

**FROM OBJECT TO SUBJECT: ETHICS AND POLITICS IN CARE FOR DRUG USERS**

**DE OBJETO A SUJEITO: ÉTICA E POLÍTICA NA ASSISTÊNCIA AO USUÁRIO DE DROGAS**

**DE OBJETO A SUJETO: ÉTICA Y POLÍTICA EN LA ATENCIÓN A USUARIOS DE DROGAS**

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**ABSTRACT**

This article aims to analyze Brazil's care policy for users of alcohol and other drugs, articulating the ethics of psychoanalysis and Harm Reduction (HR) strategies to understand the advances and setbacks of public policies in recent decades. By revisiting the history of the Psychiatric Reform and the establishment of the Psychosocial Care Network (RAPS), it demonstrates how the rise of Therapeutic Communities (TCs)—marked by moralizing, religious, and punitive practices—represents a return to the asylum-based model, with serious human rights violations supported by prohibitionist policies and State funding. In contrast, Harm Reduction, like psychoanalysis, proposes a non-universalizing approach, guided by case-by-case analysis and by the subject's implication in their treatment, considering their choice of use, misuse, or abstinence. Thus, the article argues that any mental health, alcohol, and drug care must be guided by a commitment to listening to singularity, respecting human rights, and fostering territorial and community-based care. As a “not-all” policy, this perspective must be capable of including different modes of jouissance within the complexity of each subject's relationship with drugs and their uses.

**Keywords:** Psychoanalysis. Drug Users. Harm Reduction. Therapeutic Community.

**RESUMO**

O presente artigo pretende analisar a política de assistência aos usuários de álcool e outras drogas no Brasil, articulando a ética da psicanálise e as estratégias de Redução de Danos (RD) para compreender os avanços e retrocessos das políticas públicas nas últimas décadas. Ao revisitar a história da Reforma Psiquiátrica e da constituição da Rede de Atenção Psicossocial (RAPS), demonstra-se como a ascensão das Comunidades Terapêuticas (CTs) – marcadas por práticas moralizantes, religiosas e punitivas – representa um retorno ao modelo manicomial, com graves violações de direitos humanos, sustentadas por políticas proibicionistas com o financiamento do Estado. Em contraponto, a Redução de Danos, assim como a psicanálise, propõe uma abordagem não universalizante, orientada pelo caso a caso e pela implicação do sujeito em seu tratamento, considerando sua escolha pelo uso, pelo abuso ou pela abstinência. Dessa forma, o artigo defende que qualquer

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cuidado em saúde mental, álcool e outras drogas deve orientar-se pelo compromisso com a escuta da singularidade, pelo respeito aos direitos humanos e pelo cuidado territorial e comunitário. Constituindo-se como uma política não-toda, essa perspectiva deve ser capaz de incluir os distintos modos de gozo na complexidade da relação de cada sujeito com as drogas e seus usos.

**Palavras-chave:** Psicanálise. Usuários de Drogas. Redução de Danos. Comunidade Terapêutica.

## **RESUMEN**

El presente artículo pretende analizar la política de atención a los usuarios de alcohol y otras drogas en Brasil, articulando la ética del psicoanálisis y las estrategias de Reducción de Daños (RD) para comprender los avances y retrocesos de las políticas públicas en las últimas décadas. Al revisar la historia de la Reforma Psiquiátrica y de la constitución de la Red de Atención Psicosocial (RAPS), se demuestra cómo el ascenso de las Comunidades Terapéuticas (CTs), caracterizadas por prácticas moralizantes, religiosas y punitivas, representa un retorno al modelo manicomial, con graves violaciones de derechos humanos, sostenidas por políticas prohibicionistas y con financiamiento estatal. En contrapunto, la Reducción de Daños, al igual que el psicoanálisis, propone un enfoque no universalizante, orientado por el caso a caso y por la implicación del sujeto en su tratamiento, considerando su elección por el uso, el abuso o la abstinencia. De este modo, el artículo sostiene que cualquier cuidado en salud mental, alcohol y otras drogas debe guiarse por el compromiso con la escucha de la singularidad, el respeto a los derechos humanos y el cuidado territorial y comunitario. Constituyéndose como una política no-toda, esta perspectiva debe ser capaz de incluir los distintos modos de goce en la complejidad de la relación de cada sujeto con las drogas y sus usos.

**Palabras clave:** Psicoanálisis. Usuarios de Drogas. Reducción de Daños. Comunidad Terapéutica.



## 1 INTRODUCTION

The existence of specific public policies on drugs is quite recent in Brazil, coinciding, almost entirely, with the history of our Republic. For many years, legislation was directed exclusively by authoritarian and hygienist models, following the North American standards that guided the practices of justice and public security, as well as the methods of health treatment. Based on war practices – inspired by the U.S. policy of the 1970s – and abstinence, such legislation and actions followed the guidelines of international treaties that, although they have their importance, never considered the singularities of each country or the complexity required by the subject.

In this way, the relationship of the Brazilian State with the drug trade has been structured based on prohibitionist and moral precepts, which sustain an unprecedented war in certain territories, targeting a specific portion of the population. Called "police operations" by the State and with the territories of favelas and peripheries as the scene of confrontations, this war victimizes black and poor populations, both through the summary execution of young people recruited by drug trafficking or criminalized by racism and through the "stray bullets" that hit residents and curtail their rights to come and go<sup>3</sup>. In the field of health, the asylum and biomedical model imposed a logic that destined people to long hospitalizations in psychiatric hospitals that for decades functioned as warehouses for individuals segregated by society, such as drug users, people with mental disorders, and even political prisoners during the military dictatorship (1964-1985).

With the political opening, the *1988 Constitution* (BRASIL, 1998) and the establishment of the SUS (BRASIL, 1990), Brazil constituted a new path based on democratic bases that inspired various movements such as the anti-asylum struggle – the foundation of the so-called Psychiatric Reform<sup>4</sup> – in which the policies of assistance to drug users are inserted. Thus, advances have become possible in the construction and execution of policies that treat users from the perspective of public health, recognizing them as subjects and considering territorial differences as a guide for their work. However, recently, we have witnessed a significant setback in this field, once again leading users to long hospitalizations in asylums and religious institutions, known as Therapeutic Communities (TCs).

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<sup>3</sup> Among so many examples, the most recent and brutal of them left 122 dead in Complexo da Penha, in the North Zone of the capital of Rio de Janeiro, on October 28, 2025.

<sup>4</sup> After World War II (1939-1945), a set of distinct experiences in several countries brought in common the questioning of the current asylum model, becoming known as the Psychiatric Reform Movement. For a more in-depth discussion of the issue, see: AMARANTE, P. (1995). *Crazy for life: the trajectory of psychiatric reform in Brazil*. Rio de Janeiro: SDE/ENSP.

Over many years of clinical and institutional work, listening to drug-using subjects has led us to insist on an ethical bet that goes against the grain of proposals that prescribe abstinence, isolation and that intensify tensions guided by the utopia of a drug-free world. By reducing subjects to objects of policies aimed at the control of bodies, countless practices of violence have been instituted by a State that segregates and kills, both in territories and in TCs. Our bet, guided by the ethics of psychoanalysis – ethics of desire and lack-to-be – highlights the impossibility of any universalization in the treatment of subjects who, in various ways and for various reasons, they use drugs. Because it excels in listening to singularity and considering the loss of *jouissance* as inherent, the politics of psychoanalysis is always non-all.

Therefore, from a psychoanalytic reading, this article aims to situate these facilities in the history of policies for alcohol and other drug users in Brazil and, at the same time, to raise some complaints about the seriousness of the *modus operandi* of these spaces, including the trivialization of numerous forms of violence. To this end, we will present the public policies of mental health, alcohol and other drugs in the country, with emphasis on the advances and setbacks observed in recent decades, especially from the Psychiatric Reform and the implementation of the open and territorial devices that make up the Psychosocial Care Network (RAPS). Next, we will analyze the phenomenon of Therapeutic Communities (TCs), which represent a return to the asylum model and, in this sense, a kind of anti-psychiatric reform. By discussing the tensions between public mental health policies and neoliberal practices, we will highlight the privatization of treatment as a movement that reupdates practices of violence and segregation. These first two parts of the article have as their main methodology the bibliographic review made from legislation and reports of official bodies, as will be described in the body of the text.

Subsequently, we will present the Harm Reduction (HR) policy as an alternative to the prohibitionist logic, since it promotes care based on singularity and is configured as a possible ethical proposal, similar to the bet of psychoanalysis. By sustaining the idea of a not-all politics, represented by HR, it becomes possible to include the subject and his modes of *jouissance*, enabling less segregatory models and closer to the logic of case by case, as will be pointed out in the last two parts of the text. To do so, we will make use of the bibliography on HR, as well as the contributions of theorists who think about the field of mental health, alcohol and other drugs from the perspective of public health and, especially, psychoanalysis.

In addition, we will present the report of one of the clinical and institutional studies in which we were inserted, in order to illustrate the theoretical-clinical development of this article.

## **2 PUBLIC POLICIES ON MENTAL HEALTH, ALCOHOL AND OTHER DRUGS IN BRAZIL: BETWEEN ADVANCES AND SETBACKS**

The policy of attention and care for drug users in Brazil was built on the gains obtained with the Psychiatric Reform, consolidated in the enactment of Law 10.216 (BRASIL, 2001), after years of struggles led by users, family members and workers. The main achievement of this movement consisted of the replacement of psychiatric hospitals – an asylum and hospital-centered model, based exclusively on medical knowledge – by Psychosocial Care Centers (CAPS) which, articulated in a Psychosocial Care Network (RAPS) composed of several devices, subverted the previous model. In the new arrangement, user care takes place in open equipment, understood as integrated with the public space, the community and the territory.

Established and regulated by Ordinance 336 (BRASIL, 2002), the CAPS were organized in modalities that included the CAPS ad: an equipment intended for the care of users of alcohol and other drugs, from the perspective of a policy and a clinic based on Harm Reduction (HR) strategies, instituted with the Policy for Comprehensive Care for Users of Alcohol and Other Drugs (BRASIL, 2003). Born in Europe, HR is considered an alternative to the prohibitionist model, as it presupposes the provision of care even in the face of the subject's choice not to interrupt use. At its base, the construction of therapeutic projects with users – and not for them – aims at an approach centered on the subject and on their listening, integrating knowledge about themselves and about use – a practice that promotes autonomy and self-care – in addition to working with the community and the territory in the prevention of use and the risks arising from abuse, as we will see later.

The inclusion of a perspective in which the user came to be recognized as a subject – and not as the object of his treatment – produced effects that substantially modified the view of this population in the field of public mental health policies, which began in the last years of the Fernando Henrique Cardoso government (1995-2002) and extended during the Luiz Inácio Lula da Silva governments (2003-2010). However, this change was not enough to reach other fields that make up the issue of drug policies in the country. In relation to alcohol and tobacco – the two most used drugs in Brazil – significant changes have been implemented, such as restrictions on advertising in certain spaces, increased collection of

taxes to finance treatments for their effects and, in the case of tobacco, in particular, a significant reduction in consumption. However, with regard to the so-called illicit drugs and public security policies, progress is scarce and quite ambiguous.

In 2010, the *Integrated Plan to Combat Crack and Other Drugs* (BRASIL, 2010) introduced the proposal for the integration of public policies on social assistance, education and security. However, the word *crack*, highlighted in the title, signaled a change in focus – previously centered on alcohol – which led, a year later, to the launch of the program *Crack, é Possível Vencer* (BRASIL, 2011), during the Dilma Rousseff government (2011-2016). This initiative of the Ministry of Justice, which proposed actions in the areas of prevention, care and authority, was received with strangeness by specialists and professionals. Although the media of the time repeatedly broadcast images of the so-called *cracklands*, associating crack users with the increase in crime and depriving them of their place as subjects by representing them as "zombies", the data from the surveys pointed to another reality: alcohol and tobacco – legal drugs – continued to constitute a serious public health problem in Brazil, much more expressive than any other. In addition to this distortion, the country was preparing to host two important international events – the World Cup (2014) and the Olympic Games (2016) – which led several cities to adopt hygienist actions, such as the compulsory hospitalization of these users in public and private clinics and in shelters linked to social assistance policies.

In this regard, in 2015, the Therapeutic Communities (TCs) were regulated as entities capable of welcoming drug users and, a year later, registered to receive resources from the Unified Health System (SUS) through two ordinances: Resolution No. 01 of CONAD (BRASIL, 2015) and Ordinance No. 1,482, of the Ministry of Health (BRASIL, 2016). Although the two ordinances configure a regulatory framework for TCs, it is essential to understand that, by moving from a device recognized and regulated by the State to a device financed by it, TCs became part of the SUS, which seems much more serious to us.

Thus, advances in the destruction of public policies on mental health, alcohol and other drugs, based on the assumptions of the Psychiatric Reform, gained space and acceleration after the 2016 coup, with the insertion of the neoliberal policies of the Michel Temer government (2016-2018). With a sequence of setbacks in this field from 2016 onwards, we highlight Ordinance No. 3,588/GM/MS (BRAZIL, 2017a), CIT/SUS Resolution No. 32 (BRAZIL, 2017b) and Resolution No. 01 (BRAZIL, 2018). In them, there was a return to the centralization of the psychiatric hospital, added to the integration of TCs into the RAPS and

the disregard of HR strategies in the care policies for drug users, which began to be reoriented exclusively to abstinence.

With the government of Jair Messias Bolsonaro (2019-2022), other serious setbacks were instituted in the face of his reactionary vision, adding to an already devastated scenario. In addition to the extinction of social control bodies, such as the Councils, we highlight Technical Note No. 11 (BRASIL, 2019a) and Law 13,840 (BRASIL, 2019b) – known as the *New Drug Law*<sup>5</sup> –, which instituted: 1. the purchase of new electroconvulsive therapy (ECT) devices<sup>6</sup>; 2. the opening of new beds and the expansion of funding for psychiatric hospitals, including the hospitalization of children and adolescents; 3. the opening of beds and new accreditations of TCs; 4. the possibility of income tax rebate for those who allocated money to this equipment; 5. the dissociation between mental health policies and those of alcohol and drugs, leaving the latter in charge of the Ministry of Citizenship; 6. the transformation of CAPS ad into a mere instrument for referring users to TCs and 7. the involuntary hospitalization of users without judicial authorization, provided that it is formalized by medical decision.

Still during the Bolsonaro Government, the country – and the world – faced the worst pandemic in recent times, COVID-19, culminating in more than 700 thousand deaths in Brazil due to the disastrous conduct by the federal government. The bleak scenario of isolation, quarantine, diseases and deaths, added to the population's disbelief, aggravated many psychosocial issues: anguish, domestic violence, abuse of psychoactive substances and other illnesses, especially for some social strata:

[...] some social groups are more susceptible due to their socioeconomic conditions and the lack of adequate public policies, making visible those who are "south of the quarantine": women, precarious or informal workers, homeless people, poor peripheries and favelas, those interned in refugee camps and prisons, the elderly, physically disabled (SANTOS, 2020, p. 1)<sup>7</sup>.

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<sup>5</sup> Legally, the law would update the 2006 Drug Law – No. 11,343 – which established the system of repression and public policies aimed at the use, trafficking and production of psychoactive substances in Brazil, distinguishing, for the first time, user from dealer, although without any mention of a quantity that objectively establishes it, leaving it up to the police officer who authorizes and the judge who approves the decision to send the subject to prison or to the devices of health for treatment. In practice, the *New Law* only reinforced stigmas and instituted TCs as priority places for the "treatment" of users.

<sup>6</sup> ECTs were widely used as symbolic instruments of torture widely carried out in asylums throughout the country before the Psychiatric Reform. After the reorientation of the care model, the method still continued to be used, but as a last resort and based on many discussions in the teams of psychiatric hospitals that were still functioning.

<sup>7</sup> To this list, we would add children and adolescents, especially those in a state of social vulnerability.

Undoubtedly, those most affected by the pandemic were the recurrent users of the SUS and social protection programs. Although both have proven to be absolutely necessary for their capillarity and reach, they have also been deeply overwhelmed, as well as mental health services – situations that the country is still dealing with years after the pandemic appeared, brought about by the widespread and, in some way, late vaccination.

In 2022, with the new election of Luiz Inácio Lula da Silva for his third term, there was a promise of significant change in mental health policy since the government transition process. In fact, almost three years later, we have observed some resumption of investments to strengthen RAPS, as well as the recomposition of policies for alcohol and drugs from the recreation of the Department of Mental Health in the Ministry of Health. However, the issue of TCs still persists, as also in 2023, a support department for this equipment was created within the Ministry of Social Development (MDS). In view of this, we expand the discussion on TCs, their field and method of action.

### **3 THE NEW TCS FOR DRUG USERS AND THE OLD ASYLUM MODEL**

According to Amarante (1995), the first TCs appeared in Europe based on the same criticisms that supported the Psychiatric Reform Movement. In Birmingham, England, T. H. Main called a work he developed at the North Field Hospital, with psychoanalysts Wilfred Bion and Erich Fromm-Reichmann, for the treatment of soldiers affected by psychic suffering after World War II, the Therapeutic Community. However, the term would have been consecrated by Maxwell Jones – a South African psychiatrist based in the United Kingdom – with the theorists cited above as a basis:

[...] the term therapeutic community comes to characterize a process of institutional reforms, predominantly restricted to the psychiatric hospital and marked by the adoption of democratic, participatory and collective administrative measures, aiming at the transformation of the institutional dynamics of asylum (AMARANTE, 1995, p. 29).

With the introduction of operative groups, Jones' proposal dealt with the summoning of patients to the place of subjects in their treatments, establishing, with all those involved – from physicians to support workers – the democratization of access and institutional opportunities as the focus of work (DE LEON, 2003). Subsequently, institutions named in the same way emerged in the USA, but distanced from the original proposal, both in terms of the target audience – which began to be composed of drug users – and in terms of methodology

and work premises – restricted to the asylum model and the Twelve Step method. Popularized by Alcoholics Anonymous and Narcotics Anonymous (A.A. and N.A.), this method is guided by the strengthening of identifications among the members of the groups, called brotherhoods, who must comply with a sequence of twelve steps to control what they name, based on medical knowledge, chemical dependency.

With drugs at the center of the proposal, elevated to the category of enemy – the same *modus operandi* advocated by the American War on Drugs policies –, phrases such as "I am a recovering drug addict", "alcoholism is a chronic, incurable disease", "just for today", "avoid people and places" and "I must admit that I am powerless in the face of drugs", commonly said in meetings and outside them, they reinforce the character of bonding to illness and moral weakness. Oscillating between a sick person and a social scourge, their bodies are always taken as objects subject to intervention by knowledge such as medicine, justice, public security or religion.

Amarante (2007, p. 19) points out that there is, in the practices of mutual aid groups, an emphasis on the "loss of control of the person in relation to the substance and the surrender to a 'higher power'", which evidences a practice of "confessing oneself to others". This same point is highlighted by Fossi and Guareschi (2015, p. 94), when they situate the practices of TCs as confessional, by evidencing "the articulation between religious morality, discipline technologies and biopolitics" in the treatment of drug users. In Brazil, TCs arrived around the 1970s and were established as a model very similar to the North American one, therefore absolutely different from the European one. Based on an important survey of the first TCs in Brazil, Alberti and Bastos (2019) point out that, of the first six, only one differed from the American project, while the others remained anchored in the paradigm of religious morality that still sustains them today.

Integrating the RAPS since 2011, the TCs are defined as "points of care of the Psychosocial Network in residential care of a transitory nature" (BRASIL, 2011), despite having absolutely divergent orientations from the other devices of the same network. On the Federal Government website, we find the following definition for TCs:

[...] private, non-profit entities that provide free shelter for people with disorders resulting from the use, abuse or dependence of psychoactive substances, in a transitional residential regime and exclusively voluntary (spontaneous). The reception period varies from 3 months to 12 months, depending on the entity's therapeutic project. The main instrument used in the Therapeutic Communities during treatment is the coexistence between peers. The Therapeutic Communities are not part of the

Unified Health System (SUS) or the Unified Social Assistance System (SUAS), but they are equipment of the supplementary network of care, recovery and social reintegration of addicts of psychoactive substances, so that these entities are part of the National System of Public Policies on Drugs – SISNAD, by virtue of Decree No. 9,761/2019 and Law No. 13,840/2019 (BRAZIL, 2025, n.p.).

To demonstrate how they are inserted in Brazil, we will start from three important reports: the *Profile of Therapeutic Communities in Brazil*, carried out in 2017 by the Institute of Applied Economic Research (IPEA) and commissioned by the National Anti-Drug Secretariat (SENAD); the *National Inspection Report on Therapeutic Communities*, prepared by the Federal Council of Psychology (CFP), the National Mechanism for Preventing and Combating Torture (MNPCT) and the Federal Prosecutor's Office for Citizens' Rights of the Federal Public Ministry (PFDC/MPF); and the report *Public Financing of Brazilian Therapeutic Communities between 2017 and 2020*, produced by Conectas Human Rights and the Brazilian Center for Analysis and Planning.

With the asylum model, with long and predetermined hospitalizations, in TCs "the deprivation of liberty is the rule that sustains this model of care" (CFP, MNPCT; MPF, 2018). In all the TCs inspected by the *National Inspection*, walls, locks, bars, security guards, retention of documents, bank cards and restrictions on means of communication were found. Without the consent of users, more than 80% of hospitalizations are carried out or interrupted by family members (IPEA, 2017), depriving them of their most fundamental rights and, of course, not considering them subjects.

Reports of compulsory hospitalizations – **or of initially voluntary hospitalizations converted into involuntary ones through** dissuasive practices, retention of documents or contractual fines – are common and are added to other complaints: mechanical or chemical restraints **carried out** by the inmates themselves; internments of adolescents to comply with socio-educational measures **without any integration into the formal education** system; and the practice of medicalization without a medical prescription, **even reaching the participation of users in the dispensation of medicines**. The facilities, often **located in areas of difficult access and far from any public policy**, promote isolation and the rupture of social ties, with several users – the elderly, in particular – **living in the TCs**, some without any issue related to drug use, **but only because of their condition of vulnerability** (CFP, MNPCT, PFDC/MPF, 2018).

Spirituality is described **as directly linked** to religious institutions, especially neo-Pentecostal evangelicals, **basing** the "recovery" of inmates on the divine order and placing

religiosity as an objective criterion of access and permanence, in affront to Article 5 of the *Constitution* (BRAZIL, 1988). In addition, religious rites are often used as practices of embarrassment, punishment and torture in the face of disobedience to institutional rules and/or as forms of conversion, including the so-called "gay cure" <sup>8</sup> <sup>9</sup>(CFP, MNPCT, PFDC/MPF, 2018).

Work, another of its pillars, is named as labor therapy – the use of work or some craft as a form of treatment. However, observation shows that this practice is used without any purpose of social reintegration or learning a new trade. On the contrary, the reports point to its forced and unpaid use, either as a method of punishment or to favor coordinators or owners of the institutions through profit. Labor therapy, therefore, functions as a veil that covers the practice of exploiting labor in precarious, mandatory conditions analogous to slavery.

The last pillar, discipline, is not disconnected from the previous ones, as several disciplinary practices are used for a supposed pedagogical and/or therapeutic purpose, although they are only configured as punishment and/or torture: mechanical and/or chemical restraints; isolation and confinement for long periods; sleep deprivation; suspension of alimony; physical and psychological violence. The reported practices flagrantly violate article 2, sole paragraph, item II, of Law No. 10,216/2001; article 20, item IV, of Anvisa's Resolution RDC No. 29/2011; and the Penal Code (BRASIL, 1940). All these rules prohibit the use of physical, psychological or moral punishment by institutions, even for people with disorders resulting from the use of alcohol and other drugs.

The funding of TCs usually comes from federal, state, municipal and private sources. Based on data from the Ministries of Health and Citizenship, between 2019 and 2021 there was an increase of about 65% in funding for TCs and, on the other hand, CAPS ad had a growth of only 11% in the same period. From the point of view of financing, TCs can be considered public facilities; however, a public policy needs to be based on institutional rules, target audience and clearly delimited objectives, in addition to obedience to the principles of transparency and publicity of its actions and resources, as determined by the *Constitution*

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<sup>8</sup> The gay cure was a terminology that became known after parliamentarians tried to pass a bill in Congress that would allow psychologists to practice sexual reversal therapies, where subjects with homosexual sexual orientation would be converted to heterosexuality.

<sup>9</sup> On this, see the article shown on Fantástico – a Rede Globo program – which showed the use of work and torture mechanisms as punishment for inmates, including in TCs coordinated by Brazilian politicians, such as Pastor and Sergeant Isidório de Santana – federal deputy with the most votes for Avante da Bahia, owner of a TC – who appears with a machete in his hand, named as a "psychiatrist", uttering several homophobic insults to the inmates: Available at: <https://www.youtube.com/watch?v=JTYFhdKG-yw>

(BRASIL, 1988) and the *Fiscal Responsibility Law* (BRASIL, 2000). Furthermore, the way TCs are organized in Brazil prevents the construction of a clear typology that classifies them as health or care equipment, as they do not establish the necessary criteria for classification in any of these areas, favoring the difficulty of inspection. In their vast majority, TCs are institutions of a religious nature and, therefore, considering them as health institutions, within the scope of the SUS, is absolutely serious, as it violates the constitutional principle of secularism.

Human rights violations were found in all the institutions visited by the *National Inspection* (CFP, MNPCT, PFDC/MPF, 2018). Deregulation or weak regulation of any institution creates opportunities for illegal or criminal activities in these spaces. By being financed by the government without the proper legal criteria, TCs are left on an institutional edge: at the same time that they receive public funding, they are outside the fundamental rules that constitute a network for the promotion of care and health rights, precisely the greatest promoters of rights in the country. The government is financing private institutions without articulation with the systems that have their network spread throughout the country and obey extremely strict requirements.

We know that hospitalizing people with mental disorders and/or drug use has always yielded and still yields a lot of money to this day in Brazil, even at the expense of a lot of violence. In view of the foregoing, added to the fact that we still have more than 2,000 TCs in activity in the country, it seems clear to us that the marketing intention at stake in these institutions is clear. It is extremely serious that subjects – regardless of whether they use drugs or not – are exposed to the conditions reported in these documents so that a few people profit and enjoy them in such cruel ways.

In 2024, already in the current government of Luis Inácio Lula da Silva, the National Council of Social Assistance began not to recognize TCs as social assistance organizations, demanding their disconnection from the Unified Social Assistance System (SUAS). Thus, the TCs could no longer receive resources from the National Social Assistance Fund. As a result, it was possible to cancel the Accreditation Notice 8/2023 (BRASIL, 2023) – the main financing instrument, which already had the accreditation of 585 TCs – by Ordinance 1,104/2025 of the Ministry of Social Development (MDS). This decision responds to the demands of several anti-asylum movements and reinforces the importance of inspection and social control bodies, such as the Councils, and their actions with entities and parliamentarians, with a view

to guaranteeing care in freedom, community and territorial, as recommended by the 1988 Constitution.

#### **4 HARM REDUCTION STRATEGIES: A BET ON THE ETHICS OF THE SUBJECT**

Born in the international context, Harm Reduction (DR) strategies are widespread in several countries as part of the policy of care for drug users in the field of health. In a more comprehensive and continuous way, the beginning of HR as a policy in the 1980s, in the Netherlands, is recognized; However, some previous practices already presented their principles as a bet, even without yet receiving a formal conceptualization.

**As psychoanalysts, however, it seems essential to remember that, in Freud's biographies (JONES, 1953; GAY, 1989; ROUDINESCO, 2016), we find the well-known and controversial episode involving cocaine. In 1884, still a young doctor in Vienna, Freud began studies on the substance, recently isolated at the time and considered promising for various medical applications. Motivated by scientific enthusiasm and the desire for academic projection, Freud tried the drug on himself and prescribed it to Ernst von Fleischl-Marxow, a physiologist and his former teacher. Published in the article *Über Coca*, Freud (1884/1962) defended its use to treat fatigue, chronic pain, depression and, especially, as a substitute for morphine.**

Initially, cocaine allowed Fleischl to reduce his morphine use<sup>10</sup>, but it quickly led to a new dependence, accompanied by symptoms triggered by the systematic use of the substance, such as paranoia and physical deteriorations. Fleischl died in 1891 and the episode generated criticism of Freud's conduct, later being called the "cocaine scandal". Despite the negative developments, Freud's studies indirectly contributed to Karl Koller, a close colleague, discovering the use of cocaine as a local anesthetic in ophthalmology, later also used in the treatment of migraines. Freud, throughout the 1890s, gradually abandoned the use of the drug and began to avoid the topic in his later writings.

Subsequently, two specific situations deserve to be highlighted. The first, which occurred in England, concerns soldiers who had left the First World War (1914-1918) who, after having their wounds treated with morphine and other opioids, became dependent on these substances provided by the State itself. In view of this, a group of

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<sup>10</sup> Analgesic drug – from the group of opioids – used to this day for the relief of intense, acute and chronic pain, which has great potential for dependence due to the immediate sedative effects.

ex-combatants demanded the continuity of the supply, in order to avoid the damage resulting from an abrupt withdrawal or the need to resort to the illegal market. This care strategy was formalized by the Rolleston Report <sup>11</sup> (Great Britain, 1926), which recognized the possibility of mitigating harm and reducing harmful effects associated with the use of these substances (SANTOS; SOARES; CAMPOS, 2010). The second situation refers to the emergence of methadone<sup>12</sup>, between the 1930s and 1940s, in Germany, proposed as a strategy to replace heroin<sup>13</sup>.

In the 1980s, Junkiebond, a Dutch association of drug users and former users, faced with the spread of sexually transmitted infections (STIs) through the sharing of contaminated syringes, demanded that the State adopt public policies that mitigate the risks of contamination and deaths, without the interruption of use being an imposition. Faced with the concern – especially about the transmission of Hepatitis B and AIDS – the Dutch government implemented the first Syringe Exchange Program (STP).

In the following decade, the cities of Santos (SP) and Salvador (BA) managed to implement the first STPs in Brazil, with the main target being the population that used injectable cocaine and controlling the spread of STIs. This scenario gains a fundamental boost when, in 2003, HR actions are no longer just a strategy of the STD/AIDS program and start to serve as a guide for the Ministry of Health's Policy for Care for Users of Alcohol and other Drugs within the scope of the SUS. According to Passos and Souza (2011, p. 154), HR can be defined as "an alternative health production strategy to strategies based on the logic of abstinence, including the diversity of demands and expanding health offers for the population of drug users".

The field of the SUS is the condition for the existence of HR. There is no possibility of thinking of a strategy like this other than for comprehensiveness, gratuity, capillarity and the intersectionality of the articulations of the SUS with the other public policies of the State. Contrary to neoliberal projects, the SUS, in its perspective of universality as a basic right, is

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<sup>11</sup> The *Rolleston Report* was a set of recommendations made by a commission chaired by the UK Health Minister, Humphrey Rolleston, which authorized British doctors to prescribe opium to addicts at risk.

<sup>12</sup> Analgesic drug – from the group of opioids – with effects similar to those of heroin and morphine, still used today in DR strategies as a substitute for the latter because it has less sedative effects.

<sup>13</sup> In his book *High Hitler: how the use of drugs by the Führer and the Nazis dictated the course of the Third Reich*, Ohler Norman (2017) reports that there are journalistic findings narrating the emergence of Methadone in studies commissioned by Hitler, due to the abusive use of drugs by German soldiers and his own use. However, it should be noted that the Nazi regime adopted a very prohibitionist stance, executing many drug users in concentration camps.

opposed to a system that can function as a service provider that considers health to be an access only for those who can pay for it, that is, a market product.

In *The Peripatetic Clinic*, Lancetti (2012) describes HR strategies as capable of providing another way of apprehending drug users, in which many subjects could be included and recognized as inhabitants of the city in fact, even if in different ways. The creation of the figure of the harm reduction professional, a health agent that often has a close relationship with the territory, allowed the offer of care to the most segregated places: the alleys of the favelas, the streets where residents, prostitutes, transvestites, wanderers live – mostly black and poor – that is, where the scenes of use are, both people in great social vulnerability and those who, for various reasons, do not want to interrupt consumption. By this same logic, the knowledge that sustains HR is not the property of specialists. They come mainly from users, former users, family members and residents of the territories and places of consumption.

Among the various strategies that the HR clinic presupposes, we can mention the practices of disseminating information about the harms and techniques linked to the use and referrals, such as guidance on rights, prophylaxis, distribution of inputs, drug substitution therapies and assistance (BRASIL, 2005). As a practical and theoretical strategy guided by an ethics of care and by a conception of drugs as part of the human experience, HR is guided by the reduction of risks linked to this reality (TORRES; VIDAL, 2017). Thus, the bond between the user and the figure of the harm reducer is an essential part of the work of building or reconstructing a bond that allows the drug user to invest in the social bond, from which he is often precarious or separated. Therefore, although it is common to hear that HR is an "incentive to use" or mere substitution of drugs, it is essential to highlight that it can presuppose substitution, but it is not a synonym for treatment by the object. Treatment from HR necessarily involves transfer with professionals and decisions proposed and constantly rethought. As Laurent (2008, p. 15) points out:

There is also processing by object, by objects of substitution. 'You are a heroin addict, let's propose Methadone or Subutex. This substitution is less deadly, it gives you access to a legal object, to rights, there is a social status'. It is a way of rewriting the subject separated from an entire discourse, in a social bond.

Therefore, if all the definitions of objectives, goals and procedures are not imposed, but discussed, even substitution is thought of in the uniqueness of each case, as well as abstinence, which can be a goal, an end or even its beginning, never the only strategy. This

decision is up to the subject and may or may not be part of his/her therapeutic project, which, established on a case-by-case basis, aims at self-care and autonomy over treatment and use. What is at stake in a practice that, guided by the clinic, proposes to reduce harm, is precisely the implication of the subject and his responsibility and not the offer of a tutelage that fixes him in the place of object of intervention.

The construction of the singular projects, carried out in partnership with the RAPS devices, is essential for the implementation of the strategies, based on **the treatment of the case by case**. In this context, in addition to ensuring rights, it seeks to **consider the user as the protagonist** of his own treatment, bringing him, at this point, closer to psychoanalysis. It is not, obviously, a matter of equating the two fields, but of **thinking about parallels** that structure the clinical and political strategies of HR – through the subject's knowledge about its use – and psychoanalysis based on unconscious knowledge and the position that drugs occupy in their libidinal economy. The articulation between clinic and politics has been highlighted since Freud (1919 [1918]/2020) as the one that made it possible **to listen to segregated subjects**, reaffirming the analyst as the guiding thread of this process that, based on his desire, allows psychoanalytic listening to be present in any device. As Elia (2000, p. 28) points out and defends:

It is thus possible to do psychoanalysis in any social stratum, in any institutional environment. As long as there is an analyst, on the one hand, and a divided subject, on the other. The analyst should not confuse his criteria with social criteria. Thus, elitism is demonstrated here as impossible in a psychoanalytic posture.

Even when it is a demand that, initially, is configured as a request for a guarantee of rights – frequent in psychosocial care – the psychoanalyst must operate with his clinical and ethical rigor. Especially because this may be the only way in which these people can address some demand to us, since most of these subjects still do not reach private offices. Warned of its listening function, however, the bet needs to be guided by the emergence of a subject, even in the most adverse conditions. If, with the use of drugs, what is intended is the placation of the malaise, the bet of psychoanalysis needs to be to construct new possibilities that point to another way of treating this malaise: through speech and including its partialization.

As much as we can hear them in their discourses from a set that identifies them and presupposes them as equals – drug addict, addict, drug addict, pothead, drug dealer – drug abuse does not define these subjects (MARTINS, 2011). When we propose to listen to their



stories in the clinic – whether in the public or private field – we perceive the existence of an initial discourse, promoting a certain collage between the subject who uses it and the object-drug used, as if he were submerged there. Thus, they present themselves only by their uses, by a mode of jouissance, petrified into signifiers and linked to an identification with a name that, by itself, says nothing about the subject (ALBERTI, 2003). Therefore, it is essential to call on them to talk about their uses, but, above all, about their stories that are not limited to drugs. Starting from the singular of each case, it is the signifiers that emerge in the speech of each subject **that interest us:**

The subject is therefore always supposed. We do not find it in reality, but we suppose it. Or rather, we are forced to suppose it from the moment we recognize the incidence of the signifier in human experience, that atom of the symbolic which, because it has no meaning in itself, summons, in the living being, when it is speaking (that is, when it is inhabited by the symbolic), the response that is called the subject. We are forced to suppose the subject when we recognize the signifier because, in fact, it is the signifier (and not us) who presupposes the subject. The subject is, therefore, a supposition of the signifier, which imposes itself on us (ELIA, 2010, p. 70).

The subject is constituted by signifying marks that will be placed in a chain: "everything that is language is obtained from this alterity, and it is for this reason that the subject is always an evanescent thing, which runs under a chain of signifiers" (LACAN, 1976, p. 206). If there is no relationship between the subject and the drug-object that does not occur in the field of the symbolic, as psychoanalysts, then our work in any device needs to be an invitation to speak. Only with the sliding of the signifying chain, proposed by the free association, can the subject's ills and problems appear. In no way are they limited to drugs, but they certainly converge to their relationship with the Other and to the anguish in the face of castration.

The universalization present in groups and institutions operates by suppressing differences and subjectivity, which ends up opening space for segregation. Alberti and Figueiredo (2006) point out that perhaps the greatest lesson of psychoanalysis in a public field such as mental health is to retreat from what is daily imposed as an attempt at understanding, letting each subject, in his or her own time, conclude something about himself that brings a singular mark of jouissance. In this way, the exercise of psychoanalysis in the institution requires the presence of an orientation committed to its theory, its clinic and its particular ethics, "in order to underline its specificity in contributing to the support of the patient and user of the services as a subject" (ALBERTI; FIGUEIREDO, 2006, p. 14).

Thus, the ethics of psychoanalysis can never be regulated by a norm, nor according to the requirements of the ideals of the professionals or of the institution itself. By understanding symptoms as formations of the unconscious and not being guided by their immediate suppression, psychoanalysis ends up operating against what institutional mandates preach. As a challenge, there is the hole in the norms, making the case by case prevail, listening to the unconscious, pointing out the impossibility of dealing with all the issues, that is, healing as a path to normality. If we think of the offers of public policies based on the cessation of malaise, they will always be seen as failure; Therefore, our bet not only includes malaise as a possibility, but as an inherent one.

## 5 FROM THE MALAISE IN CULTURE TO THE MALAISE IN DRUG POLICY

For two years, we were a professor and preceptor of medical students at UFRJ – Macaé Campus – in a CAPS ad, where we heard from many students that the work in that equipment was to "dry ice", "rain on the wet", "without effectiveness". The malaise of future doctors arose in the presence of users in the institution under the influence of drugs, reporting their "relapses", missing appointments, circumventing medications – not taking them or exceeding use – that is, not remaining abstinent. In view of their mandates to heal the organic body – learned in the eight periods that preceded their "passage" through the chair of Mental Health – it was very difficult to introduce a cut that could lead them to understand that, for some subjects, seeking care during or after use, or offering them a break in this use by listening to or caring for the body – even if for a few hours – represented the possibility of building new paths *a posteriori*. In addition, as an "open-door" service, the CAPS was also a space of circulation **not restricted** only to those who interrupted drug use. On the contrary, guided by HR and, as psychoanalysts, we knew that dealing with drunkenness, intoxication, agitation, drowsiness and other effects was included. Welcoming them in this way was a gamble... And this is no small feat.

Having contact with mental health only at the end of graduation, they brought the strangeness that Paula, a student was able to express:

We spend almost five years just learning how to diagnose and treat organs and, when we get here, do you tell us that we have to listen to the subject? I'm trying, it has moved me in many ways, but many colleagues don't see the slightest use in it and I understand them.

At the time, there was a discussion at the University about the possibility of anticipating the contact of academics with mental health earlier, but, for this, it was necessary for other professors to give space, which did not happen. At that time, of the six mental health professors, there were two psychoanalysts and, at CAPS ad, two others. Therefore, the insistence on "listening to the subject" was an offer that, based on their own anxieties, caused desire in some students. The medical course is marked by the presence of knowledge that seeks, in various ways, to veil any possibility of absence. It is not by chance that the overwhelming anguish of the students was almost always followed by numerous defenses in the face of the impossibilities that the education itself imposes. In Paula's words:

I took three years of prep school to get here, it was a dream, but I saw all my ideal quickly unravel. Most teachers are happy to take us close to giving up, and this possibility is like a little voice in the back of my head. I sought analysis to remind myself weekly of why I am here. I saw up close that this is unbearable for some.

At the beginning of that semester, a classmate of Paula's died when he threw himself from the tenth floor of the student dormitory where he lived. This was already the third case since she started college. However, Paula was able to bet on her desire and, perhaps because of this, she was also able to see mental health and HR as a bet. From that same class, another student, after a class on drug policy and many questions about its "effectiveness", said: "I don't understand spending money on those who don't want to be treated. Either you can intern or do as the governor said: 'just aim at the little head and...". The student was referring to a speech by the former governor of the state of Rio, Wilson Witzel, in 2018<sup>14</sup>, about how the police should act in the face of any subject who was in a situation of suspicion. His words bothered part of the population, but he was acclaimed by another significant portion that brings in its bet the possibility of executing people based on the premise "a good criminal is a dead criminal". This *modus operandi* of the State is affirmed based on another Brazilian mark: that the "good citizen" is the only one who can enjoy the right to circulate in the city. The others, including drug users, the insane, the black and the poor, need to gain destinations out of their sight.

In view of such reports, we recall Foucault (1972/2004), in *History of Madness*, when he brings that, in the eighteenth century, with the beginning of the so-called industrial

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<sup>14</sup> See: BARREIRAS, G. Declarations and striking images of Wilson Witzel's government. G1, Rio de Janeiro, April 30, 2021. [www.g1.globo.com](http://www.g1.globo.com). Available at: <https://g1.globo.com/rj/rio-de-janeiro/noticia/2021/04/30/declaracoes-e-imagens-marcantes-de-governo-de-wilson-witzel.ghtml>.



capitalism, work began to have an attribution of value that raised it to levels not seen before. On the other hand, poverty, which had a certain value in Christian discourse, began to be depreciated. In this way, the portion of the population that could not adapt to the world of work – the insane, beggars, prostitutes, carriers of contagious diseases, the disabled, delinquents, among others – became the target of hygienist measures. The author calls the period in which madness, before being a medical object, was treated as a moral and social problem a "major internment".

In the nineteenth century, the new parameters of modern and positivist science required medicine to undergo a reformulation, structuring methods of knowledge based on experimentation, which modified the teaching of the profession with a view to standardization. In this scenario, figures such as Philippe Pinel appeared, sustaining a psychiatry that inaugurated a field of knowledge aimed at treating madness as a mental illness, aiming at the transformation of unreason into an object of normalization. Thus, both "the great internment" and this medical and positivist science are part of a perspective of power in which submitting difference to the norm is its motto, whether by exclusion or pathologization.

Throughout his work, Foucault demonstrated a deep interest in the relations between power and knowledge, alluding to the exercise of power as something that is only possible through the use of knowledge as an instrument of justification. In other words, authoritarian practices of segregation, monitoring, and control of bodies are legitimized in the name of a single, constructed truth. Thus, Foucault (1978, p. 3) developed the concept of biopower as "the set of mechanisms by which what, in the human species, constitutes its fundamental characteristics, will be able to enter into a politics, a political strategy, a general strategy of power". The production of a knowledge-power over life, therefore, regulates it, producing discourses about what we understand as health, disease, treatments and sexuality.

Nowadays, an increasingly biologizing psychiatry moves away from clinical practice that includes listening, symptom support, and the management of anguish, in favor of a close alliance between science and contemporary capitalism, or rather, the production of a science at the service of capital. With the massive production of objects of consumption – *gadgets* – that aim to buffer any lack, capitalism produces drugs and, later, diagnoses so that drugs can be consumed or to make subjects more adequate and functional.

Returning to the Freudian text of 1930 to establish a dialogue between malaise and the so-called civilizational progress, Lacan (1967, unpublished, p. 29-30), in *A short speech to psychiatrists*, says: "the progress of universal civilization will result not only in a certain

malaise", but in a "practice, which they will see will become more and more widespread, which will not immediately show its true face, but which has a name that, transformed or not, will always mean the same thing: segregation". Then, he warns by saying that thirty or fifty years later history will demand a position from psychiatrists:

My God, the dear psychiatrists, in fact, give us a small model of what could have been done at that moment as a cogitation that could have been useful for us, but in fact they did not give it to us, because at that moment they slept, they slept, why? My God, because they never saw very clearly what was about their relationship with madness after a certain period; they did not see it, God knows why, it will be said, they did not see it precisely because they had the means to see it (LACAN, 1967, unpublished, p. 30).

Lacan states, therefore, that, instead of dealing with the effects of segregation, psychiatrists remained asleep, even though they had at their disposal the means with which they could do so, that is, psychoanalysis and its ethics. Instead of making it an instrument, they preferred to use it as a means of social ascension. More than fifty years later, what we are witnessing is psychiatry becoming more and more involved in its biologization, having diagnostic manuals as its main tool of care, leaving listening out of this process. They thus present themselves as the "gold standard" of a science that, without any constraint, joins capital with the same intention: to tame bodies and try to transform them into universals.

When referring to the relationship between psychiatrists and the madman, Lacan (1967, unpublished) says that other barriers were placed in place of isolating him, and it was no longer necessary to asylum the madman to make him docile. Psychiatry, rediscovering its purpose of being equivalent to a framework of general medicine, entered entirely into the pharmaceutical dynamism, replacing the clinical experience with the insane by its apprehension as an object of study and psychopharmacological experimentation. For a long time, science had already sought to correct the flaw that madness opened, all with the same intention: to universalize and seek the isolation of a "pure subject" (LACAN, 1967/2003, p. 28).

In *the Proposition of October 9, 1967 on the psychoanalyst of the School*, Lacan (1967a/2003) makes a new reference to an expansion of the processes of segregation as a consequence of the universalization introduced by science, taking the concentration camps as the basis for his discussion. He thus states that what we saw emerge in these places:

It represented the reaction of precursors in relation to what will develop as a consequence of the relocation of social groups by science and, nominally, of the universalization that it introduces there [...] Our future of common markets will find its balance in an increasingly harsh expansion of the processes of segregation (LACAN, 1967a/2003, p. 263).

The total institutions, named by Goffman (1987) from asylums, prisons and convents, gain new faces in Brazil with the TCs, which unite, at the same time, the moral, the religious and the medical/psychiatric discourse. We cannot fail to emphasize that the large audience of these institutions is composed of people in social vulnerability: the poor, the homeless, the unemployed – a population that, in Brazil, crosses the racial profile, a legacy of centuries of slavery, that is, of a regime that was made at the expense of the domination of a population that to this day lives its effects. Thus, the population from which a framework is most expected is also the most susceptible to drug abuse. Consequently, these people will be the priority target of totalizing policies, who will serve as slave labor in the large internments promoted by the State – in alliance with the churches and psychiatry – in the TCs. Therefore, if we can compare the TCs to the concentration camps – as some professionals committed to mental health policies and some activists have pointed out – due to the dozens of complaints exposed above, Let us not forget that there is a lot of slave ship in them.

In *Terminable and Endless Analysis*, when talking about the offices of governing, educating, and analyzing, Freud (1937/2020, p. 249) told us that they "can be given in advance the insufficiency of the result". In this way, it places them as impossible. This premise has an intrinsic relationship with the first developments of the theory of drives, when it affirmed the child as a perverse polymorph. Being always subject to the omnipotence of the pleasure principle, there is something of the drive impossible to master, expressed in the goal of the drive, that is, satisfaction. If the drive is what moves, impels the subject in one direction, it seems an impossible task to summon it to an order, to a norm and to a continuous well-being, that is, to educate it. Moreover, if satisfaction is the goal of the drive, its target – the object –, as we learned from Lacan (1964/1998), is always a void, a hollow – represented by the object *a* –, marking the partiality, the mismatch and its return. The impossible encounter institutes the compulsion to repetition, leaving a remnant that, by insisting, led Freud to the concept of the death drive.

In 1930, Freud pointed out malaise as a constant process that the subject will have to deal with throughout life as part of the instinctual renunciation necessary for the establishment of the social bond. With this, Lacan introduced the field of jouissance from the concept of

object **a**, and, moving forward, he was able, in *The Seminar, book 16: From an Other to the Other* (1968-69/2006), to bring discourse as a position that the subject occupies in language, situating it beyond speech. As a form of social bond, discourse contains an impossibility, through which it will introduce, once again, the object **a**, this time as the surplus-of-jouissance: "a function of renouncing jouissance under the effect of discourse" (LACAN, 1968-69/2006, p. 19). The concept of surplus-de-jouissance is brought by Lacan as a homologue to the concept of surplus-value, that is, made "of the same fabric, insofar as it is the scissor cut of discourse" (LACAN, 1968-69/2006, p. 45).

The concept of surplus value is introduced by Marx (1867/2008) as the alienated labor that the subject provides to the capitalist, that is, to those who own, accumulate capital and pay a small part to those who produce it. It is a disparity between the wages paid to the proletarian and the value of the labour he produces. Surplus value, then, is the profit of the capitalist, the profit granted by the worker to the capitalist, the extra time of work of the proletarian who increases the capital of those who own the means of production. Where there is profit as a goal, there is necessarily surplus value as an operator, an integral part of the organization of the capitalist system that aims at the production of a profit that will be infinitely reinvested, generating the accumulation of capital. Thus something of the proletarian's remuneration will always escape him, and his account will never be able to reach its true accounting. Without realizing it, the proletarian becomes the cog that sustains this system that has at its base the exploitation and delivery of capital only to the hands of those who do not produce and do not have the knowledge about production.

However, there is also a loss for the capitalist, as he will not be able to have the gear of his machine running without the labor power. A perception that the system itself seeks to cover up, creating a discourse that places the capitalist as someone who, by moving the economy, allows the creation of jobs and, consequently, guarantees the subsistence of the worker. When, in fact, this is only possible because a mass of proletarians has been created and alienated from their production. The loss is inherent, however, the capitalist system sustains a discourse that seeks to veil these holes.

The homology pointed out by Lacan (1968-69/2006) dates back to the entry of the human into language, partializing instinctual satisfaction and having as a consequence the rigging of jouissance, that is, a symbolic system that organizes jouissance by imposing a bar on it. When the law begins to organize jouissance in the social bond, it ends up delimiting what can or cannot be done, demarcating the modes of jouissance and thus producing a

deviation. It is precisely from this renunciation of part of *jouissance* that the surplus-de-*jouissance* is produced. In other words, in the illusory idea that there is something to be recovered, what is introduced for the subject is loss. If something of this *jouissance* is irretrievable, it also becomes impossible to be accounted for, despite being supposed to the subject.

The Freudian notes of 1920 allowed us to know that *jouissance* is that which escapes the pleasure principle, a principle that has as its premise the return to a previous state of tension reduced to the lowest possible homeostatic level. There is a non-taxable excess attributed to the Other that makes the account never close, leaving the subject to be infinitely indebted and articulating a relationship between *jouissance* and repetition, since it "is based on a return to *jouissance*" (LACAN, 1969-70/1992, p. 47). For Lacan, it was from this relationship that Freud found himself "in some way obliged, by the very structure of discourse, to articulate the death drive" (LACAN, 1969-70/1992, p. 47). Thus, if repetition is based on a return to *jouissance*, on a search for representation, "[...] it is from there that we start to give meaning to this inaugural repetition, insofar as it is repetition that aims at *jouissance*" (LACAN, 1969-70/1992, p. 47). In this gear, we observe the attempt to recover the lost *jouissance* impossible, an a-plus that cannot be symbolized by way of phallic signification. In this mathematics of *jouissance*, there is a mismatch that cannot be repaired, as in an exact calculation. On the contrary, in this account there will always be a remainder, an unsymbolized excess, which concerns the real, as Lacan (1968-69/2006, p. 30) points out: "In general, this is determined by the convergence towards an impossibility. That's why it's real."

When Freud, in creating psychoanalysis in an absolutely revolutionary way, brought sexuality as a drive, he showed us that, if the renunciation of a part of the satisfaction is a condition of the social bond, being in the bond will not be without discomfort, without a remainder that is precipitated and with which the subject will have to deal. It is castration itself, which, by bringing anguish as an effect, causes some subjects to resort to palliatives such as drugs, which buffer the malaise by producing sedative effects, but temporary. In view of this, in the course of listening to subjects who use drugs, it seems fundamental to us what psychoanalysis can offer by including lack – a structural and structuring loss. If the object is lost, "something else appears in the place of *jouissance*, that is, the trace that marks it. Nothing can be produced there without an object being lost" (LACAN, 1968-69/2006, p. 21).

Returning to the Harm Reduction proposal, Feldman (2014) reports experiences of DR in narco-rooms<sup>15</sup> installed in treatment centers located at strategic points in some cities in Switzerland. In them, heroin applications are provided under the care of health professionals, present throughout the "wave" of the drug, at scheduled times and modes of application with safe inputs. As they are shared spaces with other users and with the presence of a team, these equipment allow a certain ordering of use by inserting it into the social bond and the offer of better quality drugs. However, some users prefer the use of the more impure heroin, bought from dealers and consumed on the streets. Experience reports that the ethics of Harm Reduction include a policy that will never be universalizing. In the same way, we cannot infer that abstinence is so, although it is proposed.

In *Television*, Lacan (1974/2003, p. 508) teaches us that the word is always a flawed instrument, since "to tell the whole truth is impossible, materially: words are missing". Truth, therefore, is always a half-truth; the other half is unspeakable. This impossible, present in language, in the impossibility of saying it in its entirety, is the real, "that which does not cease not to be written" (LACAN, 1972-73/2010, p. 55). Thus, any public policy, any offer of treatment, needs to be considered possible only to some extent, that is, it must be thought of from a non-all jouissance. Lacan (1974/2003) also warns us not to treat the Other jouissance, that which is *heteros*, as underdeveloped, imputing to it a single mode of jouissance. With this, he reminds us that to have the field of jouissance as an ethic is to sustain castration as the way to allow each one to respond, singularly, to the non-existence of sexual intercourse. There is no perfect encounter and, therefore, the measure of each one can be, for example, the substitution of drugs, of modes of use that partialize a jouissance that has hitherto been deadly. For others, the measure may be abstinence. The fact is that there is not a single measure and that, in addition, it is not possible to prevent the subject from cumming in any way.

In the context of deep social inequalities in Brazil, it is inadmissible to treat drug use only with a proposal to interrupt use obtained through gluing to the signifier that identifies a group, punishments, forced labor, prayers and deprivation of freedom. When they return from long hospitalizations to their territories and their ills, added to the easy availability of drugs, a favorable scenario is created for the resumption of use. Therefore, the lack of a more

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<sup>15</sup> Narco-rooms or safe use rooms are health and HR facilities where subjects use drugs assisted by health professionals who will guarantee them access to adequate supplies, assistance if they need it, food and security.



comprehensive evaluation, centering on people willing to renounce drug use altogether as their only criterion for success, makes the high public investment in this model problematic. In this way, this discourse, like any other, contains a hole, although veiled by those who propose it. There are no simple solutions to complex problems. Our proposal insists on a model that includes a range of possibilities thought out on a case-by-case basis, taking into account each subject who makes drugs a palliative resource for their malaise (FREUD, 1930/2020) and the conjuncture in which they are inserted.

In view of the above, we affirm that hospitalization in institutions that violate human rights, even with medical approval, cannot be confused with treatment. It should occur only in specific, short-term situations, decided by a multidisciplinary team and, if possible, with the participation of the patient and family members, prioritizing devices such as CAPS ad III and IV and General Hospitals, in line with the anti-asylum logic. This is the logic contained in the Psychiatric Reform and Harm Reduction: a bet that moves towards policies that consider the subject in his or her dimension of care and choice. Allied to psychoanalysis, this is a bet that calls for speech and, therefore, will come up against loss, insufficiency, limitation, partiality – but also in reformulation and change, even if arduously achieved.

## **6 FINAL CONSIDERATIONS**

In 1913, with *Totem and Taboo*, Freud presented us with the myth of psychoanalysis through the murder of the father by a brotherhood that saw itself excluded from access to jouissance. In addition, he pointed out to us the creation of totemic systems as an affirmation of solidarity, with laws and protection mechanisms that prevent the other from being taken as an object of jouissance – that is, that prohibit because, first, they attest to and recognize the human as a being capable of killing another human. If the drive tendency aims to "treat the other as an object to be consumed: sexually and fatally" (QUINET, 2006, p. 17), the drive renunciation is the condition for the maintenance of the civilizing pact. Therefore, rethinking the laws and apparatuses that we are willing to create becomes urgent.

The call of public policies needs to be based on Eros, on the invitation to speak, on what binds and relaunches the subject in life. In this dynamic of representations that is unleashed, anything can come as a novelty, as knowledge that is not known, unconscious, even if partial, insufficient and limited, but without disregarding the insistence of the death drive, the impossibility of educating, governing and analyzing, that which escapes the significant knowledge and which, therefore, is not-all. And, once again: this is no small thing!



It is about the defense of secular, community and territorial care offers – which include the unconscious as a territory – that respect constitutional rights and promote the integrality of public policies.

With regard to mental health, alcohol and other drug policies, we already have a path that points in this direction. We need to take it up again with determination, betting on the constitutional and democratic ideals of the Psychiatric Reform in its relationship with the clinic and politics. Starting from social struggles that included users, family members and workers, listening to these actors was, for a long time, the north in the construction of psychosocial care devices. With the setbacks, we have seen that they occur precisely to the extent that one tries, once again, to exclude the subjects from this process, using, for this, discourses that objectify them. If change is only of interest to the proletariat, as pointed out by Marx, it is once again up to the same actors to fight for the reorientation of these policies. As Lacan had already said in 1967, here, psychoanalysis has much to contribute.

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