

From the psychosocial paradigm to religious morality: ethical issues in mental health

Adriana Dias de Assumpção Bastos (<https://orcid.org/0000-0002-3158-2635>)¹
Sonia Alberti (<https://orcid.org/0000-0002-5120-5247>)¹

Abstract *When therapeutic communities (TCs) began to emerge in Brazil in the 1970s, drug policy was the concern of the justice sector and aligned with prohibitionism. In the wake of political liberalization in the late 20th century and mental health reform, policies targeting drug users have now become the concern of the health sector. As a result, two antinomic paradigms have emerged within public health management: the prohibitionist paradigm and the psychosocial paradigm. The discussion of public funding of TCs is currently gaining prominence in Brazil. This raises new ethical issues concerning the limits between the public and private spheres within health governance. By exploring the role of these communities, it was possible to gain insights into their history in Brazil, their connections with religion, and the findings of TC inspection reports. The research methodology consisted of a systematic review of different data sources, including articles, books, websites, newspaper articles, TC inspection reports, and the internet. The findings show that there is a resurgence of the prohibitionist paradigm associated with religious morality, which is corroborated by researchers currently discussing policies targeting drug users.*

Key words *Health Policy, Drug Users, Mental Health Services, Therapeutic Community, Religion*

¹ Faculdade de Psicologia, Universidade do Estado do Rio de Janeiro. R. São Francisco Xavier 524, Maracanã. 20943-000 Rio de Janeiro RJ Brasil. adrianadab@gmail.com

Introduction

As workers and researchers in the fields of mental health and drug policy research since 2005, we have accompanied the progress and setbacks in public health management. We witnessed harm reduction take shape as a policy guideline and in everyday practice with the expansion of the network of psychosocial care centers (PSCCs) after their creation in 2002¹. With this, we observed the consolidation of psychosocial care, constituting a major step forward within the field of mental health, which, as will be seen below, is corroborated by the analysis of the laws that govern the field of alcohol and other drugs.

Alongside the consolidation of psychosocial care and harm reduction policy, the so-called “therapeutic communities” (TCs) have gained prominence in recent years, becoming “points of care in the Psychosocial Care Network (PSCN) for transitional residential care”² in 2011. However, unlike PSCCs, TCs do not take a harm reduction approach. Nevertheless, patient care has become divided between TCs and PSCCs and other facilities that follow the same approach as the latter. Since they are private institutions that receive public funding, TCs are distinct from the public facilities created under the 2001 mental health reform. In this respect, the marked differences between the approaches adopted by the PSCCs that treat alcohol and drug users (PSCCads) and TCs has become increasingly evident.

The implementation of the harm reduction approach has faced a number of challenges, including the social stigma attached to drug use that unfortunately still endures today. At the beginning of the 21st century – when harm reduction began to gain prominence, acquiring the status of a Ministry of Health policy guideline – the culture of hospitalization was particularly predominant and today remains part of a deeply rooted discourse, which, as our research findings show, seems to be once again gaining force. As a result of this discourse, admission to TCs has now become the new (old?) motto for the treatment of drug users.

The principles underlying the ethical, clinical and political paradigm of psychosocial care shaped from the onset of the 2001 mental health reform are “deinstitutionalization, freedom, autonomy, and citizenship”³(p.1456). It is these principles that underpinned Brazil’s harm reduction policy introduced at the beginning of this century, providing the basis for the work of the PSCCs. One of the guiding questions of the present

study was: how can we maintain harm reduction at a time when priority is given to the funding of private institutions, which, as it will be seen below, adopt a psychosocial perspective that is markedly different from the psychosocial paradigm underlying the mental health reform? This difference is demonstrated by Fracasso when she confirms that TCs adopt a psychosocial model in which the “psychosocial perspective [...] differs from the logic of psychosocial care used by the PSCN, since the latter incorporates the concept of comprehensiveness and other principals underlying the SUS (acronym for Brazil’s National Health System, *Sistema Único de Saúde*) not considered here”⁴.

The aim of this article is to demonstrate that, from a health policy perspective, there has been a shift since 2011 away from the psychosocial paradigm and harm reduction towards a prohibitionist paradigm associated with religious morality and the increasing role of TCs in the treatment of drug users.

Methodology

This article is based on a systematic review of different sources, ranging from scientific articles to websites and newspaper articles. Using this material, we begin our attempt to answer the questions that arose when we first became aware of the growth of TCs while working in a PSCCad (Table 1).

We drew on a wide variety of sources because our study encompassed various actors in the field of public policy, including TCs and mental health services, drug users, as well as religions and the history of TCs.

The choice of sources was not restricted to a single aspect. We used certain keywords designed to capture a broad range of articles. A pattern was observed in the items returned by the searches using these expressions. For example, the keyword ‘therapeutic communities’ resulted in items linked to religion, drug users, and chemical dependency, while ‘drug users’ resulted in items linked therapeutic communities, drug policy, and harm reduction. We also analyzed the websites of TCs, public bodies, and religious organizations. In some cases, the search of a given theme led us to new searches. For example, a search of the website www.aberta.senad.gov.br of the National Secretariat for Drug Policy (SENAD, acronym in Portuguese), where we found a module on the history and regulation of TCs⁴, led us to search

Table 1. Research material.

	References	Total
Scientific articles	3;18;24;27	4
Articles	13	1
Books	10;11;20;28	4
Book chapters	12;39	2
Legislation	1;2;6;7;8;9;17;26	8
Technical papers and reports	5;29;30;31;33	5
Module from a distance learning portal	4	1
Facebook	16	1
Websites	14;15;19;21;22; 2;25;34;37;38;40	11
Newspaper articles	32;35;36;41;42	5
Total		42

pioneering TCs in Brazil and their history, thus helping to understand their place within public policy and the origin of the relationship between TCs, religious organizations, and moral treatment.

In addition to scientific articles and websites, we also drew on the following sources: 1) Legislation related to the field of alcohol and other drugs; 2) Technical papers and reports produced by research institutions and professional regulatory bodies; and 3) books and book chapters written by leading scholars in the field.

Analysis of research material

The analysis of the research material demonstrated that there is a flow between what is produced in the public sphere, its policy guidelines, and their effect on the population on the one hand, and reveal important ethical questions concerning public funding of private institutions on the other. We also sought to determine the degree of affinity between the ethical positioning of public health policies and therapeutic communities.

Results

The escalation of incentives: a brief history

The findings provide a rich testimony about the way in which the discourse adopted by TCs is legitimized not only historically, but also in articulation with psychology, psychiatry, and

the social sciences. In this respect, various texts defending the current TC model were written by researchers who carry studies directly related to TCs. Clearly, many of these professionals carry out serious work. Nevertheless, this work is associated with that of the leaders of tax-exempt religious organizations who over the last decade have gained important positions, politically legitimizing the activities of TCs linked to private institutions. To this end, they also developed links with academics, often from prestigious scientific institutions, to create a discourse in tune with academic discourse, with the sole goal of defending TCs and lobbying for government funding for the current TC model.

The following extract is taken from a technical paper produced by the Institute of Applied Economic Research (IPEA, acronym in Portuguese):

In addition to direct funding, various TCs hold certifications granted by the legislative and executive branches of the government to institutions that provide services of interest to the government. These certifications constitute indirect forms of public subsidy, since they authorize the non-payment of various taxes⁵(p.31).

TCs can apply for various types of certifications, which, as can be seen from the following data taken from the technical paper⁵, are readily awarded (Table 2).

The first technical regulations governing TCs were issued by the Brazilian health surveillance agency, ANVISA⁶, in 2001, representing an attempt to ensure the quality of the services provided through inspection and monitoring. In 2003⁷, TCs appeared as a concern in the government's drug user care policy, which stated that these self-proclaimed therapeutic communities "[...] multiplied without any form of regulation, many of which were shown to be poorly functioning"⁷(p.46) and provided that the National Anti-Drug Council should establish "a basic standard for the functioning (of TCs), ensuring rights and a minimum of quality for users"⁷(p. 46, emphasis added). Yet, eight years later, a ministerial order instead institutionalized TCs as "health services devoted to delivering continuous, transitional, residential healthcare for up to nine months for adults with stable clinical needs resulting from the use of crack, alcohol, and other drugs"². This ministerial order, issued in 2011, is in fact rather paradoxical, on the one hand supporting "deinstitutionalization strategies", where therapeutic residential services are intended to be "homes incorporated into the community devoted

Table 2. Certifications awarded to TCs.

Certification	Percentage of TCs that hold certification
Declaration of Municipal Public Utility	73%
Declaration of State Public Utility	53%
Declaration of Federal Public Utility	27.60%
Certificate of Brazilian Social Assistance Entity	20%
Certificate of Social Assistance Beneficent Entity in the Area of Health (Cebas-Saúde)	6.70%

Source: IPEA

to receiving people coming out of long-term hospitalization²²(emphasis added), while on the other advocating nine-month residency for adult drug addicts. In an escalation of incentives, one year later the government created a “financial incentive directed at states, municipalities, and the Federal District to support therapeutic communities, aimed at people with needs resulting from the use of alcohol, crack, and other drugs within the Psychosocial Care Network²⁸. This incentive has yet to be released by the Ministry of Health due to the simple fact that these establishments fail to meet the regulations established by ANVI-SA⁹.

Therapeutic communities and public investment in the treatment of drug users

TCs first emerged in a recognizable form in England in the 1950s, consisting of a progressive approach for treating people with psychosis. Coined in 1959 by Maxwell Jones, a South African-born psychiatrist regarded as the creator of the concept, CTs were intended to dynamize the organization of ‘discussion groups’ and ‘operative groups’, involving hospitalized patients in their treatment. Jones “understood that therapy was a task that should be assumed by everybody, be they technicians, family members, or patients. To this end, he introduced meetings, daily assemblies, when all aspects related to the institution were debated¹⁰(p.42). Today, particularly in the United States, the term therapeutic community is largely associated with the treatment of drug users. However, although the name might be the same, the treatment approach is a far cry from the original concept. These so-called TCs for

drug users promote a treatment model that is fundamentally segregationist, since it increasingly seeks to marginalize drug users by prescribing admission, totally distorting the original idea of TCs. According to Leon, “Aside from the name, it is not clear whether the English psychiatric TCs influenced the TCs used to treat chemical dependency in North America¹¹(p.14).

IPEA’s⁵ technical paper suggests that the origins of modern-day TCs can be traced back to proposals put forward by Rev Frank Buchman (1878 to 1961), founder of the Oxford Group in the United States and England and who Fracaso associates with the AA groups, whose motto was spirituality¹². This would explain how certain practices used by Jones were adopted by TCs in Brazil and other countries, acquiring “their own characteristics, combining religious foundations with practices originating from the field of psychiatry in a work that purports to be pious and moralizing⁵(p.9).

Modern-day TCs view drug users as having an incurable disease¹³(p.5), introducing religious orientation to “generally religious ‘fazendas’ (farms) and ‘fazendinhas’ (little farms) for alcohol and drug addiction treatment that opportunistically and fraudulently call themselves ‘therapeutic communities’ to gain social and scientific legitimacy¹⁰(p.43). It is precisely due to this legitimacy that there is less and less public investment in work with drug users and people with psychosis.

In 2002, the then Health Minister José Serra formally announced that there should be one PSCC III for every 200,000 inhabitants and one PSCCad II in municipalities with over 70,000 inhabitants¹. In 2017, the Municipality of Rio de Janeiro had 33 PSCCs¹⁴, including two PSCCad IIs, four PSCCad IIIs, and one state PSCCad II, giving a total of seven PSCCads – to attend an estimated population of 6,520,266 inhabitants¹⁵. The law governing Brazil’s mental health reform came into force in 2001, while the government’s drug user care policy dates back to 2003. We are now in 2017 and there are a mere seven PSCCads for over six million people and only four PSCCad IIIs, which offer a 24-hour service and short-stay crisis admission for intoxicated patients, those experiencing withdrawal symptoms, and patients with psychosis from CAPSad.

This demonstrates that the PSCN does not have the capacity to meet the needs of people with mental health problems and drug users and an almost complete lack of government investment in secular treatment that builds on the experi-

ence gained by mental health professionals over the last 10 years in the network. Furthermore, the government has made no effort to strengthen mental health services, despite mobilizations by mental health workers and service users to draw authorities' attention to the problem, including the circulation of videos on Facebook¹⁶ and Whatsapp to avoid the closure and dismantling of services in 2017. The dismantling of services only serves to increase the public's lack of faith in deficient and ineffective public services, strengthening the justification for investment in TCs.

The majority of modern-day TCs were created by religious communities, predominantly neo-Pentecostal Evangelicals. In 2012, state funding for the treatment of people with psychic suffering by non-state institutions reappeared – precisely the activity that the 2001 mental health reform had dismissed, closing private psychiatric hospitals that received generous government incentives, lining the pockets of their owners to the detriment of the clinical, physical, and social care of their patients...

In 2016, Ministerial Order 1.482 included therapeutic communities in the “Table of Types of Health Establishments in the National Register of Health Establishments (Type 83 – Center for Disease and Health Problem Prevention and Health Promotion”¹⁷), practically legitimizing TCs as health services. This is of particular concern, given that the majority of TCs are religious rather than health services. Unlike the private colony hospitals subsidized by the government in the second half of the 20th century, the overwhelming majority of modern-day TCs are run by religious institutions, who have secured their incorporation into the PSCN, thus ensuring a broad customer base, while legitimizing themselves by adopting the traditions of the “12-step program” or “Minnesota Model” on the other.

According to De Leon, “the 12 Steps and 12 Traditions of AA are the principles that guide the individual through the recovery process [... which, in truth] emphasize the loss of the person's control over the substance and surrender to a ‘higher power’”¹¹(p.19). Among the AA principles that came from the Oxford Group are “the notion of confessing to others”¹¹(p.19). Fossi and Guareschi's analysis of the TC treatment model points to “the practice of confession in the treatment of drug users, such as the articulation between religious morality and discipline technologies and biopolitics in shaping the healthcare model in this context”¹⁸(p.94).

Six pioneering communities

In order to gain a deeper insight into TCs in the Brazilian context, it is necessary to trace their history, considering the treatment model adopted, the link between TCs and religious morality, and their induction into public policy, and examine who are the figures who claim that TCs are an effective treatment model.

We begin with the psychologist Laura Fracasso (whose curriculum vitae information varies depending on the website consulted) who holds a degree in psychology from the Methodist University of São Paulo. She is the author of a module on a course offered by the SENAD that suggests that CTs were “first developed in a social rehabilitation unit at Belmont Hospital (later renamed the Henderson Hospital), England in the middle of the 1940s”⁴(p.4). An infographic is presented with a map of Brazil showing the location of the country's first six TC experiences, each developed in the 1970s, except for one founded in the house of an Evangelical missionary couple in Goiás in 1968 called “*Movimento Jovens Livres*” (the Free Youth Movement), as can be seen on the “movement's” site. All but one of the TCs - *Clínica Pinel S.A.*, created in Porto Alegre in 1975 by a psychiatrist with a solid academic background called Marcelo Blaya Perez – were created by religious figures. *Clínica Pinel* also has a website¹⁹ featuring a text written by Dr. Perez in the *About us* section telling his own story: how he ended up in Rio Grande do Sul after finishing his residency in the United States in the 1950s; the lack of a place where he could admit patients with psychosis treated at his own clinic; and how he was initially welcomed by the Spiritist Hospital, but, due to a certain degree of religious interference in patient treatment, decided to create his own clinic in 1960. He received residents from all over the country and, after becoming Professor of Psychiatry at the Federal University of Rio Grande do Sul, the clinic began to receive psychiatry residents, who were offered both theoretical and practical training where “interacting with patients, family members, and colleagues, they learnt what the theory books taught”¹⁹. He also goes on to say that the clinic delivered pioneering treatment to people with psychosis, combining occupational and recreational group practices in a “clinical community with rules and practices that provided patients and families the conditions necessary for resocialization [and] enabled a good rate of recovery”¹⁹. Patients were given access to both the day hospital and night

hospital – also pioneering initiatives in Brazil – as soon as they and their family members accepted “the risk of living in the community”. In this way, “these programs allowed patients to spend nights and weekends with their family, remaining in the therapeutic community during the day, like school students”¹⁹. Religious orientation played no part in Dr. Perez’s work, which was inspired by avant-garde movements of the time and went against the clinical, dialectical and science-based model adopted by the numerous total institutions described by Goffman²⁰, thus representing a new way of treating people with psychosis.

According to Dr. Perez, the clinic employed the TC approach for only 20 years (between 1960 and 1980). Thereafter, the approach was completely modified and the clinic is no longer the clinic described above. For some reason, Dr. Perez ceased guiding the work of the clinic at the end of the 1980s, despite the fact that he only retired from his clinical functions in 2005²¹. The clinic’s services (four wards: two female and two male²²) are currently overseen by his granddaughter, the psychologist Beatriz Blaya. One of the male wards is dedicated exclusively to “chemical dependency among persons aged 18 years and over” and one of the female wards “provides specialist programs”²² for patients with chemical dependency. The clinic has strict visiting rules, with two one hour visits per week by “a maximum of two people at any one time, without rotation, [family members] who have participated in at least one meeting of the Family Program”²³ and have scheduled a three-hour “Family Program” appointment once a week²³. No trace remains of the approach employed by Dr. Perez, which sought to integrate clinical care, family, patient, and community. In its place, there is strict discipline regarding visiting times and lack of freedom to come and go. We might ask: is *Clínica Pinel S.A.* a member of the Brazilian Federation of Therapeutic Communities (FEBRACT, acronym in Portuguese), founded by “Padre Haroldo”⁴ on 16 October 1990? This question becomes all the more important considering that only a tiny fraction of Brazilian TCs are members of the Federation, which, according to Perrone²⁴, has the potential to be an effective regulatory body and promote the effective functioning of TCs. However, as Perrone suggests based on the results of an assessment conducted by the Federal Psychology Council, in general terms, this is far from the case. Yet, if, as Fracasso claims⁴, *Clínica Pinel S.A.* is one of Brazil’s pioneering TCs, should it not be a member of FEBRACT?

Another thing that drew our attention when delving deeper into the writings on these communities was flagrant discrepancies in the use of our mother tongue. In Perrone’s text²⁴, for example, or that written by Fracasso mentioned above⁴, great care is taken with the language. Moreover, Perrone’s text is well-written, a truly academic text, evidently the result of in-depth research. However, the texts that feature on the websites of the communities, even those that Fracasso⁴ claims to be pioneering, show language and writing problems and, in some, the presence of cookies with tacky ads. This is coupled with the offer of treatment focusing on love and spirituality and surrender to Jesus; not forgetting the persistent mention of ethics, which all fail to clarify, including Fracasso⁴ in her text on the Ministry of Justice’s website!

Of the six TCs that Fracasso⁴ claims to be pioneering, only one was created by a priest: Father Haroldo Rahm, the founder of FEBRACT. A Jesuit born in the United States, Father Haroldo Rahm moved to Brazil in 1964, where he later created “‘Prayer Experiences’, the seed of the Catholic Charismatic Renewal in Brazil - RCC”²⁵. In 1978, “he founded the ‘*Fazenda do Senhor Jesus*’ TC in Campinas to offer treatment and recovery to men dependent on alcohol and other drugs”²⁵ and in 2006 “he began the campaign Drug Prevention Through Spirituality, an ecumenical movement called ‘Faith in Prevention’”²⁵ supported by the SENAD. His outstanding work is religious, underpinned by the belief in the strength of faith and love of God. Evidently, there is nothing wrong with that. His mission must have saved many souls and clearly provided great help to numerous families. However, turning this mission into a public policy of a constitutionally secular state necessarily associates it with the matter at hand. It is well known that the Charismatic Renewal is the most radical and fanatical movement in the Catholic Church and that this ideological orientation was jettisoned from our republic over half a century ago. SENAD would be wise to reflect on this, at the very least.

The other three TCs mentioned by Fracasso⁴ are: “*Comunidade Cristã S8*” in Niterói, founded in 1971 by Pastor Geremias Sources; “*Desafio Jovem*” in Brasília, founded in 1972 by Pastor Galdino Moreira Filho; and “*Movimento para Libertação de Vidas*” in Maringá, founded in 1975 by Pastor Nilton Tuller. Unfortunately, a presentation of the findings of our research on these communities is beyond the scope of the article. However, it is possible to confirm that

– with the sole exception of *Clínica Pinel S.A* – they all emanate from North American projects based on a religious rather than scientific discourse. This is rather interesting to say the least and warrants further in-depth research. While these projects may originally have been funded by donations from Evangelicals and the sale of a range of religious products, let us not forget the importance of the tax exemptions that these religious institutions enjoy in Brazil. It appears that these exemptions are no longer sufficient, as TCs demand more and more state subsidies. Since 2003, there has therefore been an apparent move towards state investment in essentially religious TCs to the detriment of the implementation of the essentially secular harm reduction strategies envisaged under the government's drug user care policy⁷. Indeed, our analysis of the mission statements of the TCs show that the ultimate aim of every organization is total abstinence from drugs. This is clearly not the aim of the secular harm reduction policy, thus raising extremely important ideological issues.

Discussion

According to the government's drug user care policy⁷, TCs emerged due to “the void of possibilities for the recovery of people with alcohol or other drug dependence”⁷(p.39). The document emphasizes that, until that moment, there had not been a health policy targeting drug users, which corroborates the fact that the Ministry of Justice was the only actor involved in the formulation and regulation of policies to tackle alcohol and other drugs. The law that regulated the sale and use of drugs up to that point, Law 6,368, which came into force in October 1976, was totally prohibitionist²⁶. From a legal point of view, drug users were criminals, while from a psychiatric perspective they were sick; thus all that remained for drug users was prison or asylum²⁷. In any event, treatment was disciplinary – as defined by Foucault²⁸: “it operates via the normalization of deviant behavior, where the primary object of intervention for medical and criminological knowledge is the criminal, lunatic, delinquent, ‘drug addict’”²⁷(p.157).

Prohibitionism, or the war against drugs, and anti-prohibitionism, both paradigms of the justice sector, are counterposed against each other, just as the asylum and psychosocial paradigms are in the field of health³. The prohibitionist paradigm envisages an ideal drug-free world, where

the only possible treatment is abstinence. In the field of health, this implies the correlative asylum paradigm where “Individuals play a passive role in their treatment, being considered sick, thus justifying isolation from their wider family and social environment”³(p.1456). On the opposite pole, the psychosocial paradigm is aligned with anti-prohibitionism, where criminalization is understood to stigmatize users⁷.

According to Teixeira et al.³, the psychosocial paradigm was spawned by the mental health reform, from which it inherited references about suffering “that go beyond the notion of disease”³(p.1456). The vision is not “symptomatic treatment and necessary abstinence, but rather risk and harm reduction”³(p.1456).

Modern-day TCs neither emerge in contraposition to the disease/crime model, nor abstain from disciplinary power, as we have demonstrated above. Rather, they align themselves with models underpinned by the abstinence paradigm, introducing a new ingredient: “religious morality”²⁷(p.157).

Various reports have attempted to show authorities that TCs are antagonistic to the psychosocial paradigm, including the following: the *Therapeutic Community Inspection Report, funded by the Government of the State of Rio de Janeiro*²⁹; *Report on the 4th National Inspection of Human Rights: drug user admission facilities*³⁰; and *The Dossier: Report on the Inspection of Therapeutic Communities and Drug User Clinics in the State of São Paulo – Charting Human Rights Violations*³¹. In the same direction, in 2017, the Federal Public Prosecutor's Office, National Mechanism for Preventing and Combating Torture, and Federal Psychology Council produced a report outlining the results of the inspection of 28 therapeutic communities^{32,33}. Finally, it is important to mention IPEA's technical paper mentioned above⁵, *Perfil das Comunidades Terapêuticas Brasileiras* (Profile of Brazil's Therapeutic Communities), published in 2017, which outlined the results of a study commissioned by the SENAD in 2014 undertaken between 2014 and 2016. Unlike the other reports mentioned above, the aim was “to gather information that enabled the enhancement of [current TC] funding monitoring and evaluation processes”³⁴. This introduces a new approach that is deduced from the stated purpose: an explicit intention to focus on the funding of these institutions. This begs the question, why? Why the insistence on affirming TCs as health services and public funding? Who gains from this? Apparently not the population, which, as we have seen, lacks

psychosocial care services that treat individuals as citizens and subjects...

In its preface, the *2017 Therapeutic Communities National Inspection Report*³³ posed the following question: “What forms of exclusion, suffering, and cruel, inhumane and degrading treatment have been produced in the name of protection and care?”³³(p.9). With regard to the treatment delivered to drug users by TCs, the report states: “The deprivation of freedom is the rule that underpins this care model”³³(p.9) and that “practices that constitute human rights violations were indentified” in all the facilities visited³³(p.10). The report draws attention to the fact that 18 of the TCs visited informed that they receive “some kind of resource or donation from public bodies”³³(p.18), which should entail “inspection and monitoring of the practices developed by the recipient, which was not identified in the inspections”³³(p.18). Thus the “the indiscriminate funding of this kind of institution ends up resulting in the allocation of public resources where there are human rights violations”³³(p.150). In this respect, it is concluded that: “by allocating resources to therapeutic communities, (the government) fails to foment other initiatives that are more consistent with public health rules and guidelines”³³(p.150).

A proposal to change the country’s mental health policy effectively approved by the Tripartite Inter administration Commission on December 14, 2017, was met with all manner of protests on social media and newspapers^{35,36}. Various statements were released on social media by different professional regulatory bodies^{37,38}. Despite the reports and protests – not only those made by mental health workers, but also the various entities that disseminated en masse on social media the difficulties posed by these new guidelines – we are witnessing the increasing invasion of measures aligned with the prohibitionist paradigm.

Final considerations

In face of the above, how do those who want to win the war against drugs intend to do so? Based on the above observations, certainly not by investing in psychosocial care services! The “war against drugs” is a far cry from harm reduction, since, like all wars, it incites harm. The lethality of prohibitionism is expressed in the number of deaths – products of this war – and allies itself

with the working capital of trafficking, which never comes just from drugs³⁹.

Our hypothesis, therefore, is that the investment in TCs signifies the resurgence of prohibitionism and consequently the asylum paradigm, which seems to be confirmed when we come up against the “army of faith”⁴⁰⁻⁴². And why would a church want an army? Who would it want to wage war against? Judging by the content of the videos on YouTube, whose mottos are the “salvation” of drug addicts and demonization of drugs, the main target is drug users. We mention these videos merely by way of example, though many have already been removed from the internet: “With the emergence of the controversy, the Universal (Church of the Kingdom of God) blocked access to the content published about the gladiators in its official internet channels”⁴².

In their discussion of public health policies between 2000 and 2016, Teixeira et al.³ hold that “the damage reduction model gained prominence especially after 2005 with the realignment of the National Drugs Policy”³(p.1462). However, they claim that there was a shift in direction after 2016, “returning to the war against drugs paradigm centered on repression of supply and a care and treatment policy for harmful use of drugs based on the disease model present in TCs, to the detriment of the psychosocial model of the PSCN”³(p.1463).

This redirection leads to tension in the field of alcohol and other drugs and has a direct impact on public health service users – in this case drug users – undermining the principle of universal access to healthcare and the right to health for all people. The abstinence premise results in “non-access”⁷⁷ to healthcare for most drug users: “designing a policy based on a single objective [abstinence] is working in health with narrow understanding”⁷⁷(p.9), when in fact “programs should encompass large parts of the population, in such a way that abstinence is not the sole viable and possible goal for users”⁷⁷(p.8).

This is precisely the issue that is implicit in the title of this paper: the fact that we are witnessing a sway from the psychosocial paradigm towards religious morality associated with the prohibitionist paradigm, setting a new direction for policy. This redirection of policy brings into play the discussion of ethical issues surrounding mental health care, including, among other things, the treatment of drug users: i.e. whether to accept them, employing a “strategy” aimed at

“[...] defending their life”⁷, or segregate them, just as “lunatics” were treated in the past.

Collaborations

The authors worked equally in all stages of elaboration of the article which is the theme of the doctoral thesis of ADA Bastos, under the guidance of S Alberti. The authors investigated the situation of public policy intervention in the treatment of drug users. ADA Bastos researched the psychosocial paradigm versus the prohibitionist paradigm and S Alberti dedicated to deeply research the trajectory of Therapeutic Communities in Brazil.

References

1. Brasil. Portaria nº 336 de 19 de fevereiro de 2002. Dispõe sobre os Centros de Atenção Psicossocial - CAPS, para atendimento público em saúde mental, isto é, pacientes com transtornos mentais severos e persistentes em sua área territorial, em regime de tratamento intensivo, semi-intensivo e não-intensivo. *Diário Oficial da União* 2002; 20 fev.
2. Brasil. Ministério da Saúde (MS). Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde. *Diário Oficial da União* 2011; 24 dez.
3. Teixeira MB, Ramôa ML, Engstrom E, Ribeiro, JM. Tensões paradigmáticas nas políticas públicas sobre drogas: análise da legislação brasileira no período de 2000 a 2016. *Cien Saude Colet* 2017; 22(5):1455-1466.
4. Fracasso L. *Comunidades terapêuticas: histórico e regulamentações*. Aberta/Senad/MJ [Internet]. [acessado 2017 Dez 12]. Disponível em: <http://www.aberta.senad.gov.br/medias/original/201706/20170605-134703-001.pdf>
5. Instituto de Pesquisa Econômica Aplicada (IPEA). *Nota Técnica: Perfil das Comunidades terapêuticas brasileiras*. Brasília: Diest/IPEA; 2017.
6. Agência Nacional de Vigilância Sanitária (ANVISA). RDC 101, de 30 de maio de 2001. Regulamento Técnico sobre o funcionamento dos serviços de atenção a pessoas com transtornos decorrentes do uso ou abuso de substâncias psicoativas (SPA), segundo modelo psicossocial, também conhecidos como Comunidades Terapêuticas (CT). *Diário Oficial da União* 2001; 31 de maio. Revogada pela RDC nº 29, de 30 de junho de 2011.
7. Brasil. Ministério da Saúde (MS). Secretaria Executiva. Coordenação Nacional de DST/Aids. *A Política do Ministério da Saúde para a atenção integral a usuários de álcool e outras drogas*. Brasília: MS; 2003.
8. Brasil. Ministério da Saúde (MS). Portaria nº 131, de 26 de janeiro de 2012. Institui incentivo financeiro de custeio destinado aos Estados, Municípios e ao Distrito Federal para apoio ao custeio de Serviços de Atenção em Regime Residencial, incluídas as Comunidades Terapêuticas, voltados para pessoas com necessidades decorrentes do uso de álcool, crack e outras drogas, no âmbito da Rede de Atenção Psicossocial. *Diário Oficial da União* 2012; 27 jan.
9. Agência Nacional de Vigilância Sanitária (ANVISA). RDC 29, de 30 de junho de 2011. Dispõe sobre os requisitos de segurança sanitária para o funcionamento de instituições que prestem serviços de atenção a pessoas com transtornos decorrentes do uso, abuso ou dependência de substâncias psicoativas. *Diário Oficial da União* 2011; 1 jul.
10. Amarante P. *Saúde Mental e atenção psicossocial*. 20ª ed. Rio de Janeiro: Fiocruz; 2007.
11. De Leon, G. *A comunidade terapêutica: teoria, modelo e método*. 5ª ed. São Paulo: Edições Loyola Jesuítas; 2014.
12. Fracasso L. Comunidades terapêuticas. In: Diehl A, Cordeiro D, Laranjeira R, organizadores. *Dependência química: prevenção, tratamento e políticas públicas* [CD-ROM que acompanha o livro]. Porto Alegre: Artmed; 2011. p. 61-69.
13. Costa SF. *As Políticas Públicas e as Comunidades Terapêuticas nos Atendimentos à Dependência Química* [Internet]. [acessado 2017 Dez 10]. Disponível em: <http://www.uel.br/revistas/ssrevista/pdf/2009/29%20AS%20POL%20CDCAS%20P%20DABLICAS%20E%20AS%20COMUNIDADE%20TERAP%20CAUTICAS-COM%20REVIS%20C3O%20DO%20AUTOR.pdf>
14. Prefeitura do Rio de Janeiro [Internet]. [acessado 2017 Jun 14]. Disponível em: <http://prefeitura.rio/web/sms/caps>
15. Instituto Brasileiro de Geografia e Estatística (IBGE) [Internet]. 2018 [acessado 2018 Jan 27]. Disponível em: <https://cidades.ibge.gov.br/v4/brasil/rj/rio-de-janeiro/panorama>
16. Página do Facebook [Internet]. 2017 [acessado 2018 Dez 26]. Disponível em: <https://www.facebook.com/NenhumServicoMenos/>
17. Brasil. Ministério da Saúde (MS). Portaria nº 1.482, de 25 de outubro de 2016. Inclui na Tabela de Tipos de Estabelecimentos de Saúde do Cadastro Nacional de Estabelecimentos de Saúde – CNES o tipo 83 – Polo de Prevenção de Doenças e Agravos de Promoção da Saúde. *Diário Oficial da União* 2016; 27 out.
18. Fossi LB, Guareschi NMF. O modelo de tratamento das comunidades terapêuticas: práticas profissionais na conformação dos sujeitos. *Estudos Pesquisas Psicol* 2015; 15(1):94-115.
19. Perez MB. *A clínica* [Internet]. [acessado 2018 Jan 1]. Disponível em: <http://www.clinicapinel.com.br/index.php/clinica>
20. Goffman E. *Manicômios, Prisões e Conventos*. São Paulo: Editora Perspectiva S.A.; 1974.
21. Museu de História de Medicina do Rio Grande do Sul [Internet]. [acessado 2018 Jan 1]. Disponível em: <http://www.muham.org.br/?formulario=obras&submenu=5&metodo=0&id=137>
22. Clínica Pinel de Porto Alegre [Internet]. [acessado 2018 Jan 2]. Disponível em: <http://www.clinicapinel.com.br/index.php/servicos/internacao-3>
23. Clínica Pinel de Porto Alegre [Internet]. [acessado 2018 Jan 2]. Disponível em: <http://www.clinicapinel.com.br/index.php/horarios>
24. Perrone PAK. A comunidade terapêutica para recuperação da dependência do álcool e outras drogas no Brasil: mão ou contramão da reforma psiquiátrica? *Cien Saude Colet* 2014; 19(2):569-580.
25. Instituto Padre Haroldo [Internet]. [acessado 2018 Jan 2]. Disponível em: http://www.padreharoldo.org.br/?navega=paginas&id_pag=25&menu=3
26. Brasil. Lei nº 6.368, de 22 de outubro de 1976. Dispõe sobre medidas de prevenção e repressão ao tráfico ilícito e uso indevido de substâncias entorpecentes ou que determinem dependência física ou psíquica, e dá outras providências. *Diário Oficial da União* 1976; 22 out. Revogada pela lei 11.343/2006.

27. Passos EH, Souza TP. Redução de danos e saúde pública: construções alternativas à política global de “guerra às drogas”. *Psicol Soc* 2011; 23(1):154-162.
28. Foucault M. *Vigiar e punir: nascimento da prisão*. Petrópolis: Vozes; 1987.
29. Assembleia legislativa do Estado do Rio de Janeiro. *Relatório de Inspeção em Comunidades Terapêuticas Financiadas pelo Governo do Estado do Rio de Janeiro* [Internet]. ALERJ; 2013 [acessado 2017 Jun 23]. Disponível em: <http://www.cressrj.org.br/download/arquivos/relatorio-ct-financiadas-pelo-gov-est-rj-junho-13.pdf>
30. Conselho Federal de Psicologia (CPF). *Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas* [Internet]. Brasília: CPF; 2011 [acessado 2017 Jun 23]. Disponível em: https://site.cfp.org.br/wp-content/uploads/2012/03/2a_Edixo_relatorio_inspecao_VERSxO_FINAL.pdf
31. Conselho Regional de Psicologia (CRP). *O Dossiê: Relatório de Inspeção de Comunidades Terapêuticas e Clínicas para Usuárias (os) de Drogas no Estado de São Paulo - Mapeamento das Violações de Direitos Humanos* [Internet]. São Paulo: CRP; 2016 [acessado 2018 Jan 10]. Disponível em: http://fileservet.idpc.net/library/dossie_relatorio_crpsp.pdf
32. Mariz R. *Inspeção em comunidades terapêuticas encontra internações à força e instalações precárias* [Internet]. O Globo; 2017 [acessado 2017 Out 20]. Disponível em: <https://oglobo.globo.com/brasil/inspecao-em-comunidades-terapeuticas-encontra-internacoes-forca-instalacoes-precarias-21960702>
33. Conselho Federal de Psicologia (CFP). *Mecanismo Nacional de Prevenção e Combate à Tortura; Procuradoria Federal Dos Direitos do Cidadão* [Internet]. Brasília: CFP; 2018 [acessado 2018 Set 4]. Disponível em: <https://site.cfp.org.br/wp-content/uploads/2018/06/Relat%C3%B3rio-da-Inspe%C3%A7%C3%A3o->
34. Santos MPG. *Perfil das Comunidades Terapêuticas Brasileiras. Nota Técnica 2017* [Internet]. IPEA; 2017 [acessado 2018 Jan 10]. Disponível em: http://www.ipea.gov.br/portal/index.php?option=com_content&view=article&id=29865
35. Martins H. *Comissão aprova mudanças na política de saúde mental; conselhos protestam* [Internet]. Agência Brasil; 2017. [acessado 2018 Jan 15]. Disponível em: <http://agenciabrasil.ebc.com.br/geral/noticia/2017-12/comissao-aprova-mudancas-na-politica-de-saude-mental-conselhos-protestam>
36. Cancian N. Nova política de saúde mental dará brevidade a hospitais psiquiátricos [Internet]. Folha de São Paulo; 2017 [acessado 2018 Jan 15]. Disponível em: <http://www1.folha.uol.com.br/cotidiano/2017/12/1942890-nova-politica-de-saude-mental-dara-sobrevida-a-hospitais-psiquiatricos.shtml>
37. Conselho Federal de Serviço Social (CFESS). *Mudanças na Política Nacional de Saúde Mental: mais uma ameaça do governo ilegítimo* [Internet]. CFESS; 2017 [acesso 2018 Jan 24]. Disponível em: <http://www.cfess.org.br/visualizar/noticia/cod/1439>
38. Conselho Federal de Psicologia (CFP). *CFP repudia mudanças na política de saúde mental* [Internet]. CFP; 2017 [acessado 2018 Jan 24]. Disponível em: <http://site.cfp.org.br/repudio-mudancas-politica-saude-mental/>
39. Alarcon S. A síndrome de Elêusis: considerações sobre as políticas públicas no campo de atenção ao usuário de álcool e drogas. In: Alarcon S, Jorge MA, organizadores. *Álcool e outras drogas: diálogos sobre um mal-estar contemporâneo*. Rio de Janeiro: Fiocruz; 2012. p. 45-62.
40. Exército de Fé [Internet]. [acessado 2018 Jan 24]. Disponível em: <http://exercitodefe.blogspot.com.br/>
41. Martins F. *Polêmico ‘exército’ da Igreja Universal, Gladiadores do Altar chega ao Rio* [Internet]. O Dia; 2015. [acessado 2018 Jan 26]. Disponível em: https://odia.ig.com.br/_conteudo/noticia/rio-de-janeiro/2015-03-05/polemico-exercito-da-igreja-universal-gladiadores-do-altar-chega-ao-rio.html
42. Oliveira MA. *Igreja Universal monta exército da fé: Apelar à simbologia militar para projetar uma nova geração de pastores e evangelizadores* [Internet]. Verdade Mundial; 2015. [acessado 2018 Jan 24]. Disponível em: <http://verdademundial.com.br/2015/06/a-igreja-universal-monta-exercito-da-fe-apelar-a-simbologia-militar-para-projetar-uma-nova-geracao-de-pastores-e-evangelizadores/>

Article submitted 07/06/2018

Approved 15/04/2019

Final version submitted 17/04/2019

Chief Editors: Romeu Gomes, Antônio Augusto Moura da Silva

