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## **DRUG POLICY: WHAT IMPACT DOES IT HAVE ON CHILDREN AND YOUTH?**

### *POLÍTICAS SOBRE DROGAS: QUAL O IMPACTO PARA CRIANÇAS E ADOLESCENTES?*

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#### **ABSTRACT**

This article reviews the national and international literature on drug policy, focusing on harm reduction strategies and their impact on the development of children and youth in Brazil. Without using statistical criteria, this paper develops an overview of the current context and discusses the trends in the literature through an exploratory analysis of production and a non-exhaustive bibliography. The results showed that state investment in public policies for the treatment and prevention of drug abuse is recent. In addition, harm reduction is still a little known and controversial strategy, especially among children and adolescents.

**Keywords:** drug abuse; drug prevention; health policy; harm reduction; child and adolescent health.

#### **RESUMO**

O artigo traz uma revisão da literatura nacional e internacional referente às políticas sobre drogas, notadamente a propósito da estratégia de redução de danos, com o objetivo de situar, nesse contexto, as ações voltadas para o público infanto-juvenil em desenvolvimento no Brasil. Através de análise exploratória e não exaustiva da produção bibliográfica sobre o tema, e sem o emprego de critérios estatísticos, apresentamos um panorama da situação atual da discussão e principais tendências. Como resultados, identificamos que é muito recente o investimento do Estado em políticas públicas visando ao tratamento e prevenção do uso abusivo de drogas, especialmente quando se trata de crianças e adolescentes, e que a estratégia de redução de danos é ainda pouco conhecida e cercada por muita polêmica.

**Palavras-chave:** prevenção do abuso de drogas; política de saúde; redução de danos; saúde da criança e do adolescente.

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#### **Introduction**

This paper conducts an exploratory review of the national and international literature on drug policy, focusing on harm reduction strategies and examining their impact on children and adolescents in the current Brazilian context.

We initially believed that the review could be conducted using only articles found in the database available on *Portal de Periódicos Capes* (a digital database of academic publications). However, we found extremely relevant publications using other print and virtual resources. Thus, to provide a more thorough review, we also used Google Scholar, books, governmental and non-governmental websites, official reports from Brazil and other countries, and articles from national and international newspapers.

We have not conducted an exhaustive exploratory analysis of the literature on drug policy, and we did not use statistical criteria for data analysis. What we present here is an exploratory study that suggests avenues for further development and draws on a range of information vehicles and opinion makers for a broad overview of the current state of the discussion.

#### **The present state of the debate on drug use in Brazil**

Drug use by children and adolescents has become an issue of increasing concern among Brazilians. The official data (Ministério da Saúde [MS], 2005) indicate that the increased occurrence of substance abuse and suicide among adolescents is typically associated with violence. Among children and adolescents between

the ages of 10 and 19, violence is the leading cause of death (52.9%). This percentage increases among adolescents between the ages of 15 and 19, 58.7% of whom die from violence-related incidents (Secretaria Nacional de Políticas sobre Drogas [SENAD], 2009). The overwhelming majority of these deaths occur among young people who are black and impoverished (Minayo, 1990; Waiselfisz, 2011). According to Waiselfisz (2011), 46% more blacks than whites died in 2002 by acts of violence. This percentage rose to 81% in 2005 and to 111% in 2008.

In a more recent study, Waiselfisz (2012) provided further information about the violence affecting Brazilian children and adolescents, reporting that Brazil's rate

of 13 homicides per 100 thousand children and teenagers leads it to occupy the 4th place among 92 countries [in a ranking prepared by the WHO], with rates between 50 and 150 times higher than countries like England, Portugal, Spain, Ireland, Italy, Egypt, etc., whose rates barely reach 0.2 homicides per 100 thousand children and adolescents (Waiselfisz, 2012, p.79)<sup>1</sup>.

Drug use, whether prohibited or restricted (e.g., alcohol use), and the use of firearms are directly related to the violence that occurs among children and young people. Firearms are the primary means used to commit crimes and are the leading cause of violent deaths (Souza & Jorge, 2006).

Although the data show that the high mortality rate among children and adolescents, especially males, is linked to drugs, and empirical evidence indicates that substance abuse triggers behavioral changes, Minayo and Deslandes (1998) have drawn attention to the complexity of the relationship between drugs and violence. According to the authors, causal explanations are uncertain; they claim that "in fact just what we can infer is the high proportion of violent acts when alcohol or drugs are present" (Minayo & Deslandes, 1998, p.37). Though fundamental to this discussion, violence that is directly linked to drug trafficking, such as organized crime, militarization and the enormous negative impact of these activities on youth in developing countries, is beyond the scope of this paper.

According to a recent Brazilian national survey (SENAD, 2010, p.11),

almost 49% of college students surveyed have tried an illicit drug at least once in their lifetime, and 80% of respondents who said they were under 18 years old reported that they have already consumed some type of alcoholic beverage.

In addition, according to the Brazilian Report on Drugs (SENAD, 2009), Brazilians in all socioeconomic classes are beginning to use drugs at an increasingly younger age, which indicates the need to develop prevention programs that target young people.

These circumstances have motivated government and civic entities to create intervention strategies for prevention, health promotion and harm reduction. These strategies are intended to improve the psychosocial health of children and adolescents involved with the use of alcohol and other drugs.

Within the last decade, open discussion about drug laws and policies in Brazil has increased, especially in the media and on virtual social networks. The Supreme Court has intervened in favor of organized protests, such as the recent *Marcha da Maconha* (Marijuana March), and has seemed willing to publicize their ideas and to engage in further debate. However, great opposition to such publicity exists in some sectors of society, notably among the parliamentary representatives of religious groups in the legislature. If used properly, such publicity could contribute to reducing the risks created by drug abuse by improving communication with Brazilian citizens.

Opinion articles with divergent views, interviews and responsible reports have recently been published in national newspapers. These publications have increased the sophistication and urgency of the debate. However, it seems that this information is still restricted to adults, and the most serious publications appear in elite newspapers and magazines (*Jornal Folha de São Paulo*, *Revista Caros Amigos* and *Revista Piauí*, for example) and in some academic publications. A broader range of media (broadcast television and popular newspapers) report the violence and crime related to drug trafficking. These outlets are generally alarmist and rarely soften their reports with qualified and cautious information. This media contributes to a culture of fear, depicting a surging increase of criminality and violent crimes (Amaral, 2007) and identifying drugs as the enemy of the people.

During the year in which this research was conducted, many academic events and others organized by social movements approached the subject of drugs from diverse perspectives. These events attempted to propose new ways of understanding the drug debate in Brazil. This study contributes to the conversation by analyzing the current state of discussion in Brazil, especially as it concerns children and youth, to contextualize the evolution of drug policy in the Western world.

## **Historical evolution of drug policy in Brazil and across the world**

Since the mid-twentieth century, the nations of the Western world have exerted a great effort to institute effective drug control policies. With few exceptions (e.g., Holland, Germany, Portugal), most countries are waging a “war on drugs” (Benevides & Passos, 2010; Bucher & Oliveira, 1994; Nadelman, 1993). This rhetoric, which some have called the “war on drugs” or “a drug-free America”, has traditionally dominated the discourse and can be characterized as repressive and moralistic, disregarding the specific manners in which drugs are used and the social context of users’ subjectivities.

In 1971, United States President Richard Nixon dramatically announced the war on drugs. This marked the first use of the term. He declared drug abuse to be “public enemy number one” within the discourse of child protection (Barret, 2011). As many studies indicate (Barret, 2011; Comissão Global de Políticas sobre Drogas, 2011; Comissão Latino-Americana sobre Drogas e Democracia, 2011), the “war on drugs” has actually had a calamitous impact on the lives and development of children in America and across the globe, despite its agenda of child protection. Some authors claim that this contradictory discourse is a rhetorical strategy that obscures reality (Barret, 2011). As some authors have argued (Barret, 2011; Latin American Commission on Drugs and Democracy, 2009; Karam, 2006, 2007; Nadelman, 1993), the drug war policy has major disadvantages; however, it is not the purpose of this paper to discuss these disadvantages in depth.

The prohibitionist model, according to Rodrigues (2006), is based on a legal-moral and social-sanitary justification. This model was not always dominant, however; until the early twentieth century, complete liberalism was common, and international trade in psychoactive substances that are now illegal played an important role in the economy.

The “war on drugs” model was developed during the first international drug agreement talks, including the meetings in Shanghai (1906 and 1911) and the Hague Conventions (1912 and 1914). These agreements sought to end the production, trade and consumption of illegal psychoactive substances (Bucher & Oliveira, 1994; Fonseca & Bastos, 2005; Queiroz, 2001; Soares & Jacobi, 2000). Since the early twentieth century, Brazil has been among the countries that have acceded to international conventions dictating the suppression of the sale and consumption of drugs (Machado &

Miranda, 2007). The Brazilian penal code of 1940 is in line with these policies’ initial positions, which include the association of drugs with criminality.

In the beginning of the 1970s, psychiatric medicine intervened in the discourse with its technical and scientific knowledge, and the drug user became characterized as ill and/or a criminal (Queiroz, 2001). The historical research of Machado and Miranda (2007) informs us that only in the late 1980s did the Brazilian government begin to undertake initiatives to present the issue of drug use as a public health problem. However, these efforts encountered legislative and cultural obstacles because many morally minded institutions were being established to “save, recuperate, treat and punish” (Machado & Miranda, 2007, p.804) legal or illegal drug users.

In politics, the focus of the “war on drugs” is placed on reducing demand and supply; consequently, almost all political action aims to repress it. As a result, health care is un-emphasized in the discourse. The damage to children and adolescents arising from this policy is compounded by the imprisonment of many parents under the conviction of trafficking when, in fact, they are only users, a situation that primarily affects the poorest demographic in Brazil. “The census, conducted periodically by the Ministry of Justice of Brazil, ranks as absolutely poor between 90 and 95% of inmates in the Brazilian penitentiary system” (Karam, 2006, p.4).

Despite the large financial investment in repressive policies and compliance with stringent laws, the consumption of psychoactive substances has never decreased anywhere in the world (Karam, 2007). Rather, the only change that occurs refers to the predominant type of drug used in each context (United Nations Office on Drugs and Crime [UNODC], 2012). The prohibitionist model has, therefore, been called bankrupt by many institutions. Some countries, including Austria, Belgium, Denmark and the Netherlands, have established different practices. According to Rodrigues (2006), Portugal, Spain and Italy have guided their criminal legislation to decriminalize or legalize drugs for the users. (We will clarify the difference between decriminalization and legalization below.)

The Final Report of the Latin American Commission on Drugs and Democracy is categorical in stating that:

Violence and the organized crime associated with the narcotics trade are critical problems in Latin America today. Confronted with a situation that is growing worse by the day, it is imperative to rectify the “war on

drugs” strategy pursued in the region over the past 30 years. Prohibitionist policies based on the eradication of production and on the disruption of drug flows as well as on the criminalization of consumption have not yielded the expected results. We are farther than ever from the announced goal of eradicating drugs. (Latin American Commission on Drugs and Democracy, 2009, p.07)

However, some parties argue for the unrestricted liberalization of psychoactive substances. Under such a policy, all prohibitive laws must be repealed—“both those that prohibit the use of drugs and those that admit it in certain circumstances” (Rodrigues, 2006, p.91). This discourse, based on individual rights, does not accept any type of regulation and asserts that individuals can treat their bodies as they please. According to Rodrigues, this position, although it is theoretically libertarian, could be “disastrous in terms of public health and would be difficult to implement and gain public acceptance” (Rodrigues, 2006, p.91). These disadvantages arise because this position prevents any form of state control over the expansion of drug use. In addition, it could damage public health because the production, sale and circulation of illegal drugs would be subject only to the laws of the market and not to legal regulation.

These two extremes (prohibitionism and unrestricted liberalization) of the drug policy discourse are considered by some authors to be the bases of policies that tend to fail (Laurent, 2011; Nadelman, 1993). These authors believe that, for the present, the controversy has reached an impasse, which has a significant impact on the types of treatment offered to people who abuse drugs. According to Laurent (2011), however, these moments of impasse provide opportunities to reinvent practices and develop new propositions.

Rodrigues indicates that alternatives to the prohibitionist model:

range from the depenalization of the user ... or slight changes to the structure of penal control to user decriminalization, which is a bolder strategy because it involves removing drug-related behaviors from the list of crimes. Slightly bolder is the decriminalization of certain behaviors related to the drug trade, as has been done in the Netherlands, with regard to the trade and cultivation of *cannabis*. (Rodrigues, 2006, p.82)

Within the debate, some authors and organizations (Karam, 2006; Law Enforcement Against Prohibition [LEAP], 2010) support the anti-prohibitionist stance. According to them, the violence arising from trafficking and other problems related to repressive policies could be resolved through legalization.

Rodrigues (2006) differentiates legalization into three categories: (a) liberal legalization, which resembles liberalization but admits some state controls, such as prohibiting sales to minors; (b) statist legalization in which the State would take upon itself the responsibility of regulating the production and trade of substances as it does tobacco, alcohol and medical drugs; and (c) controlled legalization, which would be “a system designed to replace the current drug prohibition by regulating their production, trade and use in order to avoid abuses harmful to society” (Caballero & Bisiou, 2000, cited by Rodrigues, 2006, p. 93). The implementation of new drug policies is still being debated, and several countries have experimented with various levels of legalization. Canada, Israel, the Czech Republic and some states in the United States allow the medical use of marijuana. The Netherlands does not apply penalties to drug users, and Portugal has boldly decriminalized the use of all drugs (Boiteux, 2011).

### **Harm reduction: history, principles and applications for children and adolescents**

Researchers have identified the first historical medical use of psychotropic drugs, but this initial use may not be applicable to the present proposal on harm reduction. The Rolleston Report in which the first medical use of psychotropic drugs was recorded was written in 1926 by health professionals and discusses the use of opiates by medical inducement (Queiroz, 2001; Soares & Jacobi, 2000). However, it was not until the 1980s that the practice of harm reduction became globally recognized as publicity about the HIV/AIDS epidemic and the innovative health programs being implemented in Europe and Australia began to spread (Conte et al., 2004). Harm reduction also became more common in Brazil during the 1980s as local initiatives began to be developed in the cities of Santos/SP and Salvador/BA (Passos & Souza, 2011; Santos, Soares, & Campos, 2010). The majority of publications on practical harm reduction continue to address HIV/AIDS health programs and injection drug use.

The first practical attempt to implement harm reduction strategies in Brazil illustrates the difficulty of doing so under prohibitionist policies. The initial campaign was introduced in Santos/SP during the city’s efforts to implement the *Sistema Único de Saúde* (SUS - National Health System), and the initiative met with strong resistance. According to Passos and Souza (2011), the population of Santos was known at the time to have high rates of HIV/AIDS contamination. The proposal and implementation of



harm reduction practices were therefore perceived as incentivizing drug use. As a result, David Capistrano (Municipal Health Secretariat) and Fábio Mesquita (Coordinator of STD/AIDS Program) were sued. “The judicial and police retaliation suffered by the Municipal Health Secretariat has underlined the contradiction of the State machine, with the Judiciary Power suspending the constitutional right of access to health” (Passos & Souza, 2011, p.156).

The guiding principles of harm reduction practices are to reduce the risks associated with drug consumption and to respect drug users’ freedom of choice, including those who have established a chronic relationship with a substance (Queiroz, 2001). Treatment is therefore undertaken to accommodate that condition. For example, harm reduction practices include proposals for needle exchange, reduction of the amount of substance consumed, substitution of consumption form (i.e., from injection to oral administration) and other actions intended to reduce the harm resulting from the use of drugs. In any treatment plan, the conditions and social context of each subject must be taken into consideration. However, the most relevant factor in the practice of harm reduction is the need for professionals to connect drug users with health services and to help them develop healthier lifestyle habits (Petuco, 2009). One of the main goals of this strategy is to reduce the spread of infectious diseases, and epidemiological data on HIV/AIDS and hepatitis are important indicators of the effectiveness of harm reduction programs.

Nowadays harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community. (International Harm Reduction Association [IHRA], 2010, p.1)

Harm reduction practices differ sharply from other forms of care that require the user to be abstinent as a fundamental condition for beginning treatment. According to the harm reduction perspective, the ideal of abstinence is not a requirement acceptable to all users, and the abstinence requirement deprives many people of care. Passos and Souza (2011) suggest that a distinction be made between the “paradigm of abstinence” and abstinence as a possible clinical direction:

In the abstinence paradigm, there is a network of institutions that defines the governability of drug policy, which is exercised coercively because it makes abstinence the only possible direction for treatment.

This system makes healthcare subordinate to legal, psychiatric and religious powers. (Passos & Souza, 2011, p.157)

In the case of children and adolescents, it may seem inappropriate to suggest harm reduction strategies as a possible form of treatment because this is a vulnerable, still immature group that should be protected from harm. However, some children and youths, especially those living on the streets, are in great need of health care, and harm reduction strategies could create relationships, as a condition for receiving care, that would otherwise be impossible to develop.

Despite the many preventive interventions that have been developed within the paradigm of abstinence, studies indicate that globally, drug use is beginning at an earlier age (SENAD, 2009), suggesting that young people are not affected by abstinence-based interventions.

Schools are described in most of the national and international literature as a privileged space for preventive initiatives. According to MacBride et al. (2003), Australia, Canada and the Netherlands are open to implementing interventions based on the harm reduction paradigm. However, few studies have evaluated school programs based implicitly or explicitly on harm reduction strategies. Such studies would be fundamental to determining the usefulness of such interventions. MacBride et al. (2003) have also indicated that projects implemented in classrooms have more of an impact than those implemented outside of the classroom. Furthermore, such programs are easier for schools to implement and cost less time and money.

In a literature review published in the late 1980s, Carlini-Cotrim and Pinski (1989) identified three types of strategies used by schools to prevent drug abuse: (a) increasing social control, a conservative strategy that reduces autonomy; (b) offering alternatives, such as interventions in other settings, sports and cultural activities, that aim to reduce youthful encounters with drugs; and (c) education. According to the authors, the education strategy, represented as a line, can be divided into six theoretical and philosophical axes: the moral model, the fear-based model, the scientific information model, the model of affective education, the healthy living model and the group pressure model.

Soares and Jacobi (2000) emphasize the lack of empirical studies relating to HIV/AIDS and drug education in schools. This shortage of scientific studies affects government actions, which have remained primarily repressive as a result (Bucher, 1992 cited by Soares & Jacobi, 2000).

### **The present state of drug policy in Brazil: implications for children and youth**

The new health care guidelines, released by the Brazilian Ministry of Health in the last decade, show evidence of paradigmatic change (MS, 2004a, 2004b, 2009, 2010). This change assigns the treatment of drug users to the public health sector, reducing the impact on the legal sector and creating the possibility of increased quality of life for users.

Delgado (2005), who served as the National Coordinator of Mental Health, explains that these innovations represent a need to compensate for Brazil's historical delay in drug treatment. According to him, these innovations are based on, but isolated from, other important ongoing initiatives. They demonstrate a heightened State investment in resolving problems related to crack, alcohol and other drugs use.

Currently, the use of crack is being treated as an epidemic in Brazil. It has become one of the primary targets of public investment and has been tackled aggressively using tactics such as compulsory admission into institutions and excessive use of police force. However, there are no data to confirm the increased use of crack in the capital cities of Brazil, although it is possible that consumption has increased in smaller cities. (Tófoli, 2012).

Notably, although compulsory admission to institutions removes children and adolescents from the streets in major Brazilian cities, official documents show that this policy primarily targets adults and found little indication of care for children and youth. An important official document on mental health care for children and youth (MS, 2005) does not give any guidance for the treatment of children and adolescents in use of psychoactive substances. This omission is inconsistent with the transference of services for users of alcohol and other drugs to public mental health services. Perhaps the lack of clear guidelines and the low investment in equipment for meeting the health needs of children and young people are resulting in this fierce but ineffective policy of compulsory admission.

There is currently a care gap in Brazil that was historically generated by the lack of public policy for users of alcohol and other drugs. These users, when not condemned to long-term hospitalization in psychiatric hospitals, were left in the care of civil institutions, often managed by charities and religious organizations or, as Zaccone (2008) asserts, were imprisoned as drug dealers. We refer particularly to therapeutic communities,<sup>2</sup> which also proffer long-term hospital care but only accept users interested in becoming

abstinent. The expansion of these services occurred primarily between 1980 and 1999. These treatments were developed under a supply and demand reduction paradigm (Queiroz, 2001).

A large part of the power that subjects drug users is derived from Criminal Law and Psychiatry. This disciplinary power operates through the normalization of deviant behavior in which medical and criminological knowledge give priority to the criminal, the insane, the delinquent, and the "drugged" as objects of intervention. From this viewpoint, we could easily conclude that the conflicts involving Harm Reduction are aimed exclusively at the disciplinary tools: the prison and asylum. However, it is not only within the prisons and asylums that drug users are confined today. Therapeutic Communities and Therapeutic Farms do not exclude discipline but instead add a dimension of religious morality. (Passos & Souza, 2011, p. 157)

In Brazil, such institutions are primarily responsible for meeting the demand for care of users of alcohol and other drugs. However, according to research by Raupp and Milnitsky-Sapiro (2008), there is a large discrepancy between the practices performed in therapeutic communities and those prescribed by public policy. The most recent document corroborates this conclusion: in late 2011, the *Conselho Federal de Psicologia* (CFP - Federal Council of Psychology) released a report on the national inspection of places of internment for drug users. According to the report, dramatic and delayed situations in which human rights or the recommendations of public health policies were ignored were found in Brazil in places that do not offer health care for the population they serve. According to the document, the majority of the institutions inspected have adopted rigid religious principles, have abstinence as a condition for beginning treatment and use the 12-step method or labor therapy. The inspection found that all 68 institutions inspected violated human rights principles.

During the inspection, the inspectors of the *Conselho Federal de Psicologia* visited several institutions that receive children and youth. The largest problem faced by these institutions was the truancy from school of children and adolescent internees. Furthermore, it was found to be common for children and adolescents to share rooms with adults. These two situations violate the *Estatuto da Criança e do Adolescente* - ECA (Statute of Children and Adolescents) (CFP, 2011).

In the report, the CFP also identified "the need for such services to fulfill social-educational measures, transformed by the lack of consistent responses in pure measures of segregation" (p.193). Many adolescents in

conflict with the law are becoming internees in these institutions, resulting in

several human rights violations because of their use of isolation treatment. ... The shortcut adopted by legal entities and the Executive Branch addresses the social malaise but does not produce justice. It condemns young people with a lack of prospects to a tough punishment for the committed act and does not civilize. It is an unfair measure that does not educate or socialize. (CFP, 2011, p. 193)

The report also states that, contrary to the *Estatuto da Criança e do Adolescente*, in some institutions, children and adolescents are

alone, away from their parents and guardians when they should ... be accompanied by them in this moment of fragility. Separating them from their affective bonds, society contributes to the weakening of these bonds and consequently reinforces institutionalization as a solution. (CFP, 2011, p. 193)

Other questionable actions aiming to renovate adults, children and youth were found to exist, including the administration of controlled drugs without a previous psychiatric evaluation, the use of unremunerated labor, disregard for privacy, etc. According to Rotelli (1990 cited by Raupp & Milnitsky-Sapiro, 2008), therapeutic communities are becoming "orthopedic places," where avenues of development are standardized and there is no space for the recognition and appreciation of difference. As seen in the literature review, one of the most powerful spaces for educational and preventive actions aimed at children and adolescents is the school. In Brazil, there are few reports of the activities taking place in schools. The oldest and most widespread initiative in Brazil is PROERD - *Programa Educacional de Resistência às Drogas* (Educational Program of Drug Resistance). According to information from the program site (<http://www.proerdbrasil.com.br>), PROERD, which is proposed and executed by the Military Police, is a Brazilian adaptation of the American program DARE (Drug Abuse Resistance Education). DARE was created in 1983 and is currently present in over 60 countries. In Brazil, the program was established in 1992 by the Military Police of the state of Rio de Janeiro and is now used all over the country in both private and public schools. These schools conduct group activities designed to impart information about drug use. Every initiative is important, but this initiative requires further systematic evaluation, as indicated by Silva and Gimenez-Paschoal (2010). In a still impressive evaluation, we have found good adherence to this program (conducted in an extracurricular space) by youth. These programs, however, are not carried

out by school staff (teachers, counselors and students), which some studies say would be more effective. There is no obligation to participate or evaluation of the impact of these activities on the actual consumption of drugs. Moreover, we must consider the consequences arising from the program's development by members of an institution linked to repressive and constabulary actions. We know that guilt-inducing anti-drug discourse considers the individual to be a criminal or a sick person. This perspective compromises the construction of a more democratic and co-responsible society and represses spontaneous expressions of curiosity in youth.

O. Cirino (personal communication, August 26, 2011) indicates that it is necessary to discriminate the relationship that each subject establishes with a substance, whether legal or illegal. Control over drug intake and its consequences are highly variable. A user of drugs is not always marginal or "at rock bottom". Velho (1998) agrees that although everyone involved with illicit drugs is somehow marginalized by the illegality of drug use, drug users may live different lifestyles. Therefore, the development of drug policies, besides considering the types of drugs used, should differentiate the socioeconomic and cultural contexts in which the drug is consumed.

The most frequent information about the use of drugs by children and adolescents appears in epidemiological surveys. These surveys influence governmental action but do not discuss all dimensions and complexity of the phenomenon and sometimes marginalize certain groups. As Barret (2011) argues, publications of statistical data are relevant, but considering the magnitude of the issue, which involves social, economic and subjective determinants, these publications do not provide a complete picture. The author defiantly states, "Is the number of people who use drugs an important indicator, or should we be more concerned about drug-related harms such as overdose, crime rates, and blood-borne viruses?" (Barret, 2011, p. 3). According to the author, these issues pose major challenges. These challenges are not easy to resolve, and it will require extensive research and qualitative analyses focused on well-being and quality of life to address them adequately.

Sophisticated qualitative analysis should be performed on the data found to prevent them from being viewed in isolation, promoting segregation or strengthening stigmas. Cirino (2011) underlines the need to discriminate, but not segregate: we must distinguish the differences and coexist with them instead of refuse them. In the case of drug users, the author indicates that separating users into groups or



categories (such as *cracolândias*) and subjecting them to the same types of care is harmful. We emphasize that the marginalization or identification of certain groups as deviants is a social construction:

social groups create deviance by making rules whose violation is perceived as a deviance and applying those rules to particular people, marking them as *outsiders*. From this perspective, deviance does not describe the quality of one's act but is rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom that mark has been applied successfully. Deviant behavior is therefore defined by concrete people. (Becker, 1963, cited by Velho, 1998, p.15)

According to Cirino (2011), when drugs are legalized and decriminalized and the false distinction between licit and illicit drugs disappears, it is necessary that the drug user does not take refuge in the "disease". In all cases, he should exercise his ability to make and answer for his own choices. This is, indeed, a challenge.

Cirino (2011) shows that only after the implementation of Psychiatric Reform did the Ministry of Health begin to offer a more democratic policy proposal for users of alcohol and drugs. The author argues that there are benefits to this new proposal but that difficulties remain. Among these are the prejudices toward people who use psychoactive substances, the difficulties experienced by health professionals, the lack of criteria and a more thorough investigation of care practices, the roaming of users through different services because institutions refuse responsibility for them and the lingering "shadow" of internment. These are common difficulties present in services aimed at adults or directed at young people.

In the current policy, the structuring of new institutions, exemplified by the Centro de Atenção Psicossocial-Álcool e Drogas (CAPS-AD-Psychosocial Care Center-Alcohol and Drugs), aims to deliver a comprehensive psychosocial care to drug users. This policy is clearly integrated into the cultural environment and is attempting to promote connections with other institutions in the care network. The major innovation of the current policy, which remains controversial, is its perception of the drug user's subjectivity. Meanwhile, it is not clear whether care devices will be developed especially for children and young people; these may be provided by the *Consultórios de Rua* (Street Offices). These institutions were regulated in 2009 by the Ministry of Health and implemented in many cities. The *Consultórios de Rua* has as one of its objectives the prioritization of "actions aimed at children and young people in situations of vulnerability, considering their

increasingly early initiation into substance use and the serious repercussions of its use on the psychosocial development of youth" (MS, 2010, p.12). However, for young people who are not on the streets, such services are restricted to CAPSi (Psychosocial Care Center for Children and Adolescents), which is associated with the care of psychiatric cases. However, as observed in recent research (Passos et al., 2012), children and adolescents who are themselves drug users but do not have psychiatric comorbidity refuse to stay there. The *Consultórios de Rua* are guided by the principles of harm reduction and are defined by the Ministry of Health as

care delivered in open environments and directed at drug users who live in conditions of greater social vulnerability and are distanced from the intersectoral health services network. They are clinical community devices that offer health care for drug users in their own contexts of life, adapted to the specifics of a complex population. (MS, 2010, p.10)

Before such clinics became nationally established, this type of teamwork had already been in effect since the late 1990s in Salvador city, demonstrating its potential as an innovative practice.

### Final considerations

In contrast to treatments that depart from the abstinence requirement, harm reduction, as proposed by the Ministry of Health, is an effective treatment strategy for users of alcohol and other drugs because it promotes a creative, person-centered practice that allows the subject to be involved in their own treatment and to better understand his relationship with the drug; such treatment may even lead the user to choose abstinence (Andrade, 2004; Delgado, 2005; MS, 2004a; Queiroz, 2001). However, in the case of children and adolescents, this proposal remains controversial.

Although the Ministry of Health has established new guidelines for treatment provided through public services, and although the amplitude of discussion on the subject has increased in the last decade, the empirical research in which this literature review originated (Passos et al., 2011, 2012) found that care for child and adolescent psychoactive substance abusers is a largely underexplored topic. Moreover, public mental health services, which should referee these situations, have encountered enormous difficulties in resolving these cases. Demand, however, is growing considerably. As we have observed, there are few studies that evaluate and discuss whether the provision of services for child



and adolescent drug users is in conformity with the new Ministry of Health guidelines.

As suggested earlier, the increased demand for public services is related to the historical fact that the Brazilian state has only recently effectively offered care alternatives. Previously, these responsibilities were in the charge of charities, nongovernmental organizations and psychiatric hospitals. Fewer institutions, however, have offered to undertake the treatment of children and youth, and such services have less relevant long-term experience.

Finally, although some practical difficulties hamper the functioning of the care network, at the current time, we believe that the ministerial proposal is bold, especially in its investment in the intersectoral care network. This policy identifies such investment as a fundamental condition for the provision of care. This is especially the case for children and young people, subjects whose fragile situations are often exacerbated by vulnerability factors such as exclusion, poverty and violence. As the Brazilian Ministry of Health's policy indicates, addressing drug use among children and adolescents is not merely a matter of mental health; the care network must also incorporate the expertise found in the fields of anthropology, sociology, education, law and social assistance.

### Notes

- <sup>1</sup> All citations of Brazilian references were freely translated.  
<sup>2</sup> It should be emphasized that the vast majority of these institutions have the characteristics of a total institution and are not in keeping with the proposed Therapeutic Community of Maxwell Jones.

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