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Crack! Harm reduction has stopped, or was the death drive?

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Abstract: What does psychoanalysis have to say about so many issues involving drugs, which far outpass the question of their use? Historical, clinical and political issues, as we could say. The purpose of this text is to discuss vicissitudes that pervade them. We do not only approach the "drug problem," but also think about how the presence of psychoanalysis can deal with certain discourses that can be found in this field and which are far from questioning the subject. Working with psychoanalysis is to take the death drive into account. It is to use a knowledge that allows us a treatment orientation that considers what is deadly in the use of drugs in drug addiction, highlighting the position of jouissance of the subject. It is, moreover, to question what is deadly in certain political directions that transform the subject into an object.

Keywords: Psychoanalysis, harm reduction, public policies, drug addiction.

Introduction

For psychoanalysts, or for subjects that face the hopeless "civilization and its discontents" (Freud, 1930/2004) – whether poets, scientists, teachers, politicians, or an ordinary person –, there is no way to revoke the death drive, for the simple fact that every drive is, fundamentally, of death (Lacan, 1998), and since the speaker is a drive – and not instinctive – being, the death drive is in the basis of culture, of subjects, of every practice we undertake and, in a way, according to Freud, without us being aware of it (Freud, 1920/2004; Pernot, n.d.). Facing such fact is difficult, because it promotes anxiety, it destabilizes certainty, it requires a dialectic process and, especially, when dealing with other speakers, our fellows, it imposes working aware that setbacks are always possible, as well as there will always be dissociation, plainness, deconstruction, and why not, dismantlement. To associate, intricate, and construct will be, hence, investments of additional efforts, to which we will always be better prepared the greater our recognition of the existence of the death drive, precisely.

In 1914, Freud (1914/2006) finds himself summoned to make a change in his original drive theory because he faced, in the clinic, both the fact that the I is also a drive object – which, so far, was not contemplated – and the fact that repetition is the main way to seek drive's satisfaction: "The compulsion to repeat replaces [. . .] the drive to remember" (Freud, 1914/2005, p. 153, author's translation). [free translation] Such modification opened the way for the great reformulation, in 1920, once again driven by clinical facts that, then, indicated there was a *Beyond the pleasure principle* (Freud, 1920/2004), experiences which were translated as a compulsion to repeat. Death drive would be what underpins this compulsion, it "works quietly within the living being" (Freud, 1930/2004, p. 115, author's translation) [free translation], unlike life drives, which are "flashy and noisy" (p. 115) that, connecting things among each other, produce culture, enchant us through art, make us research and even love. But they are secondary, since originally, as aforementioned, we cannot go against the death drive, as for, in his words, "*the goal of all life is death"* (Freud, 1920/2004, p. 38, author's translation, emphasis added) [free translated].

When Lacan resumed Freud, he was one of the few psychoanalysts who, at the time, considered the concept of death drive as fundamental to psychoanalysis. Based on it since his early writings and seminars, and in the last stage of his teaching, he associated this freudian concept witht he notion of jouissance, which also implied a *Beyond the pleasure principle* (Alberti, 2007), an *impossible*. Both Freud and Lacan support the theory of this drive dualism, in which death drive is not the villain that should be extirpated, but part of speaking being. Death drive and life drives work together when considering the subject the way psychoanalysis proposes. It is precisely when they are not working together that, according to Freud (1923/2004), we witness a defusion, plainness of drives (1923/2004, p. 253). In this context, often, emerges the hate, the "pure culture of death drive" (Freud, 1923/2006, p. 54, author's translation) [free translated], as well as what the clinic of drug addiction reveals, in which this pure culture can daze the subject in their relationship with drugs.

It is the ethical duty of psychoanalysts, in their clinics, as well as in their political exercise – when working, in their specific practice – to understand the manifestations of the death drive, take them into account, in order to offer the possibility of locating them and finding instruments to deal with this impossible according to their own choice, but aiming at its association with life drives.

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As well as psychoanalysts, public policies also have the ethical duty to recognize the presence of an impossible, in order to provide guidelines for the society which enable establishing the guidelines of its institutions. To recognize it is not to deny the death drive. Of course we do not expect public policies to define the death drive as psychoanalysis does, but it is essential that such policies consider the ethical principle of a dualism absolutely distinct from any Manichaeism. This dualism does not exclude one side to harm the other, that is, it considers the fact that there is Good in every Evil and Evil in every Good, depending on the angle at which you look. An example of this dualism absolutely distinct from any Manichaeism is precisely the harm reduction policy which, while acknowledging the damage caused by the use of drugs, understands that not every use is harmful. According to this vision, a world without drugs does not match the bed of roses against the world with drugs. It takes into account the fact that drugs are part of the world, that there is no harm in themselves, they are not a demon who tempts human beings, but there may be a use that is harmful. This policy aims not to eradicate evil – that is, the drug –, but to diminish the damage of a use when such is harmful to the subject. We raised the hypothesis that any Manichean orientation in public policies, in particular those that support prohibitionism on the use of drugs, would emerge from the ignorance of the death drive.

As Teixeira, Ramôa, Engstrom and Ribeiro (2017) state, prohibitionism is similar to a war on drugs, and in a war there never has been and never will be any concern with the uniqueness of each, whereas a harm reduction policy (HR) "has as its principle the respect to the autonomy of the subjects," configuring as "an alternative to the moral/criminal models and those of disease" (p. 1,457). This hypothesis is based, specially, on the fact that "the HR model is understood as a guiding strategy of care, an ethical, clinical, and political paradigm" (p. 1,457). Teixeira et al. (2017) propose that "HR . . . dismisses the idea of harmful use of drugs, states that the same may or may not be harmful" (p. 1,457), which we understand that it should aim the wellbeing of each human subjected to this policy for citizenship reasons, which certainly also distinguishes this vision from that sustaining the ethics of psychoanalysts, which, strictly, is not concerned with the citizens and, even less, with a common good, to the extent that psychoanalysts are aware of the fact that what is good for society is not necessarily good for each individual.

A brief history of the drug problem

It is worth mentioning that psychoactive substances (MacRae, 2010) are used by society overall. For Albuquerque (2010), "'drugs' are discourses presented, in several ways, in the course of history" (p. 14). This author is based on the Focaultian notion of discourse, i.e., "on one hand, this regular set of linguistic facts, and controversial and strategic on the other" (Foucault, 2002, p. 9) [free translation], which implies a correlation of forces between the several agents in the culture, as in "games, strategic games, those of action and reaction, question and answer, domination and elusive games, as well as fighting ones" (p. 9). That is because the legality or illegality of drugs is established much more due to international or national interests than its intrinsic psychoactive qualities. If in the guidelines of the Brazilian Ministry of Health (2003) alcohol is highlighted from the other drugs in the very title of the law, this is not due to the legality/illegality status, but to the fact that alcohol and tobacco were, and still are, considered psychoactive substances that most cause harms to health, and therefore are more costly to the State. In this sense, we can perceive the importance that crack assumes in the Brazilian scenario when it is named alongside alcohol, in 2011, in the text of the Psychosocial Support Center (from Portuguese, *Rede de Atenção Psicossocial* – RAPS), that "assign the RAPS for people with suffering or mental disorder and needs arising from the use of crack, alcohol, and other drugs, within the Brazilian Unified Health System (SUS)" (Brasil, 2011b).

As noted by Freitas (2014), "As sure as the history of mankind, there is the fact that the human being has always made use of substances that change their mood, whether is alcohol, opium etc." (no page numbers), and already in the Colonial Brazil there was a concern with the criminality of the use and sale of drugs, as we can read in the *Ordenações Filipinas* of 1603 (Pedrinha, 2008). But it was in the 20th century that the first laws of the country concerning the drug problem were established (Alarcon, 2012; Alves, 2009; Fonseca & Bastos, 2012; Machado & Boarini, 2013).

In fact, at the beginning of the 20th century, we saw the drug enforcement policy being formed, which became known as prohibitionism, responsible for international anti-drug treaties, and this was guideline hegemonic also in Brazil for most of the 20th century. It was the questioning about the damage arising from prohibitionism itself, as well as the political, economic, and health configurations of the last two decades of the 20th century, that enabled the HR discourse as a possible way for dealing with the drug problem in Brazil.

According to Ribeiro and Araujo (2006, cited by Alves, 2009, p. 2,310), prohibitionism dates to the exponential growth of industrialization of alcoholic beverages at the beginning of the 19th century, in the United States of America, being propagated in such a way that it was founded, in 1869, the Prohibition Party. The American prohibition law, which established alcohol as an illegal drug in the USA, was effective from 1920 to 1932. This whole movement opposed to the wide dissemination of the "production, marketing, and consumption of substances nowadays classified as drugs, such as cocaine and opium and its derivatives" (Fonseca

& Bastos, 2012, p. 17) in the 19th century, in the world, and which produced, between 1834-1843 and 1856-1858, the famous *Opium War* between China, which profited from this trade, and England, which had other interests. Loser, China signed the Treaty of Nanjing, according to which there was "an attempt to regulate the production, marketing, and consumption of opium" (Fonseca & Bastos, 2012, p. 18), model for other international treaties to regulate substances that arose later.

The *Opium War* gave strength to the subsequent *War on drugs*. The USA joined England and, although they needed some time to reach an agreement that would consider the economic interests of the two powers, both countries were interested in a hegemonic discourse about the regulation of the psychoactive substances and which developed the prohibition movements. From all this, resulted the International Opium Convention, held in the Hague, in 1912, and its full ratification, in 1919, which left out of prohibitionism only the medical use of morphine (Fonseca & Bastos, 2012). Then, the "current system of control of different drugs" was born (Fonseca & Bastos, 2012, p. 19), which later generated a series of International Treaties, ratified by 160 Nations, aiming at the elimination of consumption and proposing that the only effective treatment for those who use drugs is total abstinence.

In the Brazilian context, we perceive an oscillation between policies that sometimes associated, sometimes discriminated the dealer, that is, respectively, an oscillation considering the *drug problem* as a concern pertaining solely to criminology, or both criminology and health. According to Batista (1997), the Decree no. 14,969, of 1921, stipulated the creation of sanatoriums for drug addicts and, while they were not created, users should be interdicted in the *Colônia de Alienados* – a kind of medical-political system (Pedrinha, 2008) that imposed the interdiction at the same time it proposed a treatment, and "although drug users were not considered criminals, the treatment of the same is not a bed of roses" (Freitas, 2014, no page numbers).

According to Machado and Boarini (2013), Decree no. 891, of 1938, regulated the use of narcotics, which comprised not only opium and cocaine, but also marijuana and heroin, in addition to classifying "drug addiction as a 'compulsory notification disease'" (p. 583). As a result, it imposed the "*compulsory or optional* hospitalization for a given time or not" of "drug addicts because of narcotics" (Machado and Boarini, 2013, p. 583, emphasis added). This decree was incorporated into the criminal code in 1941, because, according to Garcia, Leal and Abreu (2008 apud Machado & Boarini, 2013), this decree "corresponded to the aspirations of the Getúlio Vargas' Government to contain deviant behaviors, focusing on the worker" (p. 583). It should be noted that, despite presenting the possibility of hospitalization, Decree no. 891 did not impose it summarily. That is because it was subjected to the Criminal Code that were effective until 1976, according to which "drug use was not considered a crime, which demonstrated the characteristic of health prevention of drug addiction" (Freitas, 2014, no page numbers).

However, after the institutionalization of the last Brazilian Military Regime, Decree no. 54,216, of 1964, established a Single Convention on Narcotic Drugs, identifying drug dealers and users (Carvalho, 1996) and, in 1971, equating their sentences. It was only in 1976, with Law no. 6,368, that "criminal traffic members and users, especially with regard to the duration of the sentences" (Freitas, 2014, no page numbers) returned to be distinguished. If on one hand, according to Machado and Boarini (2013), in 1976 the law revoked "the compulsory character of hospital treatments" (p. 583), on the other hand, it produced a thrust towards medicalization of drug addiction, attributing legitimacy for the medical knowledge to be aware of the safety industry, separating criminals from sick people.

Still, the policy, regarding the drug problem in Brazil, tended to be univocal, underpinned by ideologies of moral nature, being isolation and, therefore, hospitalization, the current practice at the time (Alarcon, 2012). But the criticism about lunatic asylums had become increasingly fierce in those years and, with the promulgation of the new Constitution of 1988, which, among others, established the Brazilian Unified Health System (SUS), it was possible to introduce, in 2003, a new guideline, in terms of public health, for the field of care directed to users of alcohol and other drugs, field which is attached to mental health and consequently to the National Health Policy – thus separating the medical sector from the public safety.

With SUS, the new Constitution introduced, first of all, a concern with the health of the population and in fairly progressive way:

> (Art. 196.) Health is everyone's right and duty of the State, guaranteed by social and economic policies *aimed at reducing the risk of disease and other complications* and universal and equal access to the actions and services for its promotion, protection, and recovery (Brasil, 1988 , p. 116, emphasis added).

Effecting this egalitarian and democratic approach – why not coercive, on the other hand –, in 2003 a policy that has taken over the idea of HR was created and implemented, and such had already been experienced before. The first time was in 1926, when, in England, there was a proposal for a legal prescription of opium for the treatment of drug users (Alarcon, 2012). The second time, in the Netherlands, in the 1970s, it aimed to "keep way the frequent users of *Cannabis* from the risks offered by the black market [. . .] and only secondarily as an additional tactic, included the medical point of view of the reduction of physical and psychological harms" (Alarcon, 2012, p. 57). Our Constitution guides, in its Article 198, that "Public health actions and services integrate a

regionalized and hierarchical network and constitute a single system" (Brasil, 1988, p. 117). Considering this constitutional orientation, Health and Psychiatric Reforms, as well as the *Atenção Integral a Usuários de* Álcool *e outras Drogas* [Integral Care to Users of Alcohol and Other Drugs] policy, have implemented new strategies enabling greater effectiveness in relation to social inclusion and contrary to the imposition of *abstinence* for everyone through moral treatment and hospitalization, in force until then.

In addition, since the end of the 20th century, the fight against the before unimaginable Aids monster has begun, a monster which increasingly took lives due to lack of proper treatment, especially of injecting drugs users (IDU) – who, therefore, were the target of the first HR actions in Brazil. Andrade (2011) notes that "In several parts of the world, public health policies were beginning to turn to people who used drugs, because of the threat of the HIV/aids epidemic of getting out of control from this population" (p. 4,665). Reducing the harms implied, internationally, a new approach in public policies: to not explicitly prohibit the use of drugs – which had no effect –, but first, to guide the user population for them to survive! Taking care of this population, to the extent several countries have legalized the use, distributed disposable syringes[1], created care centers to users where they could seek guidance for a less-lethal drug consumption.

Thus, it emerged a political guidance that did not deny the impossibility of the extinction of drug use, use which Freud (1930/2004) has already observed as one of the only three possibilities that subjects have before the civilization and its discontents in the culture, but, on the contrary, taking this impossibility into account, he sought to make it dialectical, as we aim with our hypothesis: it is only considering the death drive that, with some additional effort, we can make each subject associate, intricate, desire [. . .] against the pure culture of death drive.

To advance in this sense, the creation of SUS demanded separating the health care sector from safety, regarding the drug problem. The Presidential Decree no. 4,345, from August 26, 2002 (Brasil, 2002), instituted the first National Anti-drug Policy (from Portuguese, *Política Nacional Antidrogas* – PNAD) that, on one hand, emerged from the international drug trafficking repression, sustained in the prohibition policy to which Brazil is allied, being, as almost all countries worldwide, signatory to the Single Convention on Narcotic Drugs of 1961 (United Nations Office on Drugs and Crime, n.d.). But, on the other hand, in line with Law no. 10,216/2001, which "regulates the protection and rights of people with mental disorders and redirects the care model in mental health," the Brazilian Ministry of Health redirected the field of practices for users of alcohol and other drugs towards a *policy of the Brazilian Ministry of Health for integral care to users of alcohol and other drugs* (Brasil, 2003). This is the second policy that opens the door to the practice of HR policy in clinics, in particular, of mental health (Alarcon, 2012; Andrade, 2011; Ramminger, 2014; Silva, 2014).

According to the aforementioned authors, the field of public policies regarding mental health, alcohol and other drugs had several advances, but also setbacks, and both have directly influenced the type of treatment effectively provided since 2003. Sometimes we were able to move towards the progressive direction that gave rise to the constitutional text, sometimes we observed setbacks implying what was not done regarding such improvements. We emphasize it because it was in the decriminalization movement that we saw, in the first years of the 21st century, the insertion of psychoanalysis in the care services to drug users. It was not the only improvement, there were others equally important, but we work with it and it is due to this work that we positioned ourselves concerning the current situation. If half a century after Getúlio Vargas a lot has changed in Brazil, with a quite progressive vision, in the second decade of the 21st century, when again we are witnesses of mandatory hospitalization, or rather, compulsory, we ask: to which aspirations does this retrocession from almost a century ago correspond?

Crack

Although created by Oswald de Andrade (1924/1971) to make a reference to the signs of the Stock Market Crash in 1929, *Crackar* (something like "to crack", considering "crack" as the drug), verb created by him and title of one of his poems, here we make use of such verb to associate public policy through the drug use – often reduced to crack in the discourses – to the crash of the guideline previously identified as progressive, to which we are faced today in the country. "To crack" the fire in the stone makes it crack, the sound we hear and which names the drug. When "cracking" the drug, the fire in the pipe often leads those who light it up to penetrate through several *quebradas*[2] (rough areas), sometimes breaking their social bonds and, sometimes, even their own lives. But there are also other rough areas, other alternatives, not every crack use leads to death. Discourses about crack, these, in fact, have been causing segregation and hatred. Crack has been even a rupture point in public policies, since, for the social imaginary, once you have used, you are addicted for good.

Here we resume our initial hypothesis: it is necessary to consider the death drive, because maybe it is not the crack that *cracks* the subjects, but they use it to satisfy their compulsion to repetition. If we disregard this choice of the subjects, even if it can be deadly – drive satisfaction that responds to the jouissance of each –, the

1 According to Mesquita (1994), in 1989 there was, in Brazil, an attempt to implement a program like this in the city of Santos, in São Paulo state, but it was contrary to the legislation in force and, therefore, was suppressed by Brazilian authorities.

2 In slang, *quebrada* refers both to sinisterness, a place with little security, but also an alternative place.

treatment provided goes into another type of repetition: hospitalization – abstinence – relapse – hospitalization. The political positioning based on the moral or organic positioning (disease) implies an idea: If you are a drug user, you are a criminal or you are sick, taking the other as an object, with "moral and spiritual 'failure,' described in psychological or existential terms" (De Leon, 2014, p. 41). [free translation] When taking the drug user as an object, the citizen is disregarded and, even more, the subject of the unconscious and their choices.

The use of drugs, regarding both the treatment and legal implications, in addition to its more violent aspect, namely, the *War on drugs*, in which are included the issues related to drug trafficking, is the issue part of our everyday lives. We verify there is a tendency, in terms of the media, if we may say, to associate acts of violence with drug use (Agência de Notícias dos Direitos da Infância, 2005; Rommanini & Roso, 2012; Roso et al., 2010; Silva, 2014; Tomm & Roso, 2013). And we know how the discourse spread in the media produces effects, sometimes, almost instantaneous! Those who work in Psychosocial Support Centers for Use of Alcohol and other Drugs (from Portuguese, *Centros de Atenção Psicossocial álcool e outros drogas* – CAPSad) – but we believe that this is also applied to other services – are faced, generally on Mondays, with a great demand for hospitalization whenever, on Sunday nights, there are TV programs about the so-called drug addicts. Well, when we assume that the *War on drugs* ignores the death drive, and then the culture of death drive predominates, we aim at the fact that, as in any war, the other is reduced to an object that can be tortured, isolated, imprisoned . . .

> Prohibition on drugs and its maintenance through the militarization of the repressive process feed the profits of criminal organizations that finance and distribute the drugs wholesale and diversify its activities, including trafficking of guns, human beings, animal and plant species, precious objects etc. (Alarcon, Belmonte, & Jorge, 2012, p. 77)

Our experience has shown that, in most cases, demands for hospitalization arise from a direct link between violence and drug use, criminalizing and classifying the user, producing and/or strengthening "subjectivities and ways of living" (Roso et al., 2010, p. 1), without considering the diversity of factors involved both in the issue of violence and in the use of drugs (Minayo & Deslandes, 1998), ignoring the warning of the Brazilian Ministry of Health policy, in 2003, against the *Main factors that reinforce the social exclusion of drug users:*

> 1. *Association of use of alcohol and other drugs with delinquency, without minimum evaluation criteria*; 2. The stigma assigned to users, promoting their social segregation; 3. Inclusion of trafficking as a work and income generation alternative for the most impoverished populations, in particular the use of young work force in this market; 4. Unlawfulness of the use prevents the social participation in an organized manner of these users; 5. The legal and equal treatment to all members of the "organizational chain of the drug world" is uneven in terms of penalties and intervention alternatives. (Brasil, 2003, p. 25, emphasis added)

In the seminar *Seminário mídia e drogas – O perfil do uso e do usuário na imprensa brasileira em 2004* [Media and drugs – profile of the use and the user on Brazilian press in 2004], researchers found that the media closely relates drugs "to urban violence, leading the issue to reach huge proportions, with similar reactions, translated into more and more repressive actions" (Agência de Notícias dos Direitos da Infância, 2005, p. 6). The notion of a *crack epidemic*[3] – that we are highlighting, to the extent it claims to be "an 'epidemic,' although lacking epidemiological data that could corroborate such statement" (Silva, 2014, p. 59) – disseminated by the media (Roso et al., 2010, p. 5) moves away from the progressive direction that health and psychiatric reforms have been implementing regarding the *drug problem*. In fact, this syntagma was initially used by Alarcon (2012), aiming both to designate "the harms that they can cause to the human body due to possible misuse," and "the harms produced by all the consequences inherent in anti-drug policies, their culture of violence, which continues, paradoxically, on behalf of the health of the population" (p. 46). The crack epidemic serves as the motto for both the media fuss (Ramminger, 2014; Silva, 2014), which takes it as that as that which causes violence, making "society lacks the means to provide a realistic and thoughtful look about it, to avoid falling into the most common stereotypes of the romanticized visions or associated solely with violence" (Roso et al., 2010, p. 7), and a retrogression in policies directed to the field of alcohol and drugs. This is the case of compulsory hospitalizations that, since May 2017, became news once again.[4] It is worth mentioning

3 According to Bertoni and Bastos (2014), "we can not say whether or not there is an epidemic of crack use and/or similar in the country, since technically an epidemic can only be characterized from results obtained from a historical series of records of estimates/accounts of the phenomenon under analysis" (p. 145, free translation).

4 Compulsory hospitalizations are provided for in Law no. 10,216, 2001. According to such, this kind of hospitalization occurs by determination of Justice. Art. 4 of the same law states that: "Hospitalization, of any kind, will only be recommended when non-hospital treatment resources may be insufficient" (Brasil, 2001, no page numbers). Several episodes of State intervention in the so-called *Cracolândias* (popular name given to areas in downtown where there is intense presence of crack users. The name derives from "crack" and "land", as a "crack land") raised the discussion on compulsory hospitalization, considering the notorious inadequacy – or even frequent lack of application – of *non-hospital resources.* We identified the police operation that took place on May 21, 2017 at the *cracolândia* in the Luz neighborhood in São Paulo, as the landmark of the intensification of forced hospitalizations. The event was widely disseminated in the media, generating a great discussion concerning the proposed compulsory hospitalizations, not only in academic means or supported by health professionals, but in the society as a whole.

that actions like these, whose justification is given by the *crack epidemic* syntagma, discursively disseminated – by advertisements – and supported by the media, manipulate the public opinion toward an immediate association of the crack use and drugs overall with violence.

> It is assumed that the media might be collaborating with the maintenance of "distorted" visions on the topic, when establishing a causal relationship between violence and crack use, being restricted, in most articles, to present "facts", and no further discussion about the causes and consequences of the phenomenon. (Roso et al., 2010, p. 7)

It is noteworthy that this way of addressing the question turns out to generate panic in the population, with the consequent promotion of increasingly segregationists, which is finally translated into the expressive approval of compulsory hospitalization for most part of the population.

The police operation in *cracolândia*, in São Paulo (Gonçalves, 2017), on one hand, violates the Law no. 10,216, of 2001, which states in Article 4 that "Hospitalization, of any kind, will only be recommended when non-hospital treatment resources may be insufficient" (Brasil, 2001, no page numbers). On the other hand, it shows us how the advertisement that those people are unable to respond for themselves – since it is the crack that speaks for them – focuses on the population,[5] who believes compulsory hospitalization is the only way out for those *possessed by crack*. It is as if the use of crack invalidated, at once, the subject, both in the psychoanalytical sense of the term (subject of the unconscious) when becoming the object of use, possessed by crack; and regarding the subject of the law who, unlike the others, must not walk on the streets.

However, "a systematic review of the effectiveness of compulsory treatments for drug use concluded there was no evidence of improvement in compulsory treatments," identifying, "on the other hand, studies that suggest the risk of increasing the harms" (United Nations Office on Drugs and Crime, 2017).

The mental health policy is based on inclusion, but what we heard in the city, when it comes to the use of drugs, especially crack, is the demand for segregation, and worse, often supported by the discourse of policies which, in its turn, are supported by religious/biological discourses. The vulnerability of these people is not being discussed, in addition to violence, disease, etc., but the way of public intervention to which they are the target. And, moreover, based on psychoanalytic reference, we point to the fact there is no possible treatment for drug addiction without considering, in addition to the subject of law, of the citizen, the subject of jouissance.

The harm reduction policy and psychoanalysis

Several authors (Conte, 2004; Melman, 2000; Queiroz, 2001) have studied the importance of HR policy for the advancement of psychoanalysis in the field of mental health in the first decade after 2003. According to Ribeiro (2010, no page numbers), "harm reduction implies a set of interventions that aim to prevent the negative consequences of drug use, without requiring abstinence," in such a way that many authors have estimated that such policy has contributed for a dialogue with psychoanalysis. That is because both the HR and psychoanalysis policies "fight the subjective dismissal involved in detoxification models" (Ribeiro, 2010, no page numbers). Each one, with their characteristics, are opposed to the exclusion of the subject alive and capable of making choices, proposed by the guidance that only aims at abstinence, and each acts against the forclusion of the subject that the biological discourse imposes.

However, there are some particularities. According to Araujo and Costa (2012), "public policies prioritize harm reduction and the user ends up being seen as sick or marginal," because "the Brazilian policy is focused on drugs and not on the subjects, highlighting the stigma to the drug user" (p. 1) whereas, for psychoanalysis, what needs to be highlighted is that the subject – the user –, makes the drug a way to experience "the malaise, the excess of contemporary culture, realizing that we must hear what the drug addict has to say without stigmatizing them" (Araujo & Costa, 2012, p. 1). Subjects are, for psychoanalysis, concerning what is most genuine in them, subjects capable of responding from their jouissance position. How to psychoanalytically treat subjects if what is most genuine for them should, a priori, be left out?

As for the criticism that Araujo and Costa do about HR, we must point out that although they are based on the guidelines of the Brazilian Ministry of Health (Brasil, 2003), also used by mental health, the focus of their analysis is on the National Policy on Drugs (from Portuguese, *Política Nacional Sobre Drogas* – PNAD) modified, from 2006, when HR was incorporated, then *relating it to prohibitionism*. Therefore, it seems to us that the text promotes certain confusion when calling PNAD a HR policy, because it is not. PNAD distorts, in the text of its law, the HR term originated in the health field, adapting it to its own principles, which, in fact, Araujo and Costa (2012) observe when they say "public policies for the harmful use of alcohol and other drugs refer to the issue of mandatory abstinence, harm reduction, and prohibitionism" (p. 16). The association of HR with prohibitionist policies creates a chasm, in fact, because it does not consider neither the subject of law, let alone that of the unconscious. But that is not what the law of the Brazilian Ministry of Health intended, therefore, it did not generate – according to the authors – the production of stereotypes or stigmas. On the contrary, the stigma is one of the most emphasized issues concerning drug

5 According to Datafolha survey, "60% of residents of São Paulo approve the action in *Cracolândia"* even if 80% are "in favor of mandatory hospitalization for the treatment of users" (Brandt, 2017).

users, being regarded as producer of aggravations. The original HR policy is not contrary to the psychoanalysis', but its association with prohibitionism is.

For Santiago (2001) – his reference is Lacanian, and not Foucaultian, with which Albuquerque (2010) works – drug addiction is a discourse effect. Here, the notion of discourse implies the production of jouissance, i.e., how individuals relate to one another in a given culture promoting the jouissance of each other, within the different positions that such promotion occurs from the agency that an individual imposes to the another. Psychoanalysis, in any way, disregards the culture and the discourses forged in it, nor the fact that the stigma produces segregation; it remembers the fact that between the subject and the Other there is *a* more, *a* more, *a* more. . .which is repeated in the act of using drugs. If for some psychoanalysts that means, in practice, that "this subject of whom psychoanalysis talks about is often eclipsed by the citizen of rights established by the political-social approach of psychic distress" (Ribeiro, 2010, n. p.), eclipsed, above all, within a practice that does not take into account the case-by-case basis, we cannot fail to consider the possible opening of the HR to the psychoanalytic clinic in politics.

Actually, there is a concern in the text of the Law of 2003 about the case-by-case basis, despite being a universal law, considering it is for everyone. Otherwise, let us observe. The Law is clear when it comes to characterize the use of drugs as *multifactorial* and *heterogeneous*, stressing the need to consider diversities, since it states: "when it comes to taking care of human lives, we must necessarily deal with the singularities, with the different possibilities and choices that are made" (Brasil, 2003, p. 10).

Claiming itself as *clinical-political* (Brasil, 2003, p. 11), the law recommends that "the harm reduction approach offers a promising path" precisely for recognizing "each user in their singularities," which allows us to trace "alongside them strategies that are directed not to abstinence as a goal to be achieved, but for the defense of their lives" (p. 10). On the other hand, the fact it recognizes the need to defend life, this text takes into account the existence of the death drive. The law points HR as a *method*, as a path, which does not exclude others, "linked to the direction of treatment and, here, to treat means increasing the degree of freedom, of co-responsibility for that who is being treated" (Brasil, 2003, p. 11). Still, it implies "in establishing ties with the professionals, who are also co-responsible for the paths to be followed by that user, for the many lives for which they are responsible and which are expressed by them" (p. 11). In politics, the singularity that is at stake is the history and the choices of each person, who will understand, in their own way, subjectivity as a result of "integration and interrelationship of several phenomena of biopsychosocial manifestation, in addition to being the location where these variables meet" (Brasil, 2003, p. 28).

There is, indeed, particularities concerning the analytic treatment – and maybe this is precisely its resistance force – which are not mistaken by HR. Psychoanalysis is subversive insofar as it decentralizes the I, focuses on the unconscious determination, recognizes the field of jouissance, and aims at a treatment directed by resuming the path of desire. But, in its turn, harm reduction is also subversive, since it questions, based on the psychiatric reform, the domination of the bodies by the moral/biological discourse. It also reverses the harm notion associated with drugs, insofar it assumes that not all use is harmful. HR is part of a public health strategy and it is in this context that it becomes strong, for it is related with the concept of amplified clinic, which also comprises in its specificity the possibility of resistance, as L. Elia resumes:

> We must focus the psychosocial care on its specificity, which is specified for not being based on any specialty: all professionals, all actors, all agents can and should intervene in the action and in the care, in the clinic action that is political at the same time, since it always aimed at the subject's position in relation to the concrete social body, to the social bond, to the city and to citizenship. (round table discussion, Rio de Janeiro, October 6, 2015)

Both psychoanalysis and the HR policy assume that we need to listen to the other, because we know nothing about them *a priori*. In practice, we see how difficult it is for professionals not to know what is best for the patient, the clinic with drug addictions generates a lot of anguish in the very own team, particularly when life is at risk. Hence, even if it is not necessary for mental health workers to be psychoanalysts – and probably it would not be recommended, since it is not a clinic of specialties, as stated by L. Elia (round table discussion, Rio de Janeiro, October 6, 2015), and for being a multidisciplinary clinic, which must comprise different technical-theoretical knowledge and contributions (Brasil, 2003, p. 7), and the psychoanalyst is one among the various actors who constitute the field of psychosocial care –, psychoanalysis has a lot to contribute to the HR, giving voice to the subject of law, because they must have such voice, as the psychiatric reform wanted. And in order for this not to eclipse the subject of the unconscious, psychoanalysts must not retreat in the face of impasses and they must participate in this clinic, since they are just a few.

Each subject finds in the use of drugs a very particular relationship with their jouissance and with the Other, and this is not universal, it does not work as the laws which – indeed – need to be universal... There is an impossible between universal policies and a clinic of the subject, i.e., one does not comprehend the other, even if the law can be more or less restrictive regarding the inclusion or exclusion of each subject, necessarily, submitted to it. Since, according to Freud (1937/2004), governing, to educate, and to psychoanalyze is impossible.

Lacan (1997) formulates the ethics of psychoanalysis itself as being that of desire. In practice, not to give in to point the subject whenever he is neglected, muted and even, sometimes, literally silenced. And there are plenty of discourses to silence him. It is not just the psychiatric treatment that, when using licit drugs, has no other intention but to prevent the phenomenological manifestation of subjective conflicts, clinical orientation based on the ideology of the remission of symptoms. These, according to Freud (1926/1977), are subjective manifestations and would be the last phenomena for us to wish, as psychoanalysts, to disappear, because symptoms are signs of the presence of the subject (Quinet, 2000, p. 144), signs of jouissance's cipher, of the way each subject can cipher it, with their singularities. And psychoanalysis works with it.

Health *versus* safety

Despite criticism that the HR policy may have faced by not considering the uniqueness of the jouissance position of the subject, for being a public policy – but paving the way for a clinic that included psychoanalysis –, the policy allowed a real questioning of the one-sided *treatment* that imposed abstinence for everyone and, consequently, in terms of treatment, hospitalization. It insisted on the need to decriminalize drug use to the extent that this generates stigma among users of illicit drugs. It paved the way, especially, for a clinic to assess, based on the uniqueness of each case, which way the subject uses drugs, how they enjoy it, how they use it; for some, abstinence might not be the best therapeutic solution. In addition to the field of mental health, it also implied a change in the field of safety, though not without provoking tension between both.

One of the basic precepts of safety practices is "to incessantly aim at reaching the ideal for constructing a society free of the use of illicit drugs and the harmful use of licit drugs" (Brasil, 2002, not page numbers). With the inclusion, in 2003, of health promotion practices aimed at HR, understanding treatment as singularized, and not considering abstinence as precondition and predicting the user responsibility for their treatment, we have two great actors: on one side, the Brazilian Ministry of Health, and on the other the Office of National Drug Policy (from Portuguese, *Secretaria Nacional de Políticas sobre Drogas* – Senad) (Andrade, 2011). Initially as the Institutional Security Office of the Presidency of the Republic, from 2011 Senad became part of the Brazilian Ministry of Justice (MJ) and, in 2006, it established the National System of Public Policies on Drugs (from Portuguese, *Sistema Nacional de Políticas Públicas sobre Drogas* – Sisnad), which does not decriminalize the use for which, according to Art. 28, providing for the "following penalties: I – warning about the effects of drugs; II – provision of services to the community; III – educational measure of attendance to the educational program or educational course." With the implementation of Sisnad, a new HR approach emerges, relating such to the hygienist model! (Alarcon et al., 2012, p. 78). This is because Sisnad considered the harms as a fact, directly connecting the use of illicit drugs to harms.

It was then that there was a transposition of the HR concept from the health field to the safety field and, subsequently, in 2011, to the justice's. When assimilated by the legal field, HR lost the strength to reduce the harms of prohibitionism itself that, according to our hypothesis, comes from ignorance of the death drive. Culture, according to psychoanalysis, is a way of organizing the relationships between speaking beings. One cannot simply make the other their drive object, that which they want, because there are rules. Culture, or rather, the discourses prevalent in a particular culture, dictate the way the other will be treated. If in the form of treating the other rivalry prevails, that is, if the other is treated as an object and not as a subject, then the different will be subjected to segregation. Prohibitionism raises a hate discourse, resulting from drive plainness that, against life drives, has concrete effects. Effects these widely displayed by mental health workers referred to HR, as its original proposal, and that we resume next.

Firstly, the deaths caused by the *War on drugs*. Fighting drugs introduces a series of consequences that are totally disregarded, associated with the term "war" itself. In a war, you are in a battlefield, you have to beat an enemy; the enemy, in its turn, get ready to defend themselves and fight back. Several casualties are justified by the aim sought, which is usually a consequence of massive devastation. In war, everything is permitted in the name of a breakthrough for the victory and the most vile human reactions; those which make the man the wolf to man are not only excused but, often, even encouraged. A war is never triggered without economic objectives, and these are swarming in the field of drugs, not only in the dispute between dealers for a greater trade range for their profits, but also numerous unconfessed financial interests supporting industries and governments – the aforementioned opium war is just one example of it, without the refinements that came after it.

Secondly, the high potential of the harm caused by substances mixed with drugs to the body, and which can be more harmful than drugs themselves. The War on drugs is reduced without taking into account that it is necessary to clarify the population that there are such substances that contribute in no way to the pleasure that the drug, itself, provides. We ignore the possibility that there are many users who might choose not to use drugs because of the addition of these substances, these, indeed, very detrimental. This was the motto of HR in the Netherlands − to control the product sold, to reduce the harm caused by the substances added to it.

Thirdly, the harms of prejudice and stigma. An issue developed by Freud (1921/2004) in the year following the writing of the text in which he conceptualized the

death drive, the segregation of a group by another, promotes in both a mirroring of the "Is" strengthened by the collision between groups – precisely for making One as a group – which, among themselves, do not identify differences, making the other – that which is not part of the group – the marginal, the segregable, the intractable. Whatever the user's connection with the drug, it does not matter in such segregation if the subject is very committed with the drug, or if they only use it once in a while. HR, to be more powerful, should be able to contradict all this, to contradict the very way to make every user of illicit drugs not only criminal, but necessarily someone who, if not, will be dependent on such.

But what we can perceive nowadays is that what could be a risk becomes necessary, making the drug *The Cause*[6], and if the danger is within the substance, the only thing to do is to eradicate it (Alarcon, 2012). We could say that this discourse takes the possible as necessary, excluding any contingency. It is also the fact that Law no. 11,343 (Brasil, 2006) softened "the wide logic of harm reduction as the opposite of prohibitionism" (Alarcon et al., 2012, p. 80), reapproaching the two fields, that of health and of justice, introducing, in 2010, the plan *Crack é possível vencer* [You can win Crack] and the discussion on the financing of therapeutic communities. According to L Elia: "By the bias of a supposed fight against the harmful use of drugs, the conservative forces of society" (round table discussion, Rio de Janeiro, October 6, 2015), transferring Senad to the Brazilian Ministry of Justice, started promoting judicializations, criminalizations, and gatherings in therapeutic communities with compulsory hospitalizations, earning "significant portion of the territory" (2015).

Crack! Harm reduction has stopped, or was it the death drive?

The consumption of psychoactive substances throughout the history of mankind "has always been under social regulation" (Alves, 2009, p. 2,310). More recently, however, with scientific isolation of psychoactive substances and its consequent potentiality, as well as the industrialization of the drug for both therapeutic and recreational uses, such consumption extrapolated the ability of that regulation, generating "a set of social and health issues associated with it" (Alves, 2009, p. 2,310), which culminated in a "regulatory State intervention" (p. 2,310).

As previously developed here, specifically on the "A brief history of the drug problem" topic, such State intervention – and here we refer to the history of drug policy in Brazil, although this has been constructed in accordance with the international regulatory policies of drug use – was eminently prohibitionist. Concerning the formulation of public policies on drugs in the country, as we have observed, the two main actors are: security and health. The paradigms on which each of them stands may include antagonisms, tensions, or even an approach. Considering this, Teixeira et. al (2017) are very accurate:

> In the sector of Justice and Public Safety, two paradigms, prohibitionism and anti-prohibitionism, are in dispute. In the field of health and social welfare, the internment, psychosocial, and harm reduction (HR) paradigms support the actions in mental health/alcohol and other drugs. (p. 1,456)

Prohibitionism, or the *War on drugs*, already widely discussed in the text, aimed at a world free of drugs, and therefore, a commitment to "the prevention of consumption and the repression of production and supply" (Teixeira et al., 2017, p. 1,456), opposed to the anti-prohibitionism whose main debate is the decriminalization and legalization of drugs, including the use of drugs "should not be considered a criminal offence; thus, the user should be provided with treatment and care and not incarceration in a prison environment" (p. 1,456).

According to the internment paradigm, which in the fields of health and social welfare is more prone to prohibitionism, the organic dimension at the detriment of others is highlighted, thus opposed to psychosocial care and harm reduction (Teixeira et al., 2017, p. 1456), which understand the use of drugs as *multifactorial* (Brasil, 2003). The internment approach as a model for inpatient treatment and its typical institution is the mental hospital, the disease is a justification for the isolation and the impossibility of the subjects for being responsible for themselves, let alone for their treatment. A proposal absolutely contrary to that of psychosocial care, which is based on the psychiatric reform, mainly on that proposed by Basaglia, aiming at local care and completeness, being such

> considered both in relation to the environment, and to the therapeutic act with the individual, in which its effects do not aimed at symptomatic suppression and the required abstinence, but to the reduction of risks and harms. This care model focuses on the respect to differences, on the defense of life, and on the right to freedom and dignity of the person. (Teixeira et al., 2017, p. 1,456)

Well, in terms of treatment provided for drug users, prohibitionism and the internment approach defend abstinence as a paradigm, and it is necessary to clarify that

> By abstinence paradigm we understand something different from abstinence as a possible clinical direction and often necessary. By abstinence paradigm we understand a network of institutions that defines a governance of drug policies and which

6 With the emphasis and the use of capital letter, we seek to stress *The Cause* here taken to be unique, full, total.

> is accomplished in a coercive way to the extent *it makes abstinence the only possible direction of treatment, subjecting the health field to the legal, psychiatric and religious power.* (Passos & Souza, 2011, p. 157, emphasis added)

Despite the alliance between these fields, Passos and Souza (2011) show that "the relationship between criminology and psychiatry was not harmonious and complementary" (p. 157), in such a way that "it is within this power game that drug users now finds themselves faced with the power of criminology, sometimes faced with the power of psychiatry; sometimes incarcerated in prison, sometimes hospitalized in a mental hospital" (p. 157). That is because drug use is in the prohibitionism policy connected with two explanatory models: "the moral/criminal model and the disease model" (Alves, 2009, p. 2,311). Whether as immoral or as sick, the fate of the consumer is the incarceration in total institutions: *Lunatic asylums, prisons and convents* (Goffman, 1974), or yet, we could currently, perhaps, consider a set of these institutions: therapeutic communities (TC).

According to Goffman (1974), the institutions have "'closing' tendencies" (p. 16), however, some are more closed than others. "Its 'closing' or total quality is symbolized by the barrier to the social relationship with the outside world and by bans to the exit, which are often included in the physical schema" (Goffman, 1974, p. 16). Therapeutic communities for drug users, as pointed out in several reports – for example: *Comitê de Prevenção à Tortura do Estado do Rio de Janeiro* [Committee for Torture Prevention in the State of Rio de Janeiro] (2013); *Conselho Federal de Psicologia* [Federal Council of Psychology] – CFP (2011); *Conselho Regional de Psicologia* [Regional Council of Psychology] – CRP-SP (2016) – feature characteristics of total institutions described by Goffman. First of all, because drug use is understood both as a moral issue and as a disease issue, in addition to the spiritual factor, considering abstinence as a paradigm and the isolation (hospitalization) as a treatment, which, for the patterns of the lunatic asylums, as well as of all total institutions, is exercised by a small group of supervision to "a large controlled group, which we can call the group of inpatients" (Goffman, 1974, p. 18).

We should note that under the current name "therapeutic communities" are no longer part of institutional reforms that were part of the history of the psychiatric reform. Different psychiatric reform proposals came from the social reflection of human nature and its cruelty (Amarante, 2007), since this had exposed its more aggressive face in both world wars. Thus, we can postulate that the post-war period was a propitious moment to admit the *culture of the death drive*, which in such were verified by the destruction caused. When admitting the death drive, we can think of new ways to cope with it. That is how "society directed its looks to mental hospitals and found the living conditions provided to psychiatric patients hospitalized there, which were no different from those of concentration camps. . . hence the first psychiatric reforms were born" (Amarante, 2007, p. 40).

Between the different guidelines for psychiatric reforms occurring at that time, the Maxwell Jones's best summarizes what we are pointing out: in his proposal, the therapeutic community concerned "a process of institutional reforms which aimed at fighting the hierarchy or verticality of social roles, or, anyway, a horizontality and 'democratization' process of relations, in the words of Maxwell Jones himself" (Amarante, 2007, p. 43). There is no identity between the Maxwell Jones's proposal and the current therapeutic communities for drug users, "despite the designation" (De Leon, 2014, p. 14). That original and innovative proposal no longer has

> a relationship with the current "farms" and "small ranches" for the treatment of alcohol and drug addiction, usually religious in nature, which name themselves – opportunistically and fraudulently – "therapeutic communities" to gain social and scientific legitimacy. (Amarante, 2007, p. 43)

Indeed, as Passos ans Souza (2011) remind us, both under the bias of criminology and that of psychiatry, the principle of the power of the treatment proposed by the current "therapeutic communities" is discipline – as Foucault (1987) theorized it – a "normalization of deviant conducts" (Passos & Souza, 2011, p. 157), in which they favor, "as intervention object, the criminal, the insane, the delinquent, the 'junkie'" (p. 157). Without excluding the disciplining of the bodies (Foucault, 1990), the "so-called Therapeutic Communities and Therapeutic Farms bring another element that does not exclude discipline, but complements it: the religious moral" (Passos & Souza, 2011, p. 157).

It is because we perceive that therapeutic communities are complicit with the criminal/moral model and the disease model, models which support prohibitionism, based on the abstinence paradigm, and in anything they can equate to the proposal of the psychosocial model and that of harm reduction, we can think that the increase in the financing of these communities is a rupture in the progressive direction of psychiatric and health reforms. Reforms which have led to a new form of treatment to human suffering, among them, the one of the harmful use of drugs.

On the *Infográficos – Estadão* website, we read:

> Federal Government and State do not share the same policy. While the first prioritizes home treatment, with monitoring at Psychosocial Care Centers (CAPS), the second bets on therapeutic justice, with hospitalizations – involuntary or not – in specialized hospitals and therapeutic communities for stopping the consumption for good. A mismatch that only harms

those who try to beat the addiction drama (Brandt, 2017).

Indeed, some authors have been observing the rise of hospitalizations of drug users, initially by local incentives, particularly in therapeutic communities that, as we know, have important associations with religious institutions. Currently, therapeutic communities, although often autonomous in regard to each other (De Leon, 2014), emerged from a common guideline, "an esoteric and alternative self-help approach towards a modality of human care" (p. 27), aiming to provide "moral and ethical limits and expectations of personal development" (p. 30) with the following methodology: the use of "positive reinforcement, shame, punishment, guilt, examples, and the behavior model" (p. 27).

Gradually, the Federal Government also comprises as a policy to hospitalize users, as it did before the Constituent Convention and, according to the current Minister of the Social and Agricultural Development, Osmar Terra, "The CAPS have no practical result. [. . .] the following day, they are using drugs again, because there [at the CAPS] they say: 'that's ok, just don't smoke in a can, use a glass pipe, use a disposable syringe'" (Mariz, 2017, no page numbers). Having ridiculed all the work of CAPSad, the current Minister advocates towards the criminalization of the user and small drug dealer, since, according to him, "there's got to be some kind of punishment, or [the user] will consume more" (Melo, 2016, no page numbers). Minister and physician, he is "the author of the law that provide for increasing the penalty for trafficking and compulsory hospitalization of users," and his first intervention, after appointment, directly affected the National Council for Drug Policy (from Portuguese, *Conselho Nacional de Políticas sobre Drogas* – Conad). "With the argument that the body would be dominated by an ideological thinking pro-legalization" (Melo, 2016, no page numbers), he replaced the representative in the folder of the Council, Rodrigo Delgado, and exonerated the sociologist from the post of General Coordinator in the National Secretariat of Social Welfare of the Brazilian Ministry of Social Development. Acting as if it was possible to eradicate, by decree, the death drive; therefore, reviewing the capabilities of "health, justice, social welfare professionals, community leaders and other actors involved in the drug issue" (Mariz, 2017, no page numbers), the Minister thinks the current [policies] "do not encourage treatment and abstinence, and just focus on harm reduction policy," and abstinence is not defended, thus, for Terra, "it is a wasted money" (Mariz, 2017, no page numbers). What make us astounded in such observation is that it was made by a doctor. . . Which witness a huge chasm settled in this field: on one hand, the militants of Hygienism – of which the Minister is obviously a partisan – on the other hand, the daily life of health workers, in particular of mental health, seeking to sustain the HR. For the former, the citizen is an object of biotechnologies, ignorant of themselves, to be subject to disciplines – in the Foucaultian sense of the term –, contrary to the subject of psychoanalysis. For the later, psychoanalysis can come to their scope, where, often, it lacks a theoretical support of a practice known to be part of the civilization and its discontents. But the burning question remains: if investing in CAPS is a waste of money, to where should the public funding go? To new therapeutic communities? To new lunatic asylums?

Aware of the concept of the death drive introduced by Freud and resumed by Lacan, mainly from the field of jouissance, psychoanalysis can help sustain an ethical positioning that allows working with the subject of jouissance that every citizen is. Even without being based on psychoanalytic concepts, the HR, the way it was practiced before its association with this new hygienist policy, supported life drives, since it provided as a treatment the resumption of bonds, enabling new investments considering what is possible for each person. Despite working with prevention, rehabilitation, etc., on the everyday clinic it was carried out in a case-by-case basis, considering what was possible in each case. Are we witnessing its opposite nowadays? A reality in which a Minister seeks to subdue a citizen, to make them correspond to what is expected in the discourses of domination, object of segregation? Would this not be, at least, as lethal as drugs are regarded? Or does he believe it is possible to end the death drive by decree?

Crack! A redução de danos parou, ou foi a pulsão de morte?

Resumo: O que a psicanálise tem a dizer sobre tantas questões que envolvem as drogas, que de longe ultrapassam a questão de seu uso? Questões, diríamos, históricas, clínicas e políticas. O objetivo desse texto é discutir vicissitudes que as perpassam. Não apenas nos acercarmos do "problema drogas", mas pensar como a presença da psicanálise pode fazer frente a determinados discursos que se presentificam nesse campo de atuação e que estão longe de pôr o sujeito em questão. Trabalhar com a psicanálise é levar em conta a pulsão de morte. É lançar mão de um saber que nos permite uma orientação de tratamento que leve em conta o que há de mortífero no uso de drogas nas toxicomanias, pondo em relevo a posição de gozo do sujeito. É, além disso, pôr em questão o que há de mortífero em determinados direcionamentos políticos que transformam o sujeito em objeto.

Palavras-chave: psicanálise, redução de danos, políticas públicas, toxicomania.

***Crack*! Veut-t-on arrêter la réduction des dommages ou la pulsion de mort?**

Résumé: Qu'est-ce que la psychanalyse a à dire au sujet de nombreuses questions concernant la drogue, qui dépassent de loin la question de son utilisation? Questions historiques, cliniques et politiques. Le but de cet article est de discuter des vicissitudes qui les traversent. Non seulement nous approcher du « problème drogues », mais comment penser que la présence de la psychanalyse peut faire face à certains discours qui se présentifient dans ce champ d'activité, et qui sont loin de poser le sujet en question. Travailler avec la psychanalyse est de tenir compte de la pulsion de mort. Est de prendre en compte un savoir qui nous oriente vers un traitement qui tient compte du versant meurtifère dans l'utilisation des drogues dans les toxicomanies, mettant en évidence la position de jouissance du sujet. Par ailleurs, c'est mettre en question ce qui est mortifère dans certaines directions politiques qui transforment le sujet en objet.

Mots clés: Psychanalyse; Réduction des dommages; Politiques publique; Toxicomanie.

***Crack*! La reducción de daños paró, o fue la pulsión de muerte?**

Resumen: ¿ Lo que el psicoanálisis tiene que decir sobre tantas cuestiones que involucran a las drogas, que de lejos sobrepasan la cuestión de su uso? Cuestiones históricas, clínicas y políticas. El objetivo de este texto es discutir las vicisitudes que las atravesan. No sólo nos acercar al "problema drogas", sino pensar cómo la presencia del psicoanálisis puede hacer frente a determinados discursos que pueden ser encuentrados en ese campo de actuación, y que están lejos de poner al sujeto en cuestión. Trabajar con el psicoanálisis es tener en cuenta la pulsión de muerte. Se trata de un saber que nos permite una orientación de tratamiento que tenga en cuenta lo que hay de mortífero en el uso de drogas en las toxicomanías, poniendo de relieve la posición de goce del sujeto. Es, además, poner en cuestión lo que hay de mortífero en determinados direccionamientos políticos que transforman al sujeto en objeto.

Palabras-clave: Psicoanálisis; Reducción de daños; Políticas públicas; Toxicomanía.

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