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Tensions between approach paradigms in public policies on drugs: an analysis of Brazilian legislation in 2000-2016

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Abstract *Brazilian public policy on drugs has been permeated by two diametrically opposing approaches: one focusing on prohibition and the other on non- prohibition. Similarly, there have been two opposing approaches to mental healthcare, one centered on hospitalization and the other psychosocial care and development. In the context of these different paradigms, this article presents an analysis of twenty-two documents sourced by the legislative rules over the last sixteen years. After the year 2000, a renewed focus by healthcare community on drugs was noticeable as was the immersion of a harm reducing approach. Following international trends, although there are still considerable divergencies between (a) psychosocial care and(b) residential care in the therapeutic communities there seems to be an alignment to anti- prohibition approaches.*

Key words *Harm reduction, Public policies, Alcohol and other drugs, Inter-sector cooperation and coordination*

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Introduction

Abusive use of drugs ('drug abuse') is a multi-factorial problem in public health involving biological, psychological, social and cultural dimensions, and a challenge for implementation of integrated and wide-ranging policies. It is significant worldwide: it is estimated that 246 million people in the world use psychoactive substances – or a proportion of 5.2% in 2013[1]. In the formation of public policies about drugs, there are tensions in various areas. In the area of law, the Courts and public safety, there are two paradigms – in favor of prohibition, and against prohibition – in dispute with each other. In the field of health and social work, there are three approaches in dealing with mental health in relation to alcohol and other drugs[2]: the hospital-admission approach, the psychosocial care approach, and 'harm reduction'. The prohibition approach – the 'War on Drugs' – aims chiefly to combat drug trading, and to criminalize users and traffickers, aiming for a world free of drugs. It is associated with the anti-drug discourse, it is the result of various international treaties in which the commitment is to prevention of consumption, repression of production and repression of supply. The 'anti-prohibition' approach, on the other hand, places de-criminalization, and legalization of drugs, at the center of the debate; it takes the view that the use of drugs should not be considered to be a crime and that people who make abusive use of drugs should be offered treatment and care, and not confinement to a prison environment[3].

In the health sector, the basic characteristic of the 'hospitalization' approach is the emphasis on the organic nature of the disorder, with a central belief in medication as a tool for the cure. In his treatment, the individual has a passive position; and is considered to be ill, thus justifying isolation from his/her wider family and social environment. The typical institution of this paradigm is the psychiatric hospital, which has only hospitalization as a model.

In the 'psychosocial' model, the way that practices have developed arises from social movements, and various fields of theory. The considerations of this model, at an initial moment, on psychosis in particular and on other forms of suffering, such as those associated with abuse of drugs, strongly feature considerations that go beyond the notion of illness. For this reason the resources used in the care also need to go beyond medication. For context, we take as a starting point a phenomenon based on the phenomenology of Husserl, cited by Basaglia[4], which is the proposal to place the illness 'in parenthesis', to examine the process of becoming ill together with as its economic, social and political determining factors. Healthcare is given within the point of view of territorialized Care Networks; and integrality is taken into account as a factor, both in relation to the environment and in relation to the act of therapy with the individual, in which its effects do not aim to suppress the symptoms, nor necessarily achieve abstinence, but rather to reduce risks and harm. This model of care is centered on respect for differences, defense of life and of the right to liberty, and the dignity of the person, and its objective is social inclusion and re-insertion; drug addiction or dependence is seen as a result of the meeting of a person with a drug in a given social-cultural moment, within a triad of factors: the individual, the drug, and the context[5]. Its principles are: de-institutionalization; liberty; autonomy; and citizenship – with interdisciplinary and inter-sectoriality as wider clinical practices[6].

References of this sort are the orienting guidelines for disputes in the fields of health, social care, public safety, and justice. They can be reflected in three models/approaches to the users of drugs – according to Marlatt[7]:

1. In the '*moral/criminal*' model, the use of certain drugs is defined as unlawful, and for this reason subject to punishment. This remits to prohibitionist policies, and reduction of supply, within the moral concept of pleasure associated with sin, and the individual not being capable of discerning between right and wrong, thus able to be submitted to measures that suspend individual rights. Here an association is made between Justice and Health, through practices such as Therapeutic Justice, and compulsory hospitalizations ordered by Judges, which are provided for in a Health Law, such as Law 10216[8], which underwent innumerable modifications from Draft Law no. 3657-B, in the lower house of the Brazilian Congress (Chamber of Deputies), of 1989. For this model the sole target is absolute abstinence.

2. The '*disease*' *model*[7] sees dependence on drugs as a biological illness that merits treatment and rehabilitation. The focus is on the individual, and remits to an approach of reduction of demand: its devices would include the experiences of Alcoholics Anonymous, Narcotics Anonymous and the Minnesota Model. Such approaches do not concern themselves with a world free of drugs, because they start from the principle

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that only some individuals develop dependency. However, this approach can fall into a risk of association with the 1moral' model, when the idea of incapacity to exercise reason to the detriment of pleasure is related to the subject of the condition. The only acceptable target when starting from this conception is total abstinence – indeed, total abstinence is also a condition for the treatment – because the individual needs to accept that s/he has an incurable disease, which is progressive and fatal, and for this reason cannot be in contact with the substance to which s/he is regarded as being allergic[9].

3. The '*harm reduction*' *model* is understood as a strategy orienting care, in the ethical, clinical and political paradigm[10,11]. According to Marlatt[7], harm reduction starts from the philosophical premises of Pragmatism and Human Rights; it breaks with the idea that the use of drugs is abusive, and affirms that it maybe prejudicial, or not. It becomes, also, a strategy for people who do not wish, or do not manage, to reduce or cease use of drugs, and also for the other users that have difficulty accessing health services, or achieving integrated healthcare. One of its principles is respect for the autonomy of the subjects, as part of the point of view of an amplified healthcare which opposes the practices of putting users into hospices or compulsory hospitalization. Marlatt[7] points to harm reduction as an alternative approach in public health to the moral/criminal model, and the disease model, which are sustained on different principles and assumptions than those of the harm reduction approach.

The first and second of the above models are in tune with the 'prohibitionist' paradigm; the third is related to the 'anti-prohibitionist' paradigm. A certain approximation is perceived between the public policy models presented by Marlatt [7] and the hospitalization and psychosocial paradigms. The multiple aspects of these latter two approaches have been discussed by authors focusing on the Psychiatric Reform. A choice between the two has the potential to keep policies based either (a) on a logic that imprisons, represses and isolates the drug-using subject within a model based on the idea of exclusion as a form of treatment, and supposedly, care, or (b) on another model that is sustained on the relationship between drugs and the context, and proposes an abandonment of stigmas – the model of harm reduction and psychosocial care.

Public policies in Brazil have shown themselves to be little integrated, and with barriers to access, accentuating the inequalities for people who practice drug abuse and who are in a state of extreme social vulnerability. On the other hand, there has been increasing, and promising, acceptance, in the field of drug-user healthcare in Brazil, of a widening and a reorientation of public policies that give priority to access and treatment in the context of a humanized and inter-sectorial healthcare network, with practices oriented by values and principles of participation, inter-sectoriality, and equity, grounded on the Brazilian Health System (SUS) and on the international health promotion movement[12]. The aim of this paper is to analyze the models and approaches that have permeated the development of public policies on drugs in Brazil in the sphere of the federal Executive in the 21st century, in the light of the existing paradigms.

Methodology

This is a documentary survey, in which the source of data is the group of all policies, decrees and other legislative rules published over the period 2000-16. This period was chosen because the present century has highlighted the subject of drugs in various sectors of government and society, with changes in the configuration of policies and public players involved, and increasing conflicts between them, and because there is a vast area of publication in this area in Brazil to be explored. Adoption of a documentary survey makes it possible to add the dimension of time to an understanding of the social dimension over the course of various cycles of variation in policies in this period[13]. Thus, the intention was to become aware of, characterize, analyze and propose summary concepts about the documents written and published by various instances of the federal Executive, relating to the policies on drugs in Brazil. Electronic searches were made by the authors to identify the legislation and rules in question, using the SAUDE LEGIS and SENAD databases[14].

Documents were authorized by year of publication (a time dimension), and the government protagonist sectors involved (players), and their relationship with the subject of drugs. Documents that were not converted into ministerial orders, laws or decrees were excluded. Identification of types of model according to Marlatt[7] was used to create analytical categories, with their respective influences on the organization of the health services (Chart 1). Also analyzed was the point of view of inter-sectoriality, an important

Chart 1. Brazilian legislation on drugs in 2000-2016: the legislation selected for this paper – analyzed by type of approach

Legislation	Year, Sector	Relationship with the subject of drugs; organization of services	Model*
Law 10216 of April 6, 2001	2001. Health Ministry.	Framework of the Psychiatric Reform; new model for mental health care; de-hospitalization, services on territorial basis, open doors, no exclusion from coexistence with society. Defines three types of psychiatric hospitalization: voluntary, requested by patient, and involuntary.	(3)
Collegiate Directorate Resolution (RDC) 101, of May 30, 2001 (repealed by RDC 29 of 2011)	2001. Health Ministry, Anvisa.	Technical Regulation on the functioning of care services for people with disorders arising from use or abuse of psychoactive substances, according to a psychosocial model. Also known as Therapeutic Communities (CTs).	(2)
Presidential Decree 4345, of August 26, 2002.	2002. Office of the President of the Republic, National Anti-Drugs Secretariat (SENAD)	Instituted the *National Antidrugs Policy* (PNAD). Uses the prefix *anti*, which can be associated with a position in favor of prohibition and a *society free from the use of* unlawful drugs, and unlawful use of lawful drugs – although it already indicates programs for reduction of demand and reduction of damage, since it takes into account the social determinants of health.	(1)
Ministerial Order 2197 of October 14, 2004.	2004. Health Ministry	Established the *Integral Healthcare Program for Users of Alcohol and other Drugs* ('AD'). Takes into account the decisions of the document "The Health Ministry's Policy for Integral Attention to Users of Alcohol and other Drugs" of 2003. Adopts Harm Reduction as a strategy for priority intervention. Is opposed to hospitalization of AD users in psychiatric hospitals, and makes rules governing short-term hospital admissions; proposes integration between the services and levels of healthcare.	(3)
CONAD Resolution 3/ GSIPR/CH of October 27, 2005.	2005. National Anti-Drugs Council (CONAD)	Instituted the National Policy on Drugs, substituting the prefix *anti* with *on*, reflecting a new technical/political understanding of the problem in a society protected from use of unlawful drugs and undue use of lawful drugs.	(3)
Ministerial Order 1028 of July 1, 2005.	2005. Health Ministry	Regulated actions that aim for Harm Reduction arising from the use of products, substances or drugs that cause dependence, and specifies Harm Reduction actions with availability of inputs for prevention of HIV and hepatitis.	(3)
The Drugs Law – Law 11343 of August 23, 2006.	2006. Office of the President of the Republic, President's Administrative Office.	Instituted the National System of Public Policies on Drugs (Sisnad). Lays down measures for prevention of undue use, care and social re-inclusion of drug users and addicts, and the networks of services. Establishes rules for repression of unauthorized production and unlawful traffic in drugs; defines crimes, distinguishes between user and dealer, and their respective penalties, but maintains criminalization and penalties for use of drugs.	(1)
Decree 6117 of May 22, 2007.	2007. Office of the President of the Republic.	Instituted the National Alcohol Policy, with measures to reduce undue use of alcohol, and its association with violence and criminality. Proposes expansion and strengthening of the local integral care networks using the logic of territory and Harm Reduction.	(3)
Ministerial Order 1190 of June 4, 2009.	2009. Health Ministry.	Institutes the Emergency Plan for Expansion of Access to Treatment and Prevention in Alcohol and other Drugs (PEAD). Creates and provides structuring rules for Clinics in the Street (CRs) as one of the strategies in the area of mental health; aims to diversify actions aiming for prevention, promotion and treatment through effective inter-sectorial responses.	(3)

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Chart 1. continuation

Legislation	Year, Sector	Relationship with the subject of drugs; organization of services	Model*
Law 12101 of November 27, 2009.	2009. Office of the President of the Republic, President's Administrative Office.	Makes provisions on certification of charitable social work entities; regulates exemption from social security contribution for non-profit legal entities under private law; and includes CTs in the category.	(2)
Decree 7179 of May 20, 2010	2010. Office of the President of the Republic, President's Administrative Office.	Instituted the *Integrated Plan to Combat Crack and other Drugs* (PIEC), and creates its Managing Committee. This Plan gave rise to the *It's Possible to Beat Crack* program in 2011, with three lines of action: Prevention, Care, and Authority, with the aim of promoting prevention, treatment and social re-inclusion of users; and combating of dealing in crack and other unlawful drugs. Aimed to integrate the actions of healthcare and social re-inclusion of AD users with the actions of the Single Social Assistance System (SUAS), as well as expansion of the facilities of the healthcare network.	(2 and 3)
RDC 29 of June 30, 2011.	2011. Health Ministry. Anvisa	Established health safety requirements for institutions providing care services to people with disorders arising from psychoactive substances on a residential basis. Repeals the RDC of 2001, and presents activities supposedly carried out in the CTs without naming them as such. Lacked the previous rigor of RDC 101 as to criteria for eligibility of the resident and maintains the criterion of voluntary staying. Did not define the maximum number of beds (which was 30 in RDC 101) and no longer requires the person responsible to be a health professional, but only a person with higher education.	(2)
Ministerial Order 2488 of October 21, 2011	2011. Health Ministry.	Approved the National Basic Healthcare Policy (PNAB). Revisits the organization of Basic Healthcare and its essential and derivative attributes. Incorporates Harm Reduction into Basic Care and creates the *Street Clinic Teams* (eCnaR).	(3)
Ministerial Order 3088 of December 23, 2011.	2011. Health Ministry.	Instituted the Psychosocial Care Network for people with mental suffering or disorder and needs arising from the use of crack, alcohol and other drugs (RAPS), for expansion of access to psychosocial care at the healthcare points of the network, including urgent cases. Instituted the CTs, the eCnaRs and the Psychosocial Care Centers for AD (CAPS AD), with their facilities, structures and rules.	(3)
Ministerial Order 131 of January 26, 2012.	2012. Health Ministry.	Instituted financial running-costs incentive for support to Residential Regime Care Services, including the CTs in the ambit of the RAPS. Sets 30 beds as the maximum number per service (the number first included in RDC 101). To receive the incentive payment, services must be part of a Health Region that has components of the RAPS. Presents more rigid rules for accreditation of residential services.	(2 and 3)
Ministerial Order 10 of February 28, 2014.	2014. Ministry of Justice - SENAD.	Adds a model of a report for inspection of CTs. Defines a CT as an entity that provide services receiving people with disorders arising from use or abuse of, or addiction to, psychoactive substances. Explicitly states that there is a number of vacancies contracted by SENAD, the oversight body of the CTs, using parameters of RDC 29/2011. Lays down that Work Therapy, which uses work as a means of recovery, is a right of the patient once accepted. Proposes an acceptance model in which there is no depravation of liberty.	(2)

it continues

Chart 1. continuation

Legislation	Year, Sector	Relationship with the subject of drugs; organization of services	Model*
Resolution 01 of August 19, 2015.	2015. Office of the President of the Republic, CONAD.	Regulates, under the aegis of Sisnad, the entities characterized as CTs, without prejudice to RDC 29. States that the CTs are not health establishments, but establishments working in the interests of and supporting public policies for care, treatment, protection, promotion and social re-inclusion. Establishes acceptance for up to 12 months, which differentiates from a psychosocial approach with a view to de-institutionalization. The acceptance program also allows inclusion of spiritual development as part of the method of recovery.	(2)
Ministerial Order 834 of April 26, 2016.	2016. Health Ministry	Redefines the procedures for certification of charitable social work entities in the area of health (CEBAS), and considers an entity that operates directly in healthcare to be a charity social work entity. A CT that is defined as a health entity may receive the CEBAS certificate, but there is no definition of criteria as to what characterizes a "health entity". Also states that as an exception, the CEBAS certificate may also be awarded to a CT that proves application of only 20% of its gross revenue in activities provided free of charge.	(2)

* Models of approach to users of drugs: 1) Moral/criminal/prohibition. 2) Disease/asylum. 3) Harm Reduction, and/or psychosocial care/anti-prohibition.

category when the complexity of the approach to drug abuse is considered, along with a wider understanding of health and its determining factors, dilemmas that require systemic and integrated approaches between the sectors. The items of legislation were also divided by a dimension of inter-sectoriality, classified into three levels: non-existence; incipient; and robust (Chart 2).

Results

Of the total of 22 documents identified as concerning the theme, 18, which met the criteria for eligibility, were selected for this analysis**.** These were distributed over the period in the study, but there was an increase in their number as from 2009 (Chart 1). The sectors of government involved were the Health Ministry, the Office of the President of the Republic, the Institutional Security Cabinet (National Drugs Secretariat – SENAD); the National Council on Drugs – CONAD; the President of the Republic's Private Administrative Office (the *Casa Civil*); and the Justice Ministry (SENAD). Of these documents, the largest number, and the majority (n=10), were issued by the Health Ministry, 7 by the Office of the President of the Republic, and 1 by the Justice Ministry.

On the classification of models/approaches by type, there was a predominance of the Harm Reduction model and/or the psychosocial care/anti-prohibition model, with 8 documents of this type; followed by the illness/hospitalization model, with 6 documents. Only two documents were identified with the moral/criminal/prohibition model (in the years 2002 and 2006), and there were 2 items comprising, in our assessment, more than one type of model – showing even more the dispute between models.

Looking at the beginning of the period, Law 10216[8] provided the framework expressing the Psychiatric Reform, legislating a new model for mental health care (psychosocial), with territorially-based services with open doors, replacing the psychiatric asylums. This law, although it did not specifically deal with the subject of drugs, defined three types of admission to a hospital or institution: 1) voluntary, at the patient's request; 2) involuntary – requested by a third party; or 3) compulsory – "ordered by the Judiciary". It was only in 2003 that the subject of drugs – the danger of their misuse – made a more tangible appearance on the health agenda, with the publication by the Health Ministry, of the Policy for Integrated Care for Users of Alcohol and Other Drugs (*Política para atenção integral aos usuários de álcool e outras drogas*). This took the form of a law in the following year (Ministerial Order 2197[11]), supporting the use of psychosocial care by avoiding hospitalization of users of alcohol

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Chart 2. Analysis of the components of intersectoriality.

Intersectoriality	
Not explicit or inexistent:	The documents do not address the issue of intersectoriality, with each sector considered individually without looking at integration with other sectors. 3 documents: RCD 101 from 2001; Resolution nº 01/2015 CONAD; Decree nº 834 de 2016.
Incipient:	The regulations demonstrate a connection between health, social care and human rights, but this is not yet integrated with other sectors or it considers intersectoriality implicitly. 9 Documents: Law 10216/2001; Statute nº 4345/2002; Decree nº 2197/2004; Decree nº 1028/2005; Law 12101/2009; RDC 29/2011; Decree nº 2488/2011; Decree nº 3088/2011; Decree nº 131/2012;
Robust:	The documents address intersectoriality as a "modus operandus", with connections between the different sectors as a key element of the policy or regulation. 6 Documents: Resolution nº3/GSIPR/CH/Conad/2005; Law on Drugs n º11.343/2006; Statute nº 6117/2007; Decree nº 1190/2009; Decree nº 7179/2010; Decree nº10/2014.

and other drugs in psychiatric hospitals, and recognizing drug abuse as a serious public health problem, and presenting harm reduction as a priority intervention strategy, a model which was increasingly strengthened in the following years. In 2005, actions based on Harm Reduction were regulated by Health Ministry Ministerial Order 1028[10], taking a bet on a model of care aiming to minimize the adverse consequences of drug abuse for the individual and society, and reducing the associated risks without, necessarily, interfering in the supply or consumption of drugs.

Convergent with the trend seen in Health, in the same period other sectors underwent changes in the approach to drugs, moving in the direction of anti-prohibition. This was expressed in the realignment of the title of government policies and sectors in the area: there was a change from the National '*Anti*-drugs' Policy (Política Nacional '*Anti*drogas' – 2002) to the National Policy *on* Drugs (Política Nacional *sobre* Drogas – 2005[15]); and with the National '*Antidrug*' Department (*Secretaria Nacional 'Antidrogas' – SENAD*) and the National '*Antidrugs*' Policy (*Política Nacional 'Antidrogas' – PNAD*), giving way, with the '*anti*' changed to '*on*', to the construction of a new identity in the approach to drugs, and a movement which was consolidated in the National Council for Policies *on* Drugs (*Conselho Nacional de Políticas sobre Drogas – CONAD*). A first result of this change can be seen in 2006, with Law 11343[16], which abolished the penalty of imprisonment for possession of unlawful substances for personal use, emphasizing actions of prevention, treatment and social re-inclusion – although it maintained the prohibition on use, with sanctions distinguishing a user from a dealer. However, this law left a gap in the form of non-specification of precise parameters of differentiation, including between user and dealer, opening loopholes for interpretations as to the type of user, which in practice increased the volume of imprisonments for possession of drugs[3].

The National Policy on Alcohol (*Política Nacional sobre o Álcool – 2007*)[17], although focused, presented an innovative formulation in the integrality of actions to reduce social damage, damage to health and damage to life, associated with the consumption of this substance, and also the situations of violence and criminality associated with the abuse of alcohol, in an inter-sector approach. Amplifying the scope of healthcare to people practicing drug abuse, in 2010, the Health Ministry recognized the gap in care and launched the Emergency Plan for Widening of Access to Treatment and Prevention in Alcohol and Other Drugs (*Plano Emergencial de Ampliação do Acesso ao Tratamento e Prevenção em Álcool e Outras Drogas – PEAD*) in the SUS[18], in a cross-sector perspective with various lines of intervention.

It should be noted that expansion of the Harm Reduction model in healthcare was incorporated in the National Basic Healthcare Policy (*Política Nacional de Atenção Básica*)[19] (reviewed in 2011), by recommending this strategy in primary care, and instituting a new modality of family health team, which we can call the 'Clinics in the Street' (*Consultórios na Rua*), to provide care, literally, to people living in the street, and drug users. As a capillary aspect of this model in other sectors, in 2016 the Social Development and Hunger Combat Ministry (*Ministério do Desenvolvimento So-*

cial e Combate à Fome), in collaboration with the Justice Ministry/SENAD, launched the Technical Orientations Manual of the SUAS[20] in the field of Harm Reduction, in which it recognized the multi-causal nature of consumption of drugs, the serious consequences in the lives of people and their families, the vulnerabilities associated with the use of crack, and the need for territorialized integration in Networks (Healthcare and Social Work).

Paradoxically – in relation to the strengthening of the Harm Reduction model and of psychosocial care – at the end of the 2000 decade rules were passed which reinforced the model centered on illness, especially through the Therapeutic Communities (CTs) – evidence the continuing existence of controversy and disputes. In 2009, Law no. 12101[21] certified Charitable Social Care Entities, including the CTs. In 2011, Anvisa [the health oversight authority] presented its Board Resolution (RDC) 29[22], which defined the *health safety requirements for functioning of institutions that provide care services to people with disorders arising from use or abuse of, or dependence on, psychoactive substances* – under a residential regime, but did not denominate them as CTs. Also in 2011, the Health Ministry instituted the Psychosocial Care Network for people undergoing suffering, mental disorders or needs associated with the use of crack, alcohol and other drugs (RAPS) (Ministerial Order 3088)[23], including the CT as one of the items of this network. In 2012, the Health Ministry itself instituted an effort to regulate the CTs in the mold of the Receiving Units, issuing Ministerial Order 131[24] which stated criteria for registry of the CTs in the ambit of the RAPS. One of these was compliance with the religious orientation of the resident. In 2013, a Health Ministry Technical Note[25] provided clarification on RDC 29 and its applicability in the CTs, presenting them as non-governmental institutions, of civil society, for care gaps in the SUS. In this political tension, the CTs began to be financed by SENAD, through the Justice Ministry, in 2014[26]. In 2015, CONAD Resolution No. 1 of 2015[27] regulated, in the ambit of the Sisnad, the entities that carried out (voluntary) collection of people with problems associated with drug abuse, and these were, now, characterized as CTs. These were not to be health establishments as such, but entities of interest and support for public policies in care, treatment, protection, promotion and social re-inclusion – thus being connected to the Justice Ministry, and supervised and inspected by SENAD. However, in 2016, in a statement that negated that link, responsibility for the CTs was returned to Health, with Health Ministry procedures creating rules for certification of charitable social work entitles in the area of health – CEBAS (Ministerial Order 834)[28]. This Order laid down that the institutions recognized in the legislation, with care services in a residential and transitory regime (including the CTs) that provide services for the SUS, may be certified, provided they are qualified as health entities and with provision of services proven by a statement by the manager of the SUS. However, a duality was established in terms of financing of the CTs, which was able to be done by either the SENAD of the Justice Ministry or the Health Ministry.

In relation to the specific policies for crack, these became more evident as from 2010, coinciding with the profusion of media reports on the supposed epidemic of crack. Within the outlook of integrated interventions between sectors, in 2010 the Integrated Plan for Dealing with Crack and Other Drugs (*Plano Integrado de Enfrentamento ao Crack e outras Drogas*)[29] was launched. This created the *It's Possible to Beat Crack* Program (*Programa Crack é Possível Vencer*) in 2011, which had substantial financial investment and actions that directly involved the policies on health, social work, public safety and education, bringing with it, as a directive, integration of the actions of the various sectors – care, authority and education.

This paper explores the inter-sector characteristics of the documents with the division of categories used in Chart 2. This showed that the majority of the documents (a total of 8) dealt with inter-sectoriality in a way that was still incipient; a further 6 involved the concept in a robust manner; and in only 3 there was no approach at all to the concept (the category 'non-existent') – and, thus, that this is an important dimension for analysis of public policies.

This categorization is important not only for the possibility of expanding inter-sector alliances in the development of projects and draft legislation, but also for an understanding of the competencies that are necessary for implementing actions, dealing with political and personal disputes for spaces of power, new competencies and skills for working with new bodies of information and practices, and a cross-sectional reading on the problems underlying a policy[12]. According to Buss and Carvalho[30], inter-sectoriality cannot be restricted to mere rhetorical intentions, nor to fragile accords, and should be systematized in "concrete projects directed to concrete popula-

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tions (...) submitted to procedures of evaluation that make it possible to scale their impacts on health and on the quality of life".

It should be highlighted that in 2002, the National Antidrugs Policy[31] presented, although only in an incipient fashion, a widened perspective involving both health and social work. In 2005, with the realignment of the policy, inter-sector integration became more robust. With the National Policy on Alcohol[17], in 2007, the inter-sectoriality and integrated nature of actions being taken became more visible; and in 2011, the *It's Possible to Beat Crack* program actually required an intersectorial treatment, by proposing integrated work through inter-sector Committees.

Discussion

Formulation of public policies in Brazil on the subject of drugs in the period studied did not experience a linear progressive tendency in the direction of the Harm Reduction / psychosocial model, although that had predominated in the provisions of law that were passed. There is an alternation between (a) the approach that emphasizes public safety and justice, reaffirming the 'War on Drugs' paradigm, and (b) the approach to drugs as a public health problem[32]. However, in all these sectors the Harm Reduction model has been gaining the principal protagonist role, as from 2005, with the realignment of the National Policy on Drugs[33].

The use of Harm Reduction practices as an important strategy for health, and the psychosocial care model, has, in contrast to the disease model, benefited people who use drugs, their families and the community because these are interventions that are based on a strong commitment to public health and human rights[34], the main focus of which is its actions, and the supply of integral care, reducing the harm that attaches to the use of drugs, and preventing those that have not yet taken route, without necessarily interfering in the use of drugs. Harm Reduction, thus, becomes a strategy orienting care; and an ethical, clinical and political paradigm showing itself to be more problem-solving for the users of crack and other drugs. This therapy is considered to be 'low-demand' because it does not demand abstinence as an obligatory requirement. Abstinence is not denied, it merely does not enter the picture as the sole alternative for treatment for harmful use of drugs[9].

Tensions that appear in this analysis focus on the disease model used by the CTs for drug-dependent subjects. This model tries to break with the conception of failure of character which was until then attributed to people dependent on alcohol, based on the concept of disease, since in the society of the 18th century behaviors classified as addictions or vice were considered signs of weakness and moral failure[9]. The report of the Federal Psychology Council's 4th National Inspection of Human Rights (*Relatório da 4ª Inspeção Nacional de Direitos Humanos do Conselho Federal de Psicologia – CFP*)[35] presented a positioning contrary to the practices implemented by these entities, due to identification of various violations of human rights. Based on the Health Ministry document "*Mental Health in Data, 12*" (*Saúde Mental em Dados 12*)[36], and the Census of Therapeutic Communities (*Censo de Comunidades Terapêuticas*)[37], it was seen that the community base structures such as the Psychosocial Care Centers for Drug Abuse (CAPS-AD) received less investment than the CTs. In 2011 there were 277 CAPS-ADs compared to 1,179 CTs.

In the legal field, even after Law 11343[16], which supposedly made a distinction between drug users and dealers, there was no de-criminalization nor de-penalization of any drug: possession for use continued to be a crime, though this law no longer specified imprisonment, but rather alternative penalties (warning about the effects of drugs; community service; and education measures such as attending an educational course)[38]. In spite of this law, there was an increase in the rate of imprisonment for possession of drugs in the country. Data from InfoPen (2013) reported 574,027 people in prison, of which 146,276 due to dealing in drugs, related to Article 33 of Law no. 11343[16], with an increase of approximately 317.9%, from 74 to 300.96%[39].

In this paper we discuss the process of creation of laws as imposed by the policies on drugs in Brazil, in the context of the SUS. The gradual growth, in the policy, in the direction of community-based psychosocial care, protection of the individual rights of users, and a multi-disciplinary and intersectorial approach, stands out clearly. In this paper it is not the decision process that is analyzed, but the outlines of the tendencies that were in progress in the debate, and the conflict of ideas.

However, it can be emphasized that various theoretical traditions seek to analyze decision-making process in public policies. Several areas of action are important, in particular the

actions of government specialists, teaching and research institutions, and groups that defend vulnerable sectors of society, as in the case of advocacy coalition frameworks (in Portuguese, *coalizões de defesa*). Further, against this, veto groups play an important role in the outcomes and the political paths. Studies of a multidisciplinary type have been used to investigate mechanisms through which information is transmitted to governments and which affect their decision-making processes[40], and policies oriented towards drugs are very sensitive to flows of information from specialists and interest groups in this format.

In government institutions where political specialists and sectors share the arenas of decision with leaders and groups of active interests, Kingdom[41] identifies flows of decision where players take initiative, and when there are certain windows of opportunity and favorable conditions of public opinion can establish a virtuous coordination able to produce innovation and political change. A recent study made an updating of these theoretical traditions for the Brazilian case in terms of concepts and methods[42] that was important, and could potentially orient a vigorous agenda of research on policies on drugs in Brazil.

In terms of the current situation at any time, certain events in the legal sphere can affect the path of policy as analyzed here. At present, there is a case before Brazil's Federal Supreme Court dealing with decriminalization of drugs: Extraordinary Appeal 635659/2015, which in August 2016 had not yet been decided. However, due to the changes in the people leading the ministries of Justice, Health and Social Development, the policy of the Health Ministry for integral care for users of alcohol and other drugs, guided by the principle of Harm Reduction, is currently halted. There are signs of a conservative approach in the area of drugs policy, from 2016 – a resumption of the 'War on Drugs' paradigm centered on repression of supply and a policy for care and treatment of people misusing drugs based on the disease model present in the CTs, to the detriment of the psychosocial model of the RAPSs[43]. It should be remembered that the Brazilian State is non-religious, and democratic, and for this reason cannot, on the pretext of treatment, impose any religious belief on any of its citizens. It is the role of the State to respect and promote the citizenship of users, refusing all proposals that violate their rights, such as compulsory hospitalization and restriction of liberty as a method of treatment. The CTs, although they are part of the RAPS, do not share the same ethical and technical criteria, because they do not work with the notion of territory, nor with the concept of expanded health, nor with criteria for acceptance based on the logic of Harm Reduction.

Final considerations

The 2016 report of the Global Commission on Drug Policy[44], of 2016, points to the damages caused by criminalization: increase in the prison population, increase in infectious contagious diseases, and contribution to the increase in the number of deaths related to drugs – which, in 2013, was close to 200,000 worldwide. Due to these damages, the paradigm of prohibition has been strongly debated at a global level. Harm reduction, as a measure taken in public health, has been considered as the most appropriate approach to the problem of drugs in relation to human rights. In the last 15 years, a new wave of countries has moved in the direction of the drugs decriminalization model, suggesting recognition at global level of the failures of the criminalizing approach, and reinforcing a line of policy in the direction of an historic change in direction of paradigm[44]. This opening has happened in various countries with milder penalties for users of drugs, aiming for savings in costs[44]. Decriminalization is in tune with the model of psychosocial care, because it helps in the process of leading drug users to treatment, very much diminishing their stigmatization, and protects users from the devastating effect of criminal conviction.

It is concluded that policies on drugs should not have as their focus only the use of drugs, or the attempt to eliminate their production – the direction taken by the prohibition-based policy – but rather should invest in education with clear information on their effects so that (i) people can use drugs without causing much greater damage to their own lives, and (ii) for those who do use drugs in a damaging way, there should be a guarantee of access to healthcare in the psychosocial care model, with Harm Reduction as premise and point of departure.

Collaborations

MB Teixeira, ML Ramôa, E Engstrom and JM Ribeiro took part in the conception of the paper and the final drafting.

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