I here? Or they wonder how long after discharge they will return to using drugs since they did not ask for help to stop using them. Five of the patients heard after admission returned to use drugs, in some cases (three employees) perceived that they started to use more than they did before the hospital stay. Two reported that after hospitalized they should have the right to access to justice to protect themselves from involuntary hospitalization. Everyone reckons they have been pressured into accepting the family's hospitalization in some way.

Users reported situations where they felt humiliated, exposed in their weaknesses and treated as children or inability to make choices on their own, others report cases of incarceration in strong cells, beatings, forced vigils, sleep deprivation, food and water. They identified that in some places there is a difference between the user who was hospitalized of his own volition and another who did not, but that over time these issues are forgotten. The mean hospitalization time of these patients was nine months to one year.

Difficulties and possibilities after hospitalization

Family members in the study reported that in general only one or two family members were actively involved in the decision-making process for hospitalization, the others supported, but were not involved in bureaucratic issues. There was financial support from all who could contribute to the maintenance of drug user hospitalization in services with either money or food, medication or hygiene and cleaning products.

For them this fact exposes a greater problem that is the risk of reprisals that these relatives suffer when the user flees of the institution and when returning home directs his revolt specifically for these members of the family. A family member said that the house was burned by one user after the escape, another was threatened with a firearm, one had to change the city, because
he was threatened with death by the user and several reports of verbal and physical aggression. Three family members are responding to a lawsuit filed by users.

The interviewed users who stayed for one year (three employees) evaluated that their lives were better than before the hospitalization, this perception is in agreement with the perception of the family that points to issues related to greater affectivity, closeness and collaboration with the family, Commitment to work, and the desire to have a better life and value life can prove this.

There was no consensus among the interviewees about what would be objectively indicated for non-voluntary hospitalization, this recurrent theme seems to generate doubts and generally the perception about it is based on the emotion aroused by the physical and psychic condition of the patient at the moment of hospitalization or the perception of lack of control and decision-making power.

For users non-voluntary hospitalization for being something that extrapolates their will has consequences that become visible throughout the hospitalization, in general they point out that even though they are not aggressive people, they become when approaching the professionals, although they understand that They are in that place just doing their job. Cases of physical and verbal aggression against the team that accompanied them during hospitalization were reported by four users. For family members this is a matter for the service to solve, in general they only pay the expenses with goods that have been damaged by the users and understand that this reaction is natural, but that they resolve with the time.

**DISCUSSION**

In France in 2011 the law regulating compulsory hospitalizations was modified in order to enable and guarantee the rights of defense and expression of the subject of non-voluntary hospitalization actions, especially in relation to the criteria for hospitalization defined by health professionals, the person's ability to understand the process of hospitalization and the ability to consent to it.22

A study conducted in the United States of America points to a pathologization of drug abuse, where the user is to blame for their life situation, that drug use is a disease, a reflection of social ills, which must be treated under penalty of contamination of the whole society. Non-voluntary treatment performs the function of sanitizing the evils of society without considering the real motives that generate these ills, which for the author of the study are socio-economic issues.5

Some authors argue that the use of crack in public space has contributed to stir up the spirits of society and the state to the issue of drug abuse in particular associated with the media perspective that drug use is uncommon in society, and which shifts this phenomenon from fundamental political and social issues to understanding it. It is observed as a response to this demand the implementation of policies that point to hospitalization as the only possibility for the issue leaving aside the implementation and compliance of health and social policies that privilege quality public care spaces and with sufficient resources to meet to this clientele as it foresees the principles of the Unified Health System, constitution of the country and the legislations and resolutions that deal with the subject.23 4

The tension experienced between the parties involved influences the decision for non-voluntary hospitalization that does not necessarily require a court order to take place. In all situations, psychiatric hospitalization should only be performed by means of a detailed medical report with the characterization of the reasons and after the extrahospital resources are insufficient in relation to the treatment. Hospitalization is an extreme situation and should be treated as such. To consider it as a first-line therapeutic option is a mistake.25

Issues such as capacity and inability to exercise their rights, discrimination, violation of private autonomy for the area of law are not always interpreted by the area of health as they should and vice versa which can induce the error of judgment of the processes of interdiction and hospitalization is another important point are the legal shortcomings of law no. 10,216 that give rise to different interpretations.25

For some authors, non-voluntary hospitalization may be disguised as involuntary detention when the person is ‘granted’ the possibility of voluntarily or legally admitting to it, or opting for medical treatment indoors or on the street, or being collected from a criminal institution. In this sense it is understood that coercion can be verbal, by means of threats or use of physical force and can be carried out by family members, friends, mental health professionals, justice operators. After the hospitalization the subject deprived of his
freedom may continue to be a victim of coercion during treatment. 26

Coercion for non-voluntary hospitalization as if it were voluntary is also concerned with the fact that some services at the time of admission record that the perception of coercion by the patient is linked to symptoms of their clinical condition, more precisely paranoia and delusions of a persecutory nature that would validate the hospitalization, especially in the case of substance use. In this case even in the case of a patient who has the capacity to make decisions regarding hospitalization or not, he is deprived of this capacity at the moment when a delusional symptom is recorded in his chart.27

A survey of 110 patients admitted to a closed institution after involuntary hospitalization in the United States indicates that 5% of the patients perceived some degree of coercion during treatment, especially regarding the treatment received by the team of professionals. The collaborators of this study also pointed out that they perceived a difference in the treatment of voluntary inmates for involuntary inmates and pointed out that a limitation of the study was the fact that the patients were heard during hospitalization, which may affect the testimonies for fear of reprisals by the health team. Another important point is that with the passage of the days of hospitalization the perception of being coerced diminishes and is higher than that of the outpatient clinic and its results are not effective.28

A study carried out with nursing assistants on their practices and work with drug users points out difficulties in the care of this clientele, generally permeated by stigmas, prejudices.29

A study of 442 patients hospitalized in a Psychiatric Hospital in France, where 45% of the hospitalizations were non-voluntary, showed that hospitalizations were increased aggression, suicide, legal proceedings against the family, institutions and doctor. 22 In Germany and Switzerland, the phenomenon of maintaining legislation that supports non-voluntary hospitalization is discussed as a trans-institutionalization of subgroups of patients considered violent and difficult to control. The non-voluntary hospitalization of these groups generates violence, delinquency, problems with justice and psychic sequels. In addition, the cost of non-voluntary treatment is higher than that of the outpatient clinic and its results are not effective.29

A study carried out to evaluate the experiences of non-voluntary hospitalization shows reports of experiences of good relationship with the professionals based on the treatment approach. In cases of medication administration against the patient's will, feelings of coercion and deprivation of liberty associated with violation of rights, such as not having the right to make a telephone call, were seen as impeding factors of good relationship with the caregiver and recovery. For patients who felt minimally respected in their rights despite non-voluntary hospitalization, the relationship with caregivers of services was considered important for their recovery. In this study, the patients pointed out that flexible care plans and respect for the subject's individuality contribute to the recovery even in the face of non-voluntary hospitalization. The direct violation was pointed out as distressing, stressful, and a source of tension between them.25

**CONCLUSION**

The research data corroborate the scientific production in the area, although it presents the limits of the cultural context in which it was developed. The discourses of the research collaborators are interlaced in different moments, sometimes approaching a consensus on the subject, sometimes distance, divergent but complementary.

The results point out advances in the perception and understanding of the theme by the actors involved in the study. Some advances and retreats can be identified, among them, the need for research with groups in specific contexts; the creation and validation of instruments to objectively measure the perception of coercion by individuals, and to evaluate how the experiences of non-voluntary hospitalization may be beneficial or not in the treatment of drug users.

It is necessary to research and discuss how and what to do to sensitize the health professional in relation to the topic, and how to deal with the tensions between the actors involved when there is a divergence between the understanding of the same. The study, despite its limitations, advances and innovates when it gives voice to different actors involved in the issue, and suggests a new perspective for research in the area.

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