Principles of a street clinic and the functioning of crack cocaine

Erick Araujo [1], *Fermin Roland Schramm* [2]

Abstract

The present study was based on an ethnography produced with a team from a Street Clinic in the city of Rio de Janeiro through their encounters with crack cocaine users. It describes: the functioning of the clinic based on principles; the consequences of this mode of functioning on those it seeks to help; and other knowledge about crack that emerged from the encounter between a health service and the people who use the drug. It was concluded that the Street Clinic establishes opportunities for drug users to transform their lives, and embraces increasingly heterogeneous lives. It can therefore expand access to the Sistema Único de Saúde (the Unified Health System), and offer a path for the system to become increasingly open to differences.
Keywords: Homeless persons. Crack cocaine. Unified Health System.

Resumo

Princípios da clínica na rua e os funcionamentos do crack

A partir de etnografia realizada com equipe de Consultório na Rua da cidade do Rio de Janeiro em seus encontros com pessoas em cenas de uso de crack, apresentam-se: seu modo de funcionamento por meio de princípios; as consequências desse modo sobre as pessoas que busca atender; e outros saberes acerca do crack que emergem a partir desse encontro entre um serviço de saúde e usuários de tal substância. Conclui-se que o Consultório na Rua instaura aberturas para que aquelas pessoas que se tornam suas usuárias o transformem, fazendo-o acolher vidas cada vez mais heterogêneas. Dessa forma, torna-se capaz de ampliar o acesso ao Sistema Único de Saúde, calcando um caminho para que este seja cada vez mais permeável às diferenças.
Palavras-chave: Pessoas em situação de rua. Cocaína crack. Sistema Único de Saúde.

Resumen

Principios de una clínica en la calle y el funcionamiento del crack

A partir de una etnografía realizada con el equipo de un Consultorio en la Calle, en la ciudad de Río de Janeiro, en sus encuentros con personas en situaciones de uso de *crack*, se presenta: su modo de funcionamiento a través de principios; las consecuencias de esta modalidad en aquellas personas que se pretende atender; y otros conocimientos sobre el *crack* que emergen de este encuentro entre un servicio de salud y los usuarios de dicha sustancia. Se concluye que el Consultorio en la Calle instaura aperturas para que aquellas personas que se tornan usuarias lo modifiquen, haciéndose apto para acoger vidas cada vez más heterogéneas. De esta forma, se torna capaz de ampliar el acceso al Sistema Único de Saúde (Sistema Único de Salud), trazando un camino para que éste sea cada vez más permeable a las diferencias.
Palabras clave: Personas sin hogar. Cocaína crack. Sistema Único de Salud.

1. Doutor ericklaraujo@gmail.com – Universidade Federal Fluminense (UFF), Niterói/RJ **2. PhD** rolandschramm@yahoo.com.br – Escola Nacional de Saúde Pública (Ensp/Fiocruz), Rio de Janeiro/RJ, Brasil.

Correspondência
Erick Araujo – Rua Eusébio Sardinha, 67, Alter do Chão CEP 68109-000. Santarém/PA, Brasil.

Declaram não haver conflito de interesse.

The article is the result of qualitative research carried out between 2013 and 2015 with the staff of a Street Clinic (Consultório na Rua - CR) in the city of Rio de Janeiro, Brazil, and people who find themselves in scenes of crack use and either do or do not become health service users. One of the authors followed the visits of the SC to such scenes of crack use, and under the supervision of the team and especially Community Health Workers (Agentes Comunitários de Saúde - ACS) helped distribute supplies (condoms and information materials), introduce the work of the SC and complete user records. This researcher was also allowed to observe team meetings and moments when users waited to be seen at the clinic. From these experiences, which were recorded in the field diary, the data - spoken, gestures, silences – from which this article was produced emerged.

Firstly, it is important to note the technical use of the term "scene", used in the expression "scenes of crack use", which is applied to denote the presence and prominence of this variation of cocaine in certain locations covered by the CR. The staff, from the first visits to these places, realized that they could not simply configure their own plan for how to provide care for homeless people in scenes of drug use. It was necessary to enter the scene to experience the use in action, rather than inserting the patient in a previously defined institutional context based on therapeutic spaces and *a priori* systematized categories.

In most health services, when a patient arrives at the clinic, the simple passage into the interior of the building operates as a purification process, in which aspects of where and how they live, which have both positive and negative effects on their well-being, are excluded from the analysis. The same occurs with procedures based on programmed actions, in which the groups receiving care are predetermined (hypertensive or diabetic, for example), along with the dates, schedules and strategies of the actions. There is a certain prior "categorial purification" that allows the action to take place, even if it is more focally based, as occurs in the Family Health Strategy. This is the nature of a scene authored by health institutions, in which patients participate according to their institutional classification. The present study, on the other hand, questions how the CR inserts itself and acts in scenes that are outside of its authorship.

The aim of the study was to identify the principles that guide the work of the Street Clinic. These follow the elements that make up a strategy for applying bioethics outside the clinical context [1]: ethnography; variation/creation of principles; and the provision of such principles to other fields related to the problem in question. The study does not only deal with the application of the principles governing the Unified Health System (Sistema Único de Saúde - SUS) - universality, equity and completeness - but of a creative process. Through it, several principles are produced, to achieve universal access to health, the adaptation of care to different modes of existence and their demands, and the expansion and multiplication of the pathways between services, ensuring access, acceptance and resolution in various stages of the health-disease process.

The study seeks to explain three of these principles: subtraction, passage and engagement. It is argued that one of the effects of the operation of this set of principles is the opportunity for analysis related specifically to crack and its use, which intends to bring together three knowledge bases: of those providing care, of those who use the drug and of those who carry out analysis. Hence the usefulness of ethnography, a method that consists of the production of data from the sharing of experiences between those who carry out research and those with whom the research is performed. It is considered that the data produced from this encounter between alterities – the CR, those in scenes of crack use, and those in the role of researcher – are effects of the contact between heterogeneous knowledge bases.

Operation of the street clinic

The emergence of the CR is due to the existence of the formal and informal barricades the homeless population suffers when trying to access the SUS and especially basic health care services. One example of such obstacles is the requirement to carry their documents with them. The smell of the body and clothing of the individual seeking care is also used as a justification for refusing to provide treatment. In view of this, the CR's aim is to facilitate and open up such access. This is expressed as *the reorientation of the health services for vulnerable groups, acting in prevention, promotion and attention with a focus on the integrality of health actions and from the perspective of extended care, with respect to the sociopolitical context in which such actions are inserted, as well as the local individual cultural characteristics* [2].

It is said that the CR works more by principles than by quantitative goals, [3] as is shown by the team member motto: "*the production is zero, but it exists*." The principles are those of the SUS, but it can also be

 http://dx.doi.org/10.1590/1983-80422017253204

said that other principles function in the daily activities of the team, notably in processes in which strategies, actions and their consequences are dealt with based on a specific problem and in a given space-time.

One might think that such an agency would be configured based on the application of previously established principles. However, the practical variations of problems, strategies, actions and their consequences require a complete mutation of the initial principles. These changes make it possible for the service to work with those living on the streets. It should be stated *that there are few preconditions for coordinating health care, and the approach is always to be performed together with the user receiving care (at the actual meeting and at the time), so that the locations of the identity of each profession are reconfigured in the act* [4].

The service is transformed through the variations in the lives that it encounters. The CR's professional creativity is being able to mesh with the existential creativity of the lives on the street. To do so, there is "*effort*" on the part of the team, as the SC doctor stated, yet "*the tension remains*". There is still parallel activity and, at the same time, activity subsequent to the theoretical composition of a principle, the moment in which one seeks to compose strategies, actions and their concrete consequences in relation to a certain problem to create a principle that can be applied in the practical field and extrapolated for use in other circumstances.

Thus, a theoretical-practical treatment is sought, the usefulness of which depends on the practical treatment of the theory. This can be said to be a parallel activity, since it seems to be lateral to the practice, as a virtual-theoretical presence of such practice, and at the same time subsequent, when the practice is lateralized and becomes the virtual-practical presence of the theory. For this reason, the creation of principles is a collective, practical and theoretical work. It can therefore be said that this work seeks also to capture the process of relay between theory and practice, in the search to consolidate the principles of action. This process is established from the principles in action in the field: subtraction, passage and engagement, which are abstractly distinct and mixed in their concrete operations.

Principles of a street clinic: subtraction

The principle of subtraction is put into operation by the SC, and against its very nature, as the SC in question is born orbiting around crack – the reason for its existence, described at a Local Health Council, derives from what is known as the "specificity of Manguinhos": the intensive use of crack and other drugs. Not only the service, but the streets and lives that inhabit them are fully under the effects of crack. There would be no need, then, for the question "*do you need anything in terms of health*?", such a key part of the work of the ACS when they circulate on the streets and, in particular, through scenes of crack use, offering the services of the CR. The answer would be: "*you need to stop using crack*" and in this way, the question is an act of subtraction, exemplifying the principle.

Not that the staff pretend not to see crack; instead they see it, talk about it and people show them how it is used. The difference is that in the scene the team "subtracts" crack as though it were an enemy or an epidemic agent. They subtract the role of crack as the protagonist. This allows them to see the lives in such scenes in all their complexity and, at the same time, imagine how such lives are placed under the yoke of a certain empty model of life. Through this principle, they can try to learn something about how crack works: either as one component among others or as a means of destruction. Therefore, there is no reason to consider the crack *itself*, but instead the crack *and* the life of those who use it. Therefore, this principle makes it possible to see crack from other perspectives. It becomes possible to ask "*what does the drug do for you*?" [5].

But it is not only this. The principle of subtraction allows one to avoid seeing crack where it is not present; after all, as one member of the Movimento Nacional da População de Rua (the National Movement of the Homeless Population) has said, not everyone who is homeless makes use of psychoactive substances [6]. Such thinking leads to the spread of terms like "*cracolândia*" (crack-land) and "*cracudos*" (crackheads) about lives on the street, as classifying people or places by such terms tends to function as justification for stigmatizing and arbitrary actions.

These actions may be state-controlled, such as in cases of removal, compulsory hospitalization, police violence and even the denial of health service care. They may also be indirectly linked to the state, such as the actions of militias, partly composed of agents or ex-agents of the State, such as police officers and firemen [7], and drug trafficking, the existence of which is linked to the criminalization of drug use and its mirroring of the state structure, since it presents *a centralized political command, a defined hierarchical*

framework, territorial control (...) *and the participation of those with public roles in its networks* [8].

The principle of subtraction does not only work in relation to crack. In evaluating a possible CR member, the team believes that such individuals still think like those who work with HIV. In other words, once a positive diagnosis occurs, everything revolves around the disease. In this scenario, the virus becomes the protagonist, and life - in the evaluation of the team - slides into the shadows. Similarly, in dealing with possible centralization in relation to biomedical procedures, there tends to be subtraction to allow certain other ways of proceeding to emerge, such as those of people who work as ACS. But "*the tension remains*," and the danger of everything revolving around biomedical procedures is constant.

The importance of this principle is pointed out by a member of the CR in Rio de Janeiro: "*If we had seen the boy before, we would have provided care beyond crack ... beyond the stress of social care, and he wouldn't have died. We got caught up in the crack addiction, but the problem was something else*." [9] Here we return to the question "*do you need anything in terms of health*? " This fundamental question emerges as an act of this principle: it displaces the crack from the center of the scene. This question already concerns another principle, that of passage; it connects and differentiates the two principles.

Principles of a street clinic: passage

The principle of passage is defined by the quest to make *something* pass. In other words, it implies that there can be no passivity in the act of listening applied by the CR through the question "*do you need anything in terms of health*?". And, of course, there is no passivity in answering it, even if the answer is a long silence. There are gaps, forms of passage between the street and the health service. It is based on the assumption that the institutional nature of a service works by blocking and/or filtering the effects of its encounter with otherness and configuring it in terms of itself.

Thus, at the same time as listening to the user of the service, it is a question of installing a detection system that will ignore elements with transformational force and will find institutional anchorages "outside". In this way, a line can be drawn on multiplicity and, from within, the pairs of a binary system can be applied (doctor-patient, police-criminal), establishing in the particularities found in this pair the general relational assignments (what is a drug-dependent individual and how should the relationship between such an individual and the institution function).

The "*do you need anything in term of health*?" question is the opening moment, but it depends on a certain activity so that fragments flow from the outside world toward the institutional interior. It is understood that the most difficult obstacles are applied to minorities. In this way, we look for situations in which those people who are in the street can speak for themselves and express their problems to the institution that provides care for them.

Hence the importance and effectiveness of the ACS as a professional whose community experience makes them a specialist in the health team: they are the outside but within the service. The role of the ACS can be identified as being in passage: it is through them that the treatment given in the community "outside" imbues itself "within" the health service and at the same time that the treatment given "within" this service passes to the "outside" community. They are the professionals with a vision other than that of the institution as the center of an existence, as there also is the community; and who offer the institution as a possible existential component to the community.

Due to its preliminary status and position, as there is no training for the role in the strict sense of the term in the area of health, it was not surprising to note the precarious nature of the working conditions of the ACS: low wages, little legal protection and few formal instruments to deal with the conditions of field work, in addition to the insistence on the part of other health professionals in making them follow their orders [10]. In other words, while the outside is established within the institution, but concomitantly, ways of curtailing it are also instituted.

In short, it is only through the ACS that the complex and multipurpose question "*do you need anything in terms of health*?" emerges, notably in the form of actions that arise from this principle and establish institutional openings. But soon he or she begins to act through another principle, that of engagement. Again, this principle connects and differentiates the others.

Principles of a street clinic: engagement

Engaging in an existence as a component, rather than making it orbit around you, is the principle of engagement. This means dealing with movements, flows. The functioning of the CR is

 http://dx.doi.org/10.1590/1983-80422017253204

to engage in certain flows (as well as by blocking others, as in the case of attempted blocks in relation to persons who become domiciled). The question "*do you need anything in terms of health*?" is the moment of preparation, the almost stationary position that precedes the start of action.

The answers - whether a long silence, a tear, a smile, a life story or a dry "no" - have the power to propel the CR into unfamiliar areas as long as the team remains alert and willing to engage in such movements. Here, the term "user" gains strength, meaning. A service is used when a certain movement is employed; however, in order for such movement to be possible, the service, for its part, needs to hoist its own anchor, thus allowing itself to be engaged in the flow of the person or group that makes use of it.

Engagement does not simply happen. There is a transfer procedure, a term used in the sense of transport, of the passing of a flow from one place to another. Thus, the flow employed by the user towards the team will necessarily change according to the possible methods offered by the clinic. A certain malfunctioning is also expected, "*a tension*" that "*cannot be undone*" inherent within this coupling. Such a transfer ultimately "*requires*" that "*the user must also organize themselves to enter into the flow of the* [basic health] *unit*," in the words of the doctor.

After all, there are still schedules, rules and a certain distribution of resources and centrality in relation to the biomedical procedures of the health service, which impose limits on the means of transfer between street and clinic. This limitation causes several heterogeneous flows to undergo a process of homogenization, a kind of filtering of the diverse, as they mesh to clinical flows. The smaller the resources of transfer, the greater the homogenization processes.

The principles and drugs

Other than the affirmation of imperatives in relation to the substance, from which would emerge the question "*are you in favor of or against drugs*?", tackling the form in which the principles listed are tools for other dimensions in relation to narcotics - usually obstructed in their possible passages to other fields, such as macro-politics and science - can overcome blockages. This seems to be one of the possible means for the so-called "drug policy" to deal with the various dimensions of relationships between people, groups and drugs.

The operation of the principles of subtraction, passage and engagement has a relative effect on crack: we know more about it from the perspectives of these scenes. It can be said that the other dimensions of the drug *pass* beyond the boundaries of the so-called "*cracolândias* ". In this way, the uses and functions of crack are distinguished from the users. It is not, therefore, a question of principle, one from which the "pro" and the "anti-drug" emerge, but how principles can work in the multiplicity of issues. The principles emphasized here are a tactical conjuration against the "should or shouldn't" content and, one might say, a strategic vision against the desire to eradicate differences, invested in the smallest everyday moments. After all, drugs are not alone; they are intertwined with a diversity of existences.

Crack

Many eyes see crack, and such seeing gives rise to many opinions. These eyes act as the various lenses of a large, seemingly uninterested eye that arrives at "objective" conclusions about crack itself. Truths are therefore imposed through pharmacological and social contents that give meaning to crack - the speed of its action, the brevity of its effects and the leap to dependence (as if this were merely a logical effect of speed and of brevity), the shift from dependency to marginality, and hence to crime.

These leaps contain an element that goes beyond such the ideas themselves: a procedure of *faith* that allows the belief that it is possible to arrive at a raw fact, the point at which there is no more interpretation, only the "truth" about crack. From that moment on, this truth establishes a model, a weapon of judgment and an appeal for salvation. Hence one can understand the act of making abstinence, however brief, a condition for any treatment: "we will help you, but you have to stop using drugs", and variations on the theme.

This statement can be read, simultaneously, as a judgment directed at a life that moves away from a certain model – the so-called abstinent life – and the emergence of a savior spokesperson and a defender of this model of life. In fact, the effect of this statement is less the creation of a process of abstinence and more the abandonment of treatment. Studies have been carried out in the USA and the UK that relate to the attempt to contain through abstinence the AIDS epidemic among

people who used injecting drugs. These studies show a relapse proportion of 80%, leading to the conclusion that *it was illusory to hope to combat the AIDS epidemic among injectors by abstinence* [11].

This diagnosis points to the emergence of a policy of reducing risks or damages associated with drug use, promoted through the alliance between clinical knowledge and that of the user. This consortium is predisposed to changes in modes of consumption, such as the sharing of syringes. It also facilitates migrations to the use of other drugs that are less open to the risks of contamination by disease, both those circumscribed in the legal field, such as those, like methadone, used in substitution programs, and those restricted to the field of illegality.

This study identified reports that, having been informed by doctors that they needed to stop using crack in order to take medication to treat tuberculosis, people stopped taking medicine so they could use the substance. They followed the recommendation of not using the two drugs, medicines and crack, concomitantly, and chose to avoid the first. There are also radically different accounts. When informed that the most important thing is to continue treatment, with a reduction in the use of crack also ideal, new statements emerge: "*they say that crazy people don't take medicine, well I'm here for my medicine*", therefore visualizing a field in which being "crazy" and treating oneself are not opposed.

One can also observe processes in which the use does not transform the user or the service that provides care into hostages to the "truths" of crack. Thus, a CR nurse describes how he told an individual in a scene of crack use where he could find the team and how to get to the clinic. The nurse said that he believed that when the effects of crack passed, the user would not remember the meeting, let alone the information. But to his surprise, the patient appeared at the clinic that same day.

In this way, the statement "we will help you, but you have to stop using drugs" belongs to the abstinent model of life, which denies the real lives that run from it. A model that will always be revealed to be empty, because it starts from the base of a vice, then judges it, thus functioning as ecstatic morality. From this it is possible to understand what is meant when one speaks of "substance" when referring to morals and certain ideals [12]. In summary, the issue of the drug goes beyond that of substances.

The functioning of crack

One of the effects of the principles described here is the possibility that lives related to crack put the "truth" of the drug in question. They question - by means of statements such as "*there are people who smoke in front of you, I don't*"; "*I control the drug, it doesn't control me*" - the conclusion that every use of crack is destructive. It can be said, therefore, that in these expressions there is no *a priori* antithesis between crack and life. So the question becomes: "What does crack do for you?".

It is emphasized that the answer to this question will not be evaluated here; what will be evaluated is the capacity of the institutional field from which the question comes to be affected by the response. The gaze of scrutiny changes perspective. It is a question of proposing the transfer and extension of what is known, experimenting with how crack works by other means and through other concepts. It is not intended to confront such knowledge, experience and functioning with the criterion of an exogenous truth. It is intended that the meeting of different fields of experience and knowledge - the street, the clinic; the street, the theory - operates in the production of data that fosters creative actions appropriate for those who use crack. With this intention, the following are excerpts from the discourses recorded in the observation that show some of the functioning of crack, mainly in scenes of use or moments before use, during the CR.

Therapy

A person spoke into my ear and asked, "*what medicine do you have there*?", I had no chance to answer my answer, because, quickly, he began to say the names of various medicines. I asked how he knew so many, he told me he had a degree, he was an engineer, but he had problems: he had already spent R$1,600.00 on crack. The ACS, who was already part of the conversation, suggested that he go to the clinic with us, but the man answered "*I don't want another medical report, I've been hospitalized three times ... what do I want another report for*?!". The ACS insisted, explaining the work of the SC: "*Let's talk about trying to figure out a way to help you*," to which he replied: "*It's because hospitalizing does no good, I hear voices and the only way to stop listening is when I use crack ... and when I use a lot*".

The speech highlights the uselessness of hospitalization for those who use crack, but allows us to glimpse another use of the term "hospitalize".

 http://dx.doi.org/10.1590/1983-80422017253204

Remembering that many of these people have gone through various modes of hospitalization, the use of the term seems important, especially as it does not refer exclusively to the spatial relationship. In general, a person is hospitalized for a purpose. He is hospitalized in therapeutic communities to temporarily stop using and recover from the effects of crack on himself, so he can then return to using it. A person also "hospitalizes themselves" during intense crack use, spending extended periods in which they use continuously with the aim of dealing with a mental disorder and stop hearing voices, for example.

Dependence

The team met a man who had an IV drip in his arm and slept on the sidewalk. "*I left home because I couldn't get the pastor's words out of my head*". Then he was spotted using crack. He was ashamed when he noticed the presence of the team, saying, "*I want to go home, but I can't. I can't get out of here*". Thus, the use of crack seems to act as a centripetal force that keeps him there, after the centrifugal force of the pastor's words expelled him from his home.

Care

On the train tracks, a woman had a plastic cup ready for use. The cup still had the aluminum lid, where there was a hole made with the tip of a finger and, on the opposite side, small holes made with a nail or needle; distributed on top of these was cigarette ash and on top of that was a crack rock. She did not smoke in front of us, saying she was ashamed, and added: "*There are people who smoke in front of you, I don't. There are people who let themselves be dominated by drugs. I don't. I control the drug, it does not control me*." She went on, "*I would use less, just for the weekend* (...) *if I had my little house, my money, but it's not like that*." This shows that while there is a possibility of using crack recreationally, because of the user's situation it is used more often, albeit in a controlled way, as a support, a life care in the street.

Anesthetic

There was also occasional crack use to stop the pain. The definition of pain can be taken in the most elementary way, referring to the physical problem, as well as to the suffering and anguish experienced in everyday life. These two meanings are combined in the discourses on the idea of pain.

Improvement

I approached a man who was sometimes at the crack use scene, and sometimes used the drug. I was walking toward him, his back was to me. At the same time as I said, "*Hey, painter*?!" I touched him on the shoulder. At that moment he moved away quickly, startled, and turned to me with his arm raised in what seemed to be the preparation of a punch. Then he recognized me and apologized; He told me that he was alone, so he had to take care of himself; after all, there is "*so much badness*".

This "*badness*" is indicated in the reports of those who received care from the CR regarding the violent actions perpetrated by the police, the drug traffickers and the militias. Thus, it is proposed here that where there is "*so much badness*", as seems to be the case with the streets and, in particular, the locations of crack use, the so-called paranoia provided by the drug can be characterized more precisely as a heightening of the ability to distrust and react. In other words, if one lives in an environment in which there is an elevated risk of suffering violence, it seems justifiable, even recommended, to increase one's capacity to act as if any touch were a threat.

Formation of a group

Crack is a substance that has become known for its public use in groups. According to a CHW, this is a specific effect of the substance: "*crack has this thing of being a drug that makes groups. The person goes to the place, buys the drug, uses it there and hangs around with other people*." They form groups, build houses, have relationships, fight, die, eat, dance together. Thus, if, on the one hand, there is talk of crack as a vehicle of social exclusion, on the other, it can be said that such substance promotes socialization, even the formation of a community.

Capture

In observing the interactions with the SC, one can see that there is variation of the question "*what does crack do for you*?": "*What makes crack happen*?". One of the factors observed was the publicizing of the drug by the media which, according to these statements, has potential to challenge the strength and self-control of the person, seducing them or inducing the use of the drug [13]: *When Dráuzio Varela showed ... the difference between crack and oxy, said how much it cost, where it was sold and that the drug is so powerful that if you try it once you won't be able to free yourself from it, the*

population of the so-called cracolândia more than doubled the following weekend.

This discourse is in keeping with that of a person receiving care from a harm reduction team: *I did not even use drugs much, but then when they talked about crack on Globe Reporter, saying that it was a drug that got you addicted the first time you used it, I went for it* (...) *I used it and I didn't get addicted the first time* (...) *I used it until I got addicted, and today it's impossible to stop* [14].

The mode of existence of a field science

It is not a question for the CR to decide whether these results are the "true effects" of crack. It can be said that the mode of action of this institution proposes that such operations become constituent parts of knowledge about drugs and, at the same time, of the SC itself as a therapeutic device available to those who are on the street and use crack (as well as other drugs, whether licit or illicit). It is said, therefore, that the production of knowledge and techniques by the CR is that of the field science itself: it is about identifying relations, observing variations, and gathering evidence that enables reconstruction and concrete scene narration [15]. Hence the technical character of the category of *scene* used by the team.

But such a science, as practiced by the CR, is distinct from those of the laboratory: in it there is no means of enacting the very question which one wishes to answer. That is, there is no "purification" of the phenomena that would reveal to the scientist the vision of the true face of the object of study and the possibility of its reproduction in an experiment. This allows the characterization of other divergent views as mistaken. In contrast, reconstruction and scene narration in field science does not demand or institute judgement, but opens itself to the possibilities of the different elements studied in the process of the production and variation of knowledge and the techniques to emerge, interact and traverse scenes. Thus, the relationships with those individuals who are at the scene of crack use is a unique and particular experimental moment.

At such a moment, the team, on the one hand, tests approaches, statements, techniques under the scrutiny of who they are providing care to; in other words, a simple, curt "no" can always be heard. On the other hand, this scrutiny can be configured as the personal experimentation of those who use the service: institutional flexibility and the extent to which the institution can be trusted are tested, as well as the impacts and possibilities of this interaction on their existence. It may be said, then, that the conditions of the production of knowledge of one are also, inevitably, the conditions of the production of existence for the other [16].

In this sense, there is something peculiar in the very existence of the CR, which reflects the complexity of the place of ambiguous speech in which it is situated, which is - exactly - what seems to allow its functioning as an institution and as a field science: dealing concomitantly with finitude, singularization and irreversibility [17]. In this sense, it can be said that the CR is *working towards its own dissolution: the horizon of dissolution of specialized services for the street population* [18].

Finally, it is positioned in relation to other institutions and other collectives in a historical process of the struggle for access to health and, especially, the existence of those who become its users. Thus, the nexus that connects the production of knowledge, institutional production and the production of existences is revealed. Hence the principles put in place by the CR function as guides in encountering diverse modes of existence. At this encounter, the CR begins to follow these existences and to learn from them. It then goes on to not only accompany but change with these existences, making the CR a component of existential support to users.

Therefore, the analysis of the work of the CR makes it possible to verify that, at the same time, these principles act as guides for the encounter with users, they also function as ontological [17] commands for the institution itself. That is, the principles will indicate *in what way* an institution like the CR can exist, evidencing a process that inevitably derives from the encounter with otherness.

Final considerations

The CR presents visible limits related, for example, to the possibilities of a policy of replacing crack with another drug, legal or otherwise, of proven effectiveness, or to provide a greater range of harm reduction supplies, such as silicone cigarette holders and lip moisturizers. However, at the time of writing this article, these inputs were restricted to information and condoms. In addition, the CR finds itself inserted in a precarious service network which, like education, is still the preferred target of the steady cycle of resource cuts in "eras of crisis",

 http://dx.doi.org/10.1590/1983-80422017253204

which emerge more and more frequently from the interests of the macroeconomic and political game.

However, fieldwork has shown that the service has the ability to innovate in relation to its own actions, as well as possessing the possibility of transforming other SUS services. This is because, in seeking to break down the barriers that block the access of those who are on the street, and in particular those in scenes of crack use, to the health system, these teams create a tension with regard to the adequacy of these services for an increasingly heterogeneous population with heterogeneous demands.

This means that one can move from the institution of an ideal model, such as that of the abstinent life, to the proliferation of services that can support, in all their concreteness and complexity, highly different modes of existence. For this, the CR acts by principles - subtraction, passage and engagement – which are related to those of the SUS - universality, equity and completeness – yet different. Thus, in view of the ideal of universal access to health services, these principles are performed by the SC, acting as guides for the reception of the population in the street and in scenes of crack use.

It is indicated that the work of the team allows not only contact with those in scenes of crack use, but also the possibility that they can intervene in the service that seeks to serve them; that is, the term "user" becomes concrete. Finally, a task can be identified: the openness required so that the knowledge of those who use crack connects with the knowledge of those who perform research and those who work in the care of those who use the drug - different, but not hierarchical, knowledge. Thus, not only will knowledge about crack be produced, but also the concrete means to empower the lives of those who use it, even if such use persists.

Referências

1. Araujo E. Fragmentos para uma bioética urbana: ensaio sobre poder e assimetria. [Internet]. Rev. bioét. (Impr.). 2015 [acesso 2 fev 2017];23(1):98-104. Disponível: http://bit.ly/2f6cIPy
2. Engstrom EM, Teixeira MB. Equipe consultório na rua de Manguinhos, Rio de Janeiro, Brasil: práticas de cuidado e promoção da saúde em um território vulnerável. [Internet]. Ciênc Saúde Coletiva. 2016 [acesso 15 jan 2017];21(6):1839-48. p. 1841. Disponível: https://goo.gl/T8vQYi
3. Macerata IM. Traços de uma clínica de território: intervenção clínico-política na atenção básica com a rua [tese]. Niterói: UFF; 2015.
4. Londero MFP, Ceccim RB, Bilibio LFS. Consultório de/na rua: desafio para um cuidado em verso na saúde. [Internet]. Interface Comun Saúde Educ. 2014 [acesso 8 jun 2016];18(49):251-60. p. 256. Disponível: http://bit.ly/2xyShCk
5. Khantzian EJ, Albanese MJ. Understanding addiction as self-medication: finding hope behind the pain. Lanham: Rowman & Littlefield; 2008. p. 2.
6. Brasil. Ministério da Saúde, Departamento de Atenção Básica. Consultório na rua: a rua não é um mundo fora do nosso mundo [vídeo]. [Internet]. 27 set 2013 [acesso 15 jan 2017]. Disponível: http://bit.ly/1NmeOjx_
7. Mendonça T. Batan: tráfico, milícia e pacificação na zona oeste do Rio de Janeiro [dissertação]. Rio de Janeiro: UFRJ; 2014.
8. Rafael A. Segmentaridade e tráfico de drogas no Rio de Janeiro. Alceu. 2001;2(3):166-79. p. 167.
9. Macerata IM. Op. cit. p. 208.
10. Vidal SV, Motta LCS, Siqueira-Batista R. Agentes comunitários de saúde: aspectos bioéticos e legais do trabalho vivo. [Internet]. Saúde Soc. 2015 [acesso 10 jan 2017];24(1):129-40. Disponível: http://bit.ly/2vVmCXg
11. Coppel A, Doubre O. Drogues : sortir de l'impasse : expérimenter des alternatives à la prohibition. Paris: La Découverte; 2012. p. 23.
12. Nietzsche F. Genealogia da moral: uma polêmica. São Paulo: Companhia das Letras; 1998.
13. Lancetti A. Contrafissura e plasticidade psíquica. São Paulo: Hucitec; 2015. p. 28-9.
14. Domanico A. "Craqueiros e cracados: bem-vindo ao mundo dos nóias!" Sobre a implementação de estratégias de redução de danos para usuários de crack nos cinco projetos-piloto do Brasil [tese]. Salvador: UFBA; 2006. p. 135.
15. Stengers I. As políticas da razão: dimensão social e autonomia da ciência. São Paulo: Edições 70; 2000.
16. Stengers I. Op. cit. p. 167.
17. Guattari F. Caosmose: um novo paradigma estético. São Paulo: Editora 34; 2012.
18. Macerata IM. Op. cit. p. 176.

Participation of the authors
Erick Araujo performed the research and planning and wrote the final text. Fermin Roland Schramm guided the study and carried out a critical review.

Recebido: 8.2.2017
Revisado: 8.7.2017
Aprovado: 2.9.2017