HARM REDUCTION, WEAVING THE THREADS OF THE SKEIN: DRUGS, LEGISLATION AND PUBLIC POLICIES

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ABSTRACT

The consumption of psychoactive substances throughout human history has involved multiple meanings, from therapeutic and ritual uses to social and economic control. In Brazil, drug consumption and legislation have evolved over the centuries, reflecting external influences and social, economic, and political changes.

Keywords: Drug consumption. Drug legislation.

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HISTORICAL ASPECTS OF DRUG CONSUMPTION IN THE WORLD AND IN BRAZIL

Since Antiquity, man has searched in the diversity of flora for plants that were useful to him, discovering in some of them sensations, such as alteration of consciousness, mood, disposition, sleep, among others. This interaction operated multiple meanings in different contexts and civilizations: some plants served as great analgesics, fundamental to combat pain; others as stimulants, allies of energy and productivity; others granted access to the transcendent. All these effects were of great relevance in the history of humanity (CARNEIRO, 2014).

Diehl et al. (2011) point out that the Sumerians, as early as 4000 BC, made use of the opium poppy to obtain contact with the gods. In countries such as China, India and Egypt, around 2000 BC, the use of marijuana for therapeutic purposes was widespread. The use of alcoholic fermented products also represented ancient civilizations. In Egypt, for example, records of paintings are found that denote states of drunkenness with alcohol, in which men appear carrying other men.

In the Middle Ages, opium consumption on the European continent increased, due to the spread of poppy planting among peasants. The expansion of commercial navigation, from the sixteenth and seventeenth centuries, interconnected the continents, allowing the entry and exit of products such as opium, alcohol-based beverages (distilled and fermented), tobacco, marijuana and their derivatives, such as hashish. These products were considered luxury spices and played an important role in trade (AVELAR, 2014).

With the strengthening of the pharmaceutical industry, in the nineteenth century, substances such as cocaine, heroin, morphine and caffeine had their active ingredients synthesized and started to be produced and marketed (CARNEIRO, 2014). Cocaine, for example, around the 1800s, had its use expanded, including in the medical field for its antidepressant, anesthetic, and analgesic properties. Sigmund Freud (1856-1939) himself focused on the study of cocaine, indicating its use for its beneficial functions. Due to its high cost, it was considered a "drug of the elites", becoming an article of desire for all those who wanted to ascend socially. Coutinho (2014, p. 35) says that "a lifestyle was forged that ended up being associated with cocaine", since the consuming population was known for its millionaire jobs, characteristic of the production system of the time. The aforementioned author states that cocaine was considered the ideal substance for those who wanted to have high self-esteem, energy and social ambition, essential attributes for young people who were entering the market, fulfilling a beneficial function even for the American economy in the obstinate conquest of hegemony. Diehl et al. (2011, p. 140) portray the change in this scenario.

> Despite the apparently beneficial effects, its use spread rapidly around the world. At the time, the various harmful consequences resulting from its consumption were already observed, causing behavioral changes, increased aggressiveness and establishing dependence, which led to the subsequent prohibition of its use.

A decisive factor, according to Coutinho (2014), happened in the 70s of the last century, when Colombian traffickers inserted large quantities of cocaine into American territory, increasing availability and reducing prices, which made the substance accessible, especially among the excluded classes.

> [...] the fame of the psychoactive has been turned upside down: it has gone from an elite drug, associated with power and triumph in the capitalist world, to a substance used by excluded populations with great destructive potential (COUTINHO, 2014, p. 35).

The situation was intensified with the rapid popularization of one of its derivatives: crack. The compulsive consumption, the craving, the absence of refining in its production and the affordable price attracted users from the less favored classes. Coutinho (2014) adds that the State's omission in the development of protective social policies intensified its repressive and stigmatizing character to trafficking and especially to the user.

A similar transformation of meanings occurred with the consumption of alcohol. In the period of the Industrial Revolution, the mode of production that exploited the worker made the drink acquire an important role, being used as a relief from subhuman working conditions. When the use of alcohol became a nuisance, precisely because it left the worker unproductive in the eyes of the State, political changes occurred. In the United States, between 1919 and 1933, the so-called "Prohibition" was in force, which prohibited the manufacture and consumption of alcohol (COUTINHO, 2014).

Heroin, another very popular substance, became known as the solution for morphine addicts and also for its therapeutic effects, so much so that it was sold freely in pharmacies. But the solution soon turned out to be a public health problem. Around 1920, the American Medical Association called for a ban on its use, due to its highly addictive nature. However, the fight did not gain as much repercussion, since the substance was not the target of distribution by Colombian mafias. The use of heroin became more popular on the European continent, among the so-called junkies, people who consumed the drug intravenously (COUTINHO, 2014).

Substances such as marijuana and LSD were characterized by the scientific community as the mark of "social disorder", since they gained popularity among the young people who made up the hippie movements and rock bands of the time. Due to its countercultural character, the repression of use was not long in being unleashed. Alongside

these drugs, the proliferation of synthetic drugs, such as ecstasy, methamphetamine, and others, has been observed since the 1990s (DIEHL et al., 2011).

In recent years, there has been a growing spread of substances that have effects similar to those of illicit drugs, the so-called "new psychoactive substances" (NPS).[3] This result is guaranteed through combinations of herbs and chemical substances, such as herbal smoke, which cause the same effects as marijuana. An example is Salvia Divinorum, a type of sage used for ritualistic purposes. Its use has been widely disseminated due to its intense effects, which resemble marijuana, because it does not have a strong smell, because it is not an illicit substance and because of its easy access, whether in tobacco shops or on internet sites (DIEHL et al., 2011).

In Brazil, psychoactive substances also fulfilled significant functions, linked to ritualistic, therapeutic and commercial activities (AVELAR, 2014). When the Europeans arrived, the native peoples made use of tobacco and caiun, a drink distilled from the cassava root. Later, the cultivation of sugar cane and slave labor provided the production of "cagaça" or cachaça, from molasses, which became popular among slaves and free men. Due to the low circulation of metallic coins, drugs played the role of facilitating exchanges in trade. Brandy, for example, was exchanged for beans, potatoes and cassava among African slaves in the state of Bahia (AVELAR, 2014).

The legislation, which assumed to a certain extent a permissive character in the use of psychoactive substances, gradually adapted to the logic of controlling addictions, with the objective of establishing civilized coexistence, and control of profits, imposing restrictions on the sale of alcohol and other drugs (TRAD, 2010). In the mid-seventeenth century, the Portuguese Crown drafted laws that prohibited the production and consumption of cachaça. The objective was to avoid competition with Portuguese wines. In response to pressure, at the end of the same century, the Portuguese again allowed the sale of the drink. At the beginning of the nineteenth century, the prohibition of public drunkenness in Rio de Janeiro was discussed. It was alleged that the measure of provisional incarceration of the drunk person had a protective function, aiming to avoid damage until the effect of drunkenness wore off. This measure was only authorized three years later (AVELAR, 2014).

In 1830, the publication of the Code of Postures presented in its article 7 the prohibition of the use and sale of marijuana cigarettes, with the penalty being a fine and

[3] New psychoactive substances are those of misuse, either in pure form or in a preparation, which are not controlled by the Single Convention on Narcotic Drugs of 1961 or the Convention on Psychotropic Substances of 1971, but which may pose a threat to public health. In this context, the term "new" does not necessarily refer to new inventions, but to substances that have recently become available.
Source: United Nations Office on Drugs and Crime, The Challenge of New Psychoactive Substances (Vienna, March 2013).

three days in jail for slaves and other people. Rodrigues (2014) says that Rio de Janeiro was the first city in the world to enact a law against the use of marijuana, for associating it with the black capoeiras who frightened the slave society. Throughout the twentieth century, the repression of the consumption of plants, beverages and smoke only increased in Brazil, a reflection of the world scenario, which was waging the war on drugs (AVELAR, 2014).

At the end of the first quarter of the twentieth century, drug consumption was classified into "elegant vices", which categorized drugs such as heroin, morphine and cocaine, used by the white elites, and into "inelegant vices", belonging to the habits of the poor strata, formed by blacks and their descendants and popular classes, who made use of drugs such as marijuana and alcohol. It did not take long for stigmatized drugs to be spread to all social classes, even enslaving the elites (BRASIL, 2014). This picture of distinctions was also manifested in the scientific community. Trad (2010) reports that there were no studies on the evils of opium, heroin or cocaine, but they highlighted the evils of alcoholism and tobacco. It is noteworthy that Brazil was influenced by the standards determined by countries, such as the United States and others on the European continent.

It is observed that, historically, the consumption of psychoactive substances fulfills expectations and needs of a given moment in the culture, economy and social conditions of a people's life. Thus, the issue of drugs is not merely a social problem, but needs to be understood as an integral part of human history. The considerations made allow us to analyze the changes in social perception and the posture assumed by the State with regard to drug use: from sweet to bitter, from resolutive to poisonous, as well as their implications in the elaboration of public policies on drugs.

THE LEGISLATIVE TRAJECTORY AND POLICIES ON DRUGS IN BRAZIL

Until the middle of the nineteenth century, the consumption of psychoactive substances was not considered an alarming problem for Brazilian society and the State, so Brazil had not systematized official control over drug use. In the twentieth century, events that went beyond Brazilian borders3 and changes that occurred within their own limits announced the need for rearrangements in the political system (TRAD, 2010).

In the Colonial Period, social control and profit control were on the agenda in the elaboration of legislation on drugs, as already exposed. The first attempts by the State to establish control over the use, production and sale of drugs do not achieve, according to Ribeiro (2013), the status of a true legal system. The Philippine Ordinances, published in 1737, prohibited the sale of "poisonous substances", such as opium, in establishments that did not belong to doctors, apothecaries or surgeons, but the decision was revoked a year later due to pressure from merchants on the king of Portugal (TRAD, 2010).

Even during the Imperial period, there was still no legislative framework on the issue of drugs. The Criminal Code of the Empire itself, sanctioned in 1830, was subject to the positions taken by municipalities, such as Rio de Janeiro, Santos and Campinas, which prevented the sale of marijuana in public places. Ribeiro (2013) considers this provision as a prohibitionist framework.

With the Proclamation of the Republic (1889), the universal standards disseminated by world powers, such as the USA, France and England, were articulated with the Brazilian republican ideology (TRAD, 2010). The framework of legitimation and institutionalization of psychiatric medicine as a field of knowledge already experienced by Europe, reproduced similar effects in Brazil. Trad (2010) highlights that the State and psychiatric medicine were similar due to their dualistic ideologies about the individual and society: order/disorder, reason/madness, normal/pathological. Thus, as a parameter "Brazilian physicians identified the psychic 'deviation' by observing the habits and behaviors of the population in general and in contrast with the urban world of large metropolises" (ENGEL, 1999 apud TRAD, 2010, p. 106).

During this period, numerous legislative changes were felt, based on international agreements, such as the Hague Convention (1912), [4]which committed to strengthening control over the growth and use of drugs such as opium and cocaine. In 1921, the government issued a decree that established punishment for all types of use of opium, morphine, heroin and cocaine. There was also the first typification of the drug addict, followed by the institution of sanatoriums for hospitalization, whether requested by the family, judge or the user himself (TRAD, 2010).

With the Vargas Era, the State's role as a regulator and controller over drug use was intensified, establishing a specific body to fulfill this task - the National Narcotics Inspection Commission (CNFE) - in 1936 (TRAD, 2010). Among the CNFE's attributions were the establishment of standards and supervision of the production, sale, purchase and repression of the use of narcotic substances. Addiction gained the status of a contagious disease, stigmatizing users as infected people, who should be treated so that they did not spread "the plague". Trad (2010) observes that the care model was based on health intervention, without discussions for the elaboration of preventive actions.

[4] In 1912, the First International Opium Conference took place, held in The Hague, which issued the first resolutions on the international prohibition of the trade and consumption of this substance. In 1961, one of the milestones for the consolidation of the prohibitionist paradigm took place: the 1961 United Nations Convention on Narcotic Drugs, in which countries committed themselves internationally to fight drugs (FIORE, 2012).

The military dictatorship strengthened the prohibitionist-criminalizing discourse, with special repression of Brazilian countercultural movements that were born inspired by student and hippie actions in the USA and Europe around 1960.

> If before the 1960s the consumption of drugs such as marijuana and cocaine was associated with prostitution, criminality and madness, with the military dictatorship drugs were associated with youth, incorporating new meanings into the social imaginary, such as juvenile delinquency and political-social alienation (OLMO, 1990 apud TRAD, 2010, p. 116).

Ribeiro (2013) says that among the first legislative changes introduced by the military regime is the amendment of article 281 of the Penal Code, which now equates the conduct of the person who uses drugs with that of the trafficker, in 1968. The separation between the figures of the consumer and the dealer, that is, the "sick" and the "delinquent", was changed in 1976, with the advent of Law No. 6368/76, which became known as the Narcotics Law. The law provided for different disciplines for the conduct of the user (art.16) and the trafficker (art.12). It is important to emphasize that the changes made did not erase the traces that still stigmatize the user today, equating him with the trafficker. The Narcotics Law marked the structuring of official government measures, presenting actions to prevent and repress the trafficking and misuse of substances that determine physical or psychic dependence. The Law also instituted mandatory medical treatment for individuals with behaviors defined as dependence, says Trad (2010).

The government's priority was the repression of use, sale and trafficking, so financial investments were aimed at reducing supply. To this end, between 1980 and 1993, it established bodies responsible for coordinating research and actions in the field of drugs, such as the National System for the Prevention, Inspection and Repression of Narcotics, the Federal Council of Narcotics, the National Secretariat of Narcotics, linked to the Ministry of Justice. The actions developed by the Ministry of Health, on the other hand, were based on the hospital-centered model, prioritizing hospitalization in psychiatric hospitals, producing practices that violate rights, supported by the criminal/moral/disease model, and promoting incarceration and treatment with the goal of abstinence (TRAD, 2010).

Discontent with the assistance provided erupted social movements and organized groups that placed themselves in a position of criticism of the State, generating changes. The advent of the Federal Constitution of 1988 conferred the condition of public policy to health, social assistance and social security, constituting the tripod of social security in the country. From the Constitution, there is the enactment of the Organic Health Law (No. 8,080/90) and the institution of the Unified Health System (SUS), and later the Organic Law of Social Assistance (No. 8,742/93); The first expanding the concept of collective health and

the second expanding the notion of social assistance network, both, along with other social achievements, refer to bets on the integrality of care and the intersectoriality of actions that expand attention, care and protection to the individual, family and community.

For Trad (2010), these achievements heralded the emergence of a new perspective on the issue of drugs. As a result, pharmacological and criminal criteria gave way to the discussion of a sociocultural approach, pointing to new intervention models, based on preventive education and humanization in user care.

In the context of the drug issue, these changes brought about the institution of the first National Anti-Drug Policy (PNAD), establishing objectives and guidelines for prevention, treatment, recovery and social reintegration, repression of trafficking and studies, research and evaluations resulting from the misuse of drugs. It is important to highlight that the policy recognized, along with other actions, actions to reduce social and health damage as measures to be developed. In 2003, the Ministry of Health presented a Policy for Comprehensive Care for Users of Alcohol and Other Drugs, which clarifies the attribution of the Unified Health System to serve this population and establishes intersectoriality in health-related actions (primary care, CAPS, outpatient clinic, beds in general hospitals and harm reduction).

Later, in 2006, Law No. 11,343 or the Drug Law was sanctioned, which revoked laws No. 6,368/76 and No. 10,409/02, which were in force in the country until then. The new law places Brazil in the spotlight on the international scene in aspects related to prevention, care, social reintegration of drug users and addicts. Among the main highlights is the distinction between users, addicts and dealers and the end of mandatory treatment for drug addicts. The possession of illicit substances continues to be characterized as a crime, but users and addicts will no longer be subject to deprivation of liberty, but to socio-educational measures. Ribeiro (2013) states that despite maintaining the criminalization of the consumption of psychoactive substances, the Drug Law takes a more moderate position on prohibitionist policies. The Drug Law establishes the National System of Public Policies on Drugs (SISNAD), which is responsible for the organization and execution of public actions on drugs in the scope of prevention, treatment and social reintegration and the coordination of actions to repress the production and trafficking of illicit substances.

In 2008, Law No. 11,754 was instituted, which changed the name of the National Anti-Drug Secretariat to the National Drug Secretariat. The change had been awaited since the process of realigning the PNAD, which was renamed the National Policy on Drugs, in 2004. It is important to emphasize that this change is not limited to the simple arrangement of letters, but signals the attempt to address the issue of drugs from a less repressive and

stigmatizing perspective, more welcoming and humanized, although the actions undertaken by the State still adopt as a reference the "war on drugs" model, inherited from countries such as the USA.

The maintenance of obsolete models does not overshadow progress in the field of drug care policies. The proposal for the next few moments is to address in more detail the National Policy on Drugs and Ordinance No. 3,088, which establishes the Psychosocial Care Network to care for people with suffering or mental disorders and with needs resulting from the use of psychoactive substances, since the performance of these actions prioritizes the guarantee of comprehensive care.

THE NATIONAL DRUG POLICY (PNAD)

The National Drug Policy (PNAD) is a milestone for new public policies on drugs in Brazil. Its birth resulted from the interaction between government, society and the scientific community, in a broad process of discussion, with the objective of realigning the policy in force since 2002. The basic assumptions and objectives of the PNAD (prevention, treatment, recovery and social reintegration, reduction of social damage and health, reduction of supply and repression, studies, research and methods of evaluating the effectiveness of actions) were on the agenda of the debates.

The PNAD is based on assumptions, of which the following stand out: the construction of a society free of illicit drugs and misuse of licit drugs, recognition of differences and search for articulation equal treatment of illicit and licit drug users; guarantee of the right to access adequate services for all people who have problems resulting from drug use; priority to prevention actions, due to their effectiveness and low cost to society; recognition of the irrational use of illicit drugs as an important factor in the induction of dependence, and for this reason should be the object of adequate social control; integration of education, social assistance, health and public safety policies; principle of "shared responsibility", which consists of the coordination of efforts between the segments of government and society, seeking the effectiveness of actions to reduce supply, demand and damage resulting from drug use. On the topic of assumptions, PNAD highlights that harm reduction actions cannot be confused with incitement to consumption, as they are preventive strategies.

Some of the objectives presented by the PNAD are: social awareness of the losses and negative implications resulting from the misuse of drugs; education, information and training to the various segments of society for effective action regarding the reduction of supply, demand and harm from drug use; implementation and implementation of the

comprehensive public and private care network for people with disorders resulting from the consumption of psychoactive substances; evaluation and monitoring of the different treatments and therapeutic initiatives, in order to promote those that obtain favorable results; reduction of social and health damage resulting from drug misuse.

When addressing the development of preventive actions, PNAD emphasizes the philosophy of shared responsibility, through the construction of social networks that aim to improve and promote quality of life. The development of these actions relies on the continuous training of the various social actors on the prevention of misuse and licit and illicit drugs and support for preventive activities that consider the individual and his sociocultural context. The policy also deals with the realization of interdisciplinary and multiprofessional work, in order to expand, articulate and strengthen the care networks.

With regard to treatment, recovery and social reintegration, the general orientation is the development of actions so that society, including drug users and dependents, can assume ethical responsibility in treatment, recovery and social reintegration. Treatment and recovery actions should promote family, social and occupational reintegration actions, due to their usefulness in breaking the consumption/treatment cycle.

When discussing the implementation of harm reduction actions, the PNAD recognizes the strategy as a measure of preventive intervention, assistance, health promotion and human rights and provides guidance on the promotion of harm reduction strategies and actions, in an inter and intrasectoral articulated way, aiming at reducing the risks, adverse consequences and damage associated with the use of alcohol and other drugs for the person, the family and society.

ORDINANCE NO. 3,088 AND THE PSYCHOSOCIAL CARE NETWORK (RAPS)

Ordinance No. 3,088, of December 23, 2011, which establishes the Psychosocial Care Network (RAPS) for people with suffering or mental disorders and with needs resulting from the use of alcohol and other drugs, within the scope of the SUS, is addressed here because it highlights the interest of the Ministry of Health in linking the topic of drugs to an articulated care network.

As guidelines, the RAPS: brings respect for human rights; combating stigmas and prejudices; guarantees access to and quality of services that are articulated in order to provide comprehensive care and multiprofessional assistance; it promotes humanized care centered on people's needs; diversifies care strategies; develops territorial actions, considering the socio-cultural dimensions of places and relationships; develops and carries out harm reduction strategies; it emphasizes community-based services, with the

participation and social control of users and their families; promotes permanent education strategies; and develops care strategies that have the singular therapeutic project (STP) as their axis.

As objectives, the Psychosocial Care Network sustains: the expansion of access to the care network; the promotion of the link to people suffering from mental disorders and with needs resulting from the use of alcohol and other drugs to the care services; and the guarantee of the articulation and integration of the points of the network. From these general objectives, specific objectives are established, such as: health promotion to groups in vulnerable situations; the prevention of the consumption of psychoactive substances; the reduction of harm linked to alcohol and drug consumption; the promotion of rehabilitation and social insertion; the provision of information on civil rights, prevention measures and services available on the web; and the permanent training of professionals.

The Psychosocial Care Network highlights the need for integration and articulation of different sectors that offer comprehensive care, obeying the principle of integrality that, together with universality and equity, subsidize the SUS. The constitution of the RAPS includes: Primary Health Care; Specialized Psychosocial Care; Urgent and Emergency Care; Transitional Residential Care; Hospital Care; Strategies for Desistitucionalization and Psychosocial Rehabilitation.

Primary Care, also known as the gateway to the integrated network of health services, aims to offer care to the patient and family in welcoming the demand and directing and monitoring the case in the service network. In Primary Care, Ordinance No. 3,088 highlights the Basic Health Unit (UBS) as reference points, which are services made up of a multiprofessional team responsible for health actions, individually and collectively, aiming at promotion, prevention, diagnosis, treatment, rehabilitation and harm reduction actions. The Primary Care Team for populations in specific situations is another Primary Care device, such as the street clinic team, which is made up of professionals who work in an itinerant way, in order to offer actions and services to homeless populations. The Family Health Support Center (NASF) is made up of professionals from different areas, who work in the matrix support of the Family Health Teams (ESF) and Primary Care Teams for specific populations.

Specialized Psychosocial Care is made up of Psychosocial Care Centers (CAPS), made up of a multiprofessional team, which provides assistance to people with severe mental disorders and people with needs resulting from the use of alcohol and other drugs. The work at the CAPS is carried out primarily in collective spaces, in an articulated way with other points of the care network. The work is carried out with the PTS, built by the team,

user and family. The CAPS AD (Alcohol and Drugs) is the main care device, within the CAPS organization modality (CAPS I, II, III and I), in the care of people with needs resulting from the use of alcohol and other drugs. It is an open service, of a community nature, operating 24 hours a day, including holidays and weekends, as provided for in the ordinance.

In cases of hospitalization or transitional residential services, Residential Care is responsible for coordinating actions. It consists of a Shelter Unit, a point of care that offers continuous health care, operating 24 hours a day, in a residential environment, for people with needs resulting from the use of alcohol and other drugs, in situations of social and family vulnerability, who require transitional protective shelter.

In Hospital Care, specialized wards in General Hospital are articulated with CAPS and other points of the network, offering hospital care for severe cases, especially abstinence and detoxification.

The Deinstitutionalization Strategies are made up of initiatives that aim to guarantee people with mental disorders and with needs resulting from the use of alcohol and other drugs who are in a situation of long-term hospitalization, comprehensive care, through strategies that aim to promote autonomy and exercise of citizenship through progressive social reintegration. Residential services are devices responsible for welcoming people coming from long-term hospitalization.

FOR AN INTEGRATED AND TRANSVERSAL POLICY

The construction of the National Policy on Drugs has in its assumptions the integration and articulation of the various sectors (education, social assistance, health and public security) for the development and implementation of actions that range from prevention to strategies of social reintegration. If the elaboration of the policy, with its priorities and contents, was not without difficulties, the implementation process also involves many challenges.

When the discussion refers to the care of drug users, we find in Public Health Policies a fertile soil, which points to the commitment to germinate strategies that encompass all levels of care. However, in view of the accentuated social vulnerability and the shortcomings not only in the field of health, but also in education, public security and social assistance, the debate on an Integrated and Transversalized Policy is imperative. Because if, on the one hand, we can point to the advances in the care and management of public policies on drugs, with an increase in the levels of universality, equity and comprehensiveness, on the other hand, we see the fragmentation and consequent

compartmentalization of work processes, which weaken and overload the care instances, when they do not fail to assist the user, family and community.

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