CHAPTER 97

Harm reduction: buildind paths to caring

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ABSTRACT
T The expression harm reduction (harm reduction) has undergone a profound conceptual expansion and its historical construction justifies this fact since it is marked by a shift from the proposal of the control of infectious diseases to a set of policies and practices that, integrated with the actions of prevention, treatment, and social reintegration, aim to reduce individual and social damage related to the use of psychoactive substances (FONSÊNCA, 2012; TOTUGUI, 2009). Therefore, the purpose of this topic is to explore the emergence of Harm Reduction and its conceptual advances. It should be noted that the motivation for drawing this story is not to show the chronological course but to present the construction of meaning for the existence of harm reduction and the consolidation of a new paradigm of care within the scope of drugs.

1 INTRODUCTION

The expression harm reduction (*harm reduction*) has undergone a profound conceptual expansion and its historical construction justifies this fact since it is marked by a shift from the proposal of the control of infectious diseases to a set of policies and practices that, integrated with the actions of prevention, treatment, and social reintegration, aim to reduce individual and social damage related to the use of psychoactive substances (FONSÊNCA, 2012; TOTUGUI, 2009). Therefore, the purpose of this topic is to explore the emergence of Harm Reduction and its conceptual advances. It should be noted that the motivation for drawing this story is not to show the chronological course but to present the construction of meaning for the existence of harm reduction and the consolidation of a new paradigm of care within the scope of drugs.

The vast majority of authors date the emergence of harm reduction in 1926, in England, with the publication of the Rolleston Report. This report was prepared by a group of physicians who claimed that the most appropriate way to treat heroin and morphine addicts was to administer and monitor substance use (FONSÊCA, 2012; WODAK, 1998; MESQUITA, 1994). The Report defended the right of physicians to prescribe controlled supplies of opiates to drug users in situations of withdrawal syndrome, when drug

use, after evidence, could not be discontinued due to harm to the user, and in cases where it was proven that the drug patient would depend on the use of the drug to lead a normal and productive life, becoming ineffective if this use was interrupted (FONSÊCA, 2012; DOMANICO, 2006).

The Rolleston Report was a landmark because it argued that addicts could not be treated by abruptly imposing abstinence on them. It was recommended to monitor users who wished to abstain from the use of the substance in order to alleviate the symptoms of withdrawal or to help in the administration of drugs to those who wanted to continue using them, as described by Domanico (2006). In turn, Fonseca (2012) presents another reason to consider the Rolleston Report a landmark: for the first time in history, drug addiction is seen from another perspective, a complex problem that demands multiple and unique strategies. The initiative proposed by the Rolleston Report was the target of expressive attacks, even being disapproved for partisan political reasons.

The new health perspective gained expression with the exchange of used syringes for new ones carried out in the Netherlands, more precisely in the city of Amsterdam. In fact, the Netherlands has always stood out on the world stage for espousing a liberal policy. In 1972, the Dutch government, concerned about the growth of problems related to drug use, made significant changes in drug policy. The distinction established by law in 1976 between drugs of acceptable use (marijuana, hashish) and drugs of unacceptable use (LSD, cocaine, amphetamine and heroin) sought to involve people in the responsible use of psychoactive substances, signaling for the differentiated treatment of according to the risk potential of each one of them (DOMANICO, 2006).

In this context of protagonism of drug users, in 1980, the Association of Injectable Drug Users - *Junkiebond* (RIBEIRO, 2013) was created . The Dutch association, in response to concerns about the spread of hepatitis B, promoted in partnership with the government the first used syringe exchange program in 1984. The objective of the needle exchange project was to protect users from harm and provide better living conditions through safe use (DOMANICO, 2006). When it became certain that HIV was transmitted through blood, the need for effective preventive actions became even more evident, and the project that was born to fight hepatitis B was extended as a goal that also covered the fight against AIDS (FONSÊCA, 2012).).

The success of the project had repercussions throughout the European continent. In England, for example, harm reduction strategies gained support. In 1985, users were already able to offer several services, including needle exchange, education and counseling, drug substitution prescription, treatment for addiction and detoxification, employment and housing (FONSÊCA, 2012). Several public health managers and non-governmental organizations have come to understand the importance of epidemic prevention and the need for systematic and effective actions. With the development and success of such initiatives, the concept of harm reduction was revised, expanded and incorporated by many countries, such as Switzerland, Canada, Australia, Germany and even Brazil, which undertook similar programs (RIBEIRO, 2013).).

Domanico (2006) says that the policy of repression instituted by the United States against coca-producing countries gave rise to alternative routes for the cocaine trade, including Brazil, towards large consumer markets, notably the United States and Europe. As a result, there was an increase in the circulation of drugs in Brazil and the cities that were part of the trafficking route witnessed a significant increase in the number of AIDS cases. In the 1970s, drugs such as cocaine became a public health problem due to increasing abuse and dependence.

Santos, a city in the State of São Paulo, gained a prominent position in this context. Due to its strategic location, it has become one of the main ports for the flow of drugs to consumer markets. This fact caused negative impacts on the public health of the municipality, so much so that in 1988 the city was the record holder for AIDS cases in Brazil, being called the "capital of AIDS" (MESQUITA, 1994). This scenario may also have contributed for the city to stand out in the literature for its pioneering spirit in terms of strategies and implementation of an alcohol and other drug policy in the period from 1989 to 1994, according to Souza (2007).

In an attempt to contain the growing epidemic, under the coordination of Fábio Mesquita, the city of Santos in 1989 announced the first harm reduction program, with the strategy of needle exchange. The main idea, puts Domanico (2006, p. 72), was "since drug users could not give up drug use, that at least they would not get infected by sharing syringes in injecting drug use". The initiative generated great national controversy, being considered a crime and a stimulant for the use of illicit drugs by the Public Ministry, which embargoed the project and seized the materials (FONSÊNCA, 2012; MESQUITA, 1994).

> The measure generated immense national controversy in all the media and specific forums, after the Public Ministry in Santos classified it as a crime, provided for in the current drug law in Brazil, Law 6,368 of 1976. According to the interpretation of that moment , the proposal clashed with one of the articles of the aforementioned law, which considers any form of assistance/incentive to those who use narcotic substances a crime (MESQUITA, 1994, p. 169).

A series of debates and public meetings aimed at clarifying and sensitizing public opinion about the importance of carrying out harm reduction actions were initiated. In the 1990s, harm reduction gradually established itself as a government policy, linked to the National Program on Sexually Transmitted Diseases and AIDS of the Ministry of Health (PNDST/AIDS-MS) (RIBEIRO, 2013).

In 1991, in Santos, an NGO was created made up of health professionals, many linked to the first initiative, with the objective of developing research on people with AIDS and injecting drug users. These researches provided successive approximations of the users' experiences and knowledge of the rituals of use. As they were prevented from distributing syringes, the technicians sought, based on the findings, to develop alternatives from the perspective of harm reduction, such as the use of sodium hypochlorite to disinfect reused needles and syringes, since when they were used in groups, users they used to wash the syringe to remove traces of blood (DOMANICO, 2006; FONSECA, 2012). It is important to emphasize

that the distribution of inputs was always accompanied by counseling and re-education (DOMANICO, 2006).

The Instituto de Estudos e Pesquisas em AIDS de Santos (IPEAS) became the first Brazilian NGO to adopt the harm reduction method, using the syringe exchange device as a legal method, in 1995. IPEAS professionals became important articulators of the strategies through the sensitization of health managers to the need to use the device, since injecting drug users played an important role in the increase of HIV contamination. In response, health managers in Santos and the State of São Paulo began implementing the strategies (BUENO, 1998 apud SOUZA, 2007).

On December 1, 1995, World AIDS Day, in partnership with five cities in the state, the São Paulo Health Secretary developed the syringe exchange program. The actions included the distribution of prevention kits, which contained two syringes, disposable needles, a container with distilled water, skin disinfectant, 5.25% sodium hypochlorite, a cup and a mixer (SOUZA, 2007). This kit was developed by the harm reduction project that took place in Salvador, also in 1995.

The first systematic harm reduction program developed in the city of Salvador was linked to a study center at the Faculty of Medicine of the Federal University of Bahia. Domanico (2006) observes that the connection with medical studies may have been a favorable factor for the acceptance of the initiative by the community. On the other hand, several criticisms that attributed harm reduction as an incentive to drug use were raised.

The broad mobilization for the implementation of the syringe distribution program did not prevent the actions in Santos from being again embargoed by the legal power. Despite this, IPEAS employees continued to invest in syringe distribution. Police arrests and lawsuits against health workers became frequent. Such challenges, however, have not weakened the movement. According to Souza (2007, p. 71), “after the continuous lawsuits and police persecution, professionals involved with harm reduction invested in a silent intervention method, which, little by little, acquired a voice and visibility”. It is worth mentioning that the clashes about harm reduction echo to this day, generating important reflections that produce advances in the construction of the Policy.

As observed, epidemiological studies on the prevalence of HIV, its rampant growth among injecting drug users, the need to think of health strategies that reach these users, reducing the damage resulting from use and respect for the user, have contributed to the harm reduction to occupy a place in the discussion spaces on the national scene. In addition, its association between AIDS rates and injecting drugs led to the development of actions that articulated these two themes. Harm reduction gained space in intervention programs that were built around the theme “drugs”. Highlighting this crossing is important as the paradigm shift present in the construction of harm reduction begins, defining it as a care strategy for the user of drugs.

Acting through syringe exchange programs allowed health professionals to approach marginalized minorities. From this constant and participatory contact, harm reducers emerged, health agents who work

in the existential territories of drug users, according to Souza's definition (2007). Within this process, it is worth mentioning the creation of the National Association of Harm Reductionists (ABORDA), in 1997, with the objective of fighting for the rights of harm reduction workers and drug users (DOMANICO, 2006; SOUZA, 2007) . It is important to emphasize that the association was composed of users and ex-users of drugs.

AORDA strengthened the struggle through the training of harm reduction agents and the political organization of users and agents, giving rise to several NGOs that started to articulate harm reduction programs in the country. Souza (2007) emphasizes that harm reduction provided drug users and minority groups with a leading role in public policy decisions, which until then was restricted to the State. More than a care strategy, harm reduction announces its mobilizing effect.

The year 1998 was representative for the development of strategies in Brazil. The country hosted the IX International Conference on Harm Reduction, in the state of São Paulo. At the event, the government made public State Law n. 9,758/97 that authorized the performance of needle exchange actions (RIBEIRO, 2013).

> The advent of the São Paulo law was the starting point of a new stage in the history of harm reduction in Brazil, since harm reduction strategies were, from then on, legitimized and assumed as public policy. The repercussion of this measure is immediately felt, with the multiplication of new state and municipal laws, authorizing and regulating harm reduction strategies (RIBEIRO, 2013, p.54)

To end the gains from harm reduction in 1998, REDUC - Brazilian Network for Reduction of Damages, a national organization, was founded, generating the multiplication of harm reduction programs (RIBEIRO, 2013).

The first programs were initially implemented in the states of Rio Grande do Sul, Santa Catarina, Paraná, Rio de Janeiro, Mato Grosso, Mato Grasso do Sul, Ceará, Bahia and the Federal District. Fonseca (2012), when surveying the number of harm reduction projects in Brazil, states that in the year 2000 there were about

100 active projects. In 2003 this number rose to over 150. In 2005 many institutions were closed for lack of funding.

> Although associations are in the process of consolidating a political platform, their political sustainability is often compromised by financial sustainability. The main lines of financing for harm reduction came from the National Policy – STD/AIDS, through loans from the World Bank. In 2005, many associations had their actions partially suspended due to lack of funding (SOUZA, 2007, p. 76).

The scarcity of funding, however, was preceded by a milestone for harm reduction: in 2003, the Ministry of Health incorporated harm reduction into the Unified Health System (SUS), considering it as one of its strategies to prevent drug abuse. and drug abuse with actions that transversalized the services of the assistance network, especially basic services, such as the Family Health Strategy (ESF),

and specific ones, such as the Psychosocial Care Center for Alcohol and Drugs (CAPS-AD). Harm reduction distanced itself from its epidemiological character, that is, AIDS ceased to be its focus and crack and other drugs took its place once and for all. Thus, it was included in the responsibility of mental health care (FONSÊCA, 2012).

On July 1, 2005, Ordinance No. 1028 was launched, which determines that actions aimed at reducing social and health damages resulting from the use of products, substances or drugs that cause dependence, be carried out through health actions , aimed at users and dependents who cannot, cannot or do not want to stop using, with the objective of reducing risks without necessarily interfering with the offer . the art. 3 of the ordinance defines that harm reduction actions include comprehensive health care measures, based on (I) information, education and counseling; (II) social and health assistance; and (III) availability of supplies for health protection and prevention of HIV/AIDS and Hepatitis. The development of these actions, according to art.4, aims to encourage the adoption of safer behaviors in the consumption of psychoactive substances.

Legislative and social changes made it possible to develop other forms of intervention added to the initial strategies for distributing new syringes, which could extend care to users of drugs other than injectables. According to Ribeiro (2013), actions aimed at users of inhaled cocaine, with the offer of specific kits for the form of use; advances in research on the therapeutic effect of *cannabis* and possible replacement therapies (cocaine/ *cannabis,* crack */cannabis);* harm reduction related to the use of crack, such as offering pipes for personal use, filters and replacement therapies; harm reduction for the use of synthetic drugs, such as *ecstasy*, through counseling on ways of safe use to nightclub patrons, who are a consumer public; in addition to appropriate strategies for licit drugs, such as tobacco and alcoholic.

The design of the historical process of harm reduction carried out through clippings found in the literature shows the conceptual expansion suffered over the years. This expresses maturity as a care proposal. But, given what has been discussed, what is harm reduction? If the concept remains incomplete, it is not a flawed narrative or discourse without theoretical foundation, much less speculation. Harm reduction is an open concept that can be linked to any risky behavior in everyday life. Therefore, establishing ready and finished contours is the same as closing, limiting the existence of a construct that is supported by the dynamic complexity and subjectivity of social demands.

The International Harm Reduction Association (2010, p.1) conceives it as follows: “harm reduction refers to policies, programs and practices that primarily aim to reduce the adverse health, social and economic consequences of the use of licit drugs and illicit products, without necessarily reducing their consumption”. In the same way, the Ministry of Health defines harm reduction as “a set of public health measures aimed at minimizing the adverse consequences of drug use, whose fundamental principle is respect for freedom” (BRASIL, 2001, p. 11).

One of the pioneers in the implementation of harm reduction strategies, the researcher Wodak (1998, p. 55), in his reference concept, approaches the proposal as “an attempt to minimize the adverse

consequences of drug consumption from the health point of view". and its social and economic aspects without necessarily reducing this consumption". For Cruz (2006), harm reduction is a strategy to address issues related to drug use that formulates practices that reduce harm to those who use drugs and the social groups with which they live.

For Totugui (2009), the fundamental axis on which harm reduction is based is based on the right of access to services guaranteed by law, in accordance with the provisions of the Federal Constitution, which ensures in its article 196:

> Health is everyone's right and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other diseases and at universal and equal access to actions and services for their promotion, protection and recovery (CONSTITUTION OF THE REPUBLIC FEDERATIVA DO BRASIL, 1988, SECTION II, Art. 196).

As presented, harm reduction is a set of strategies that aims to offer health care alternatives that can be adopted without abandoning the practice of drug use. These definitions take the attention away from the psychoactive substance, characteristic of models that demand abstinence and the fight against drugs, to promote care for the subject. For harm reduction, while abstinence is not the user's response, measures that aim at their health need to be adopted, through the access and bond of the drug user to services that promote the reduction of vulnerability and favor social reintegration. It is added that harm reduction is not an invention of the time. It is the product of questions raised about the assistance provided to drug users. Overshadowing the drug, harm reduction contemplates the existence of the subject, and implies respect for their rights and the rescue of their humanity. By transcending technique, harm reduction is consolidated as a way of working based on welcoming, dialogue and co- responsibility (FONSÊCA, 2012).

2 PRINCIPLES AND GUIDELINES FOR ACTION FROM THE PERSPECTIVE OF REDUCING DAMAGE.

Japiassú and Marcondes (2006) define "principle" as the foundation that allows the structuring of knowledge. These "first causes" justify the existence of the known object in order to give it consistency and are evident to the point that their validity cannot be doubted. For Mello (2003), principle is defined as the core commandment of a system, its true foundation, a fundamental disposition that radiates over different standards, composing O spirit and serving in criterion for your exact understanding. These considerations are relevant when the principles and guidelines that support the work in harm reduction are objects of discussion.

As observed in the historical construction, the guiding principle of harm reduction for the approach to the drug user is respect for human dignity. And it is from there that his "principled framework", as stated by Ribeiro (2013, p. 58), unfolds. The act of giving voice to the subject of rights, giving him the power to claim and implement strategies to improve the quality of life, shows the implication of harm

reduction in the rescue of the user's social participation. Ribeiro (2013) also states that the protagonism of people who use drugs and respect in the attention given to them was already part of the founding principles of harm reduction. This was presented in the first phase, where the users themselves, members of the Dutch *junkiebond association,* made up the body of militants for the implementation of the strategy.

What unfolds from the founding principle? There is no unanimity regarding the principles that underlie harm reduction. However, there are proposals from authors that articulate and complement elements to support this practice. The expositions of Fonseca (2012) are guidelines for the construction of this topic, as they present in a synthesized, but no less grounded way, ideas that make up the construction of harm reduction politically and ideologically. The author presents five principles that, through approximation and condensation processes, are addressed here in three. Other authors are used to complement the propositions of the author.

The first principle is: harm reduction is not opposed to abstinence (FÔNSECA, 2012; MARLATT, 1999). On the contrary, it admits abstinence as the ideal path, the appropriate one when it comes to drug use, but considering the uniqueness of each subject, their limitations and the complexity involved in drug use, it recognizes that this path is not for everyone. From this perspective, alternatives that minimize harm are welcomed and implemented as long as abstinence is not the user's choice. Fonseca (2012) says that the main characteristic of this principle is the respect for the user's freedom of choice for drug consumption, which must be preserved as long as it does not exceed the freedom of the other. This principle is in accordance with the provisions of the Democratic State of Law, which recognizes the freedom of human action based on their personal convictions, as long as it does not affect the rights of others. Recognition of human dignity prevents The transformation forced of individual, O what no excludes possibilities of carrying out pedagogical work aimed at modifying risk behaviors in safe practices (CARVALHO et al., 2006). For harm reduction, small steps of care are significant to guarantee the subject's quality of life. “The gradual reduction approach encourages the individual who has excessive or high-risk behavior to take one step at a time to reduce the harmful consequences of their behavior” (FONSÊCA, 2012, p. 20).

The second principle concerns the basis that harm reduction finds in empathic pragmatism, thus opposing moralistic idealism (FONSÊCA, 2012; TRAD, 2010). Empathic pragmatism shifts the focus away from substance and use and focuses on producing and rescuing the subject. The issue is not right or wrong, good or bad, unhealthy or healthy, or any other moralistic parameter. The issue is the management of daily demands from a welcoming and attentive listening to the subject. Referring to empathic Experimentalism, Fonseca (2012, p. 22) adds:

> Harm Reduction, with its focus on contact, is a more logical strategy to be followed, as it seeks to: implement broad measures to prevent and treat harmful drug use, being together with the population, not pursuing the drug consumer, but rather, seeking forms of regulation that are socially and culturally accepted by different social segments. In practice, it aims to get closer to drug users, so that, in the near future, it is possible to create a bond of trust, an opening. Established, the link works as a solid basis to insert the discussion about the possibilities of reducing harm to the user's health, among them: the discussion of harmful use, the inclusion of

these users in the programs of the public health network and even , if the user wishes, to provide treatment for the harmful use of drugs, etc.

The last principle refers to the promotion of low demand and prompt reception to the user of psychoactive substances as an alternative to traditional approaches of high demand (FONSÊCA, 2012; TRAD, 2010; MARLATT, 1999). Traditional models not only impose the premise of abstinence, but also the maintenance of this goal for the provision of continued care. As a result, many users who fail to meet the requirements drop out of treatment and assume living conditions that accentuate their vulnerability. The principle in question points to flexibility in approaching drug users and the need to implement care services that welcome them in a more tolerant way. This implies the establishment of a bond, easy access to guidelines and encouraging the search for assistance services (ALMEIDA, 2003). This principle also addresses the challenging harm reduction proposal of finding the user where he is. Therefore, these devices must have professionals with a comprehensive and inclusive posture, inserted in the territorial reality of the user.

Marlatt (1999) adds a fourth principle, which considers harm reduction to be a "bottom-up" approach, based on addiction advocacy, rather than a "top-down" policy promoted by drug policymakers. Andrade (2002 apud CRUZ, 2006) highlights pragmatism, tolerance and respect for diversity as principles of harm reduction. The pragmatic proposal refers to the public health practice whose objective is to preserve people's lives. The author describes the principle of tolerance as the characteristic of this practice in respecting drug users in their individual choices. Respect for diversity refers to the biological, psychological and sociocultural particularities of each user that affect the interaction with the substance.

These ethical principles find support in our legal system, starting with the Federal Constitution of 1988, which guarantees fundamental rights and guarantees, highlighting citizenship and the dignity of the human person (art. 1, II, III), as mentioned by Ribeiro (2013). Here, fundamental rights meet the principles that support harm reduction. Such considerations raise questions about care models that maximize substance and stifle human subjectivity. In view of this, harm reduction poses the challenge of thinking care strategies that fight social exclusion and seek to rescue human existence, "the objective of harm reduction actions must be social inclusion and the breaking of the marginalization of users of drugs" (FONSÊCA, 2012, p. 23).

MacRae and Gorgulho (2003), exposing the position of the Brazilian Association for Harm Reduction (REDUC), bring up the need to understand harm reduction less as a set of practices and norms in the care of drug addicts and more as a posture in relation to the numerous problems related to the way to approach the issue of drugs. Therefore, when discussing guidelines for action in the harm reduction paradigm, the proposal is not to define techniques that lead to a practice, but to refer to a way of working based on an ethical professional-user relationship (ALMEIDA, 2003).

The performance in the perspective of harm reduction considers that the demand is not established *a priori* , but from listening to the user in his singularity. As Fonseca clarifies (2012, p. 19), abstinence is

"recognized as an ideal result, but alternatives that reduce harm are accepted; alternatives that are not defined a priori but in human events". Dias (2008) suggests that services guided by the logic of harm reduction accept various contracts, such as drug replacement therapies, controlled substance use, among others. Ensuring safe use or with reduced risks, whenever possible, should guide a practice in harm reduction, however, such actions must be established taking into account the issues present in the user's speech and in the way in which the demands present themselves in this speech. "Recovering the word, history, marks and memories of the drug addict, recognizing their existence and listening to their complaints, needs and demands" (FONSÊCA, 2012, p. 24) is a challenge for harm reduction actions, and this is only possible when care for the subject is centralized, which is different from fitting the person to work.

Another guideline for action is the recognition of the need and possibility of building the action plan in common agreement with the user. Harm reduction programs support a clear proposal of self-care in relation to drug use, investing in a sense of responsibility for oneself. Thus, the objective is to rescue the subject's autonomy and protagonism in the decision-making process and encourage him to take action. Harm reduction is shown as a treatment plan that is built in agreement with the user, expanding the subject's possibilities of adhering, getting involved and initiating behavior change, as Fonseca (2012) adds.

3 OPPOSITIONS TO THE REDUCTION POLICY DAMAGE.

There are two commonly adopted positions on the issue of drugs: the so-called "war on drugs", which includes the criminal, moralistic and disease model, and harm reduction. The criminal model is expressed in drug control policies that see use and/or distribution as crimes that deserve punishment. The moral model conceives of use as morally incorrect. These two models together collaborate to formulate policies that aim to promote a drug-free society. The main strategy of both the criminal and moralist models is to "reduce supply", that is, to reduce the availability of products. In turn, the disease model limits drug addiction to biological dysfunction, which needs to be eradicated through treatment programs that aim to remedy craving. In this model, the logic of "demand reduction" operates, with abstinence as its main objective. The alternative to these paradigms is harm reduction, operating by the logic of minimizing individual and social risks related to to consumption in drugs, be they lawful or illicit (FONSÉCA, 2012). The ideologies, benefits and risks associated with the different models have promoted a complex debate regarding assistance policies for users of alcohol and other drugs (ALVES, 2009).

Prohibitionist movements, resulting from the intensification of the trade in psychoactive substances, led to the elaboration of public policies (RIBEIRO, 2013). In the mid-nineteenth century, with an emphasis on moral ideology, the movement to demand a prohibitionist policy came to the fore, as it was considered the best strategy to remedy the social, psychological and biological risks related to drug consumption. In the United States, this policy gained a foundation with the founding of the Prohibitionist Party, in 1869. The alcohol industry grew wildly, culminating in the prohibition of commercialization with

the enactment of Prohibition, in 1920. The repeal of Prohibition, in 1933 was a testament to its failure, but it did not abolish its logic (RODRIGUES, 2014).

Gradually, other drugs such as morphine and heroin, cocaine, marijuana and any substance that could lead to abusive use were targets of commercial repression (ALVES, 2009). The author emphasizes that the entry of the United Nations (UN), in 1945, into the discussions strengthened the cause. In 1946, the UN founded the Commission on Narcotics (CDN) with the aim of formulating policies to repress and control the use and production of psychoactive substances. In 1998, he convened the United Nations General Assembly (UNGASS) to discuss world drug policy. As a goal, UNGASS established a drug-free world for the year 2008, with the campaign entitled "A Drug-Free World: We Can Do It" (ALVES, 2009, p. 2311).

> The prohibitionist-punitive model is based on two principles: one of a moral nature, which preaches abstinence as the only relational response of the user to these substances, and another of a hygienist order, which advocates the ideal of a drug-free world (RIBEIRO, 2013, p. 26).

Based on moral criteria and the defense of public health, the "war" was launched. Rodrigues (2014) says that it was not a crusade against inanimate substances – drugs – but against the people who produced and consumed them.

The social cleansing undertaken has its implications for imposed treatments. The condition for the assistance to the user of psychoactive substances of the prohibitionist paradigm, in turn, is characterized as "high demand". Abstinence is a requirement for the beginning, maintenance and end of treatment, with no middle ground, as Alves (2009, p. 231) says, "the health care model for users of alcohol and other drugs built on the basis of prohibitionist rationality , is characterized, therefore, by the authoritarianism of the proposed interventions". It is in this sense that Fonseca (2012) will present harm reduction as an alternative to "all or nothing".

The main criticism of the prohibitionist model is constituted around the limitations of access to prevention and treatment services for people who make harmful use of psychoactive substances, as well as intolerance to relapse or recurrence of use (ALVES, 2009). This posture casts users into two discourses. The first, and most common, is the discourse of the "defeated" user, who seeks help in a subservient way, adhering to any and all imposed strategies. The second discourse is the so-called "victorious" or "heroic", authorized to people who have overcome the use of drugs. These discourses determine the structure of services provided to drug users, as observed by Petuco (nd).

Harm reduction strategies have been criticized as opposing the abstinence model. As already discussed, this criticism is not supported, since harm reduction works to find the best way for the user and the community, with abstinence being desirable, but not imposed. In this way, the proposal of harm reduction is not to create an alternative and more comfortable discourse for the user, but to allow his/her speech as a subject of rights to be rescued and echo.

Reale (1997), one of the pioneers in the study of the intersection between drugs and harm reduction in the area of public health, created a comparative framework between the prohibitionist model and harm reduction strategies.

Table 1- Comparison between harm reduction and prohibitionist strategies. Source: REALE, 1997, The road to harm reduction associated with drug use: from stigma to solidarity.

Models	Prohibitionist	harm reduction
problem focused	Drug use itself	Drug damage/use
drug policy	war on drugs	tolerant / pragmatic
Priority	Repression of illicit drug use and trafficking	Reduction of harm to individual and collective health
State role/position	Abusive citizen control	- Provides services to the user drugs - Supports user organizations drugs - Preach the rights of drug users
drug prevention	drug free society	Harm/risk associated with abuse
Health care system Services	Individual medical care High demand Goal: abstinence	Various types of services Low demand and Active search
AIDS prevention among Uds / IDUs	Hampered by legal restrictions	Articulated as a public health priority

Resistance to harm reduction as a strategy to assist drug users is an important aspect of the debate regarding the option for its use. For Totugui (2009, p. 57), positions against harm reduction may be related to a misunderstanding of its concept, premises and applicability. Cruz (2006) presents some motivations for opposing harm reduction strategies:

i. Understanding that their strategies are contradictory, in addition to dispensing with preventive actions, not directing actions to reduce offers or demands;

Cruz (2006), in his work, emphasizes that harm reduction is not contradictory to the use of actions to reduce the supply and consumption of drugs, and citing Stimson and Fitch (2003), the author claims that the difference it is in the handling of the issues, since harm reduction is not intended to solve the problem through general prohibition. This fact is exemplified by campaigns aimed at the use of alcoholic beverages, which propose the dissociation of the act of drinking from the act of driving, without broadly prohibiting the use of alcohol, affirming the preventive nature of harm reduction, as well as the restriction measures. of places for sale and consumption, which implies a reduction in supply and demand.

ii. The understanding that their strategies serve the interests of producers and sellers of drugs;

Mentioning Karam (2003), Cruz (2006) states that attempts to resolve the issues of abusive substance use through repressive actions result in products becoming more expensive, transforming them into a million-dollar business. He adds that this would be a factor that interests producers and agents of the traffic.

iii. The understanding that their strategies are producers of inertia in relation to the frameworks of dependency;

On this idea, Cruz (2006) brings the disagreement that is shown in the work of harm reduction professionals in the face of these situations. The empathic posture of the harm reducer, instead of generating indifference, enables the creation of a bond, often followed by requests for help and referral for assistance.

iv. Understanding that your strategies are permissive;

For Cruz (2006), the idea that harm reduction acts from a permissive practice is not based on facts, since the reality of the implemented institutions and programs involves team discussion and clarification to patients of limits and institution criteria. The author uses as an example the prohibition of drug possession in the institution, which can lead to suspension of activity, but not exclusion in the care process.

v. The understanding that their strategies are messengers of discredit regarding the idea that it is possible to interrupt the use (in the individual scope) or that problems related to the use can be minimized (in the Social).

The author rejects this idea, stating that harm reduction is based on the understanding of the possibility of changing the behavioral pattern of risk in drug consumption, which is configured as interruption of use for many. However, these goals should not be imposed, but built together with the user. On the other hand, many who defend the harm reduction policy have a discourse as radical as those who advocate prohibitionist strategies, idealizing that all people can make moderate use of the drug. Reality shows that many users need to discontinue use to stop the risks and adhere to a form of treatment (CRUZ, 2006). Sensitivity in managing the situation based on listening and observing the user's demand is a challenge for the professional's performance.

4 CONSIDERATIONS FINALS

It is hoped that the reflections presented below will contribute to this practice gaining consistency in the different care services for drug users in which psychology professionals are inserted.

It was found that discussions need to advance in services to promote professional practice in harm reduction. It is not just about presenting the concept for professionals to process, since knowing harm reduction as a proposal is not enough to guarantee action. The paradigmatic proposal of harm reduction translates changes in attitudes and attitudes of professionals in relation to the issue of drugs and, consequently, to the user. For this to happen, along with the presentation of the harm reduction model, it is necessary that culturally rooted concepts about drugs, the subject who consumes them and ways of care undergo a re-signification, which demands more investment in professional training. It is also necessary that the services accept and implement the policy, not only with fragmented actions and harm reduction techniques, but as an expansion to the models of care for drug users.

An isolation of harm reduction in the health field was observed, more precisely in mental health and STD/AIDS services, which is understandable from the analysis of its historical construction. Thus,

expanding in the field of health and having a presence in other sectors is a challenge that is posed for harm reduction.

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