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Religious therapeutic communities in recovering drug users: the case of Manguinhos, state of Rio de Janeiro, Brazil

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This paper analyses the role of religious therapeutic communities in recovering and rehabilitating drug users, taking the Manguinhos complex of slums in Rio de Janeiro, Brazil, as the case. The study used a qualitative approach through interviews, participant observation and institutional materials. The technique of analysis of enunciation was applied in order to interpret the material. There is a strong presence of religious institutions that aim to form therapeutic communities for treating drug dependence. The main forms of recovery and rehabilitation comprise evangelization and religious conversion. Faith-based therapeutic communities conceptualize a treatment model focused on prayer and abstinence, which is a view at odds with public mental health policies. However, the public infrastructure has been unable to make effective responses to the demand. The controversy generated by this issue closes this paper.

Keywords: Therapeutic community. Drugs. Recovery. Religion.

Introduction

Psychoactive substances have been used in human history[1] as recreational, medicinal or religious practices. On the other hand, their configuration as a social problem dates back to the end of the XIX century[1-6].

In Brazil, caring for individuals with alcoholism and other drug addictions is introduced in the public policy agenda in the 1990s, resulting from the care conception based on user[7] rights and going against the exclusion practices adopted by psychiatric hospitals. Nevertheless, both models remain in dispute, with distinct trends taking place according to social, economic, political, and cultural contexts[8-10].

Since the year 2003, harm reduction is the official policy of the Health Ministry[11], which proposes to lessen the risks of biological, social and economic nature of drug use and adopts a rights-based approach to respect individuals and their freedom to make choices. Contrastingly, however, and diametrically opposed to the first is the abstinence applied by Therapeutic Communities (TC) [4,11,12].
Aiming at recovering drug users, a great number of churches work with evangelization services in communities – in "drug dens" and in "cracolândias" (cracklands) – and in Therapeutic Communities (TC), which are also known as "Rehabilitation Centers". They offer religious treatments as therapeutic projects and are financed or co-financed by religious organizations and the State. The religious treatment substitutes or enhances other forms of care, such as pharmacological treatments.

Although the Therapeutic Communities (TC) gain ground due to the lack of public policies or because of their low effectiveness[10,13,14,15], their presence in the Brazilian scenario is prior to 2003, when a specific public policy was introduced in the country for managing the abusive use of alcohol and other drugs[10,14]. Added to that scenario is the absence of effective strategies to cope with the growing problem of drugs, the lack of guidelines and of continuous monitoring of the few initiatives towards the abusive use of alcohol and other drugs, as well as a strong common sense favoring the confinement of drug users[16,17].

The Psychiatric Reform in Brazil led to the gradual reduction of psychiatric beds granted by the Brazilian Unified National Health System (SUS) to treat addicts. They were replaced by the expansion of Primary Care and by a series of services, such as the ones offered by the Psychosocial Care Centers (CAPS). Nevertheless, these changes do not have brought effective results to the population. Given that loss of resources, Vasconcelos[18] notes the increase of biomedical pro-psychiatry movements that are, in fact, anti-reform movements. In this context, the drug issue, notably regarding crack cocaine, begins to dominate the political, institutional, cultural, and media agenda.

Several authors have noted the positive impacts of spirituality and religiosity in the quality of life and mental health of people[19-32]. Among them, some emphasize the following topics: the role of spirituality in clinical practice and its association with health indicators; its impact on lifestyle habits, social support and coping and psychological well-being; the low prevalence of depression, abuse or substance dependence; decreasing suicidal ideation and behaviors[33,34]. Dalgalarrondo[35] highlights the growth of research on religion as a protective factor against alcoholism and other drug addictions in the last two decades. Another issue that stands out is the religious coping – "the use of cognitive or behavioral strategies" related to religion for dealing with stressors both in healing processes and treatment of diseases (p.381)[27].

Other researches, especially those involving Pentecostal religions, problematize the role of religion in recovering and rehabilitating of individuals suffering from drug use and abuse. They have highlighted the role of Faith Communities in the active search for individuals in crisis[22,29,31,32].

The proposal of Therapeutic Communities

As defined by Goffman[36], the organization of Therapeutic Communities takes as its starting point a model of total institution, in which individuals are kept in a residential setting for 24 hours, deprived from society, subsequently provoking a rupture with the roles previously played[37-39].

The purpose is to rehabilitate individuals to life in society. By treating individual disorders, it is possible to change lifestyles and educate people towards "new values such as spirituality, responsibility, solidarity, honesty and love" (p. 172)[9].

As reported by the "Crack Cocaine, It's Possible to Win" program[40], there are currently in Brazil 5,496 vacancies in 252 Therapeutic Communities (TC), and the proposal was to reach 10,000 vacancies up to the end of 2014. Notwithstanding, as noted by Kurlander[17], the National Secretariat for Drug Policy (SENAD) states that there were between 2,500 and 3,000 TC in the country, providing care services for 60,000 people a year. On the other hand, Silva[41] and Damas[39], based on the Health Ministry data, state that there are 2,500 TC offering care services for 80% of drug users. The mismatch of information suggests the existence of several entities working without registration, which represents a challenge to the enforcement of minimum standards of operation.

There is the predominance of three models of Therapeutic Communities: the religious-spiritual model, working with religious representatives and engaged former drug users; the scientific model, working with doctors, psychologists and social workers; and the mixed model, working with both arrangements[13,39,41]. There are also contributions from the Minnesota Model[16,39] of "predominantly spiritual essence, based on mutual help and applying the 12-step philosophy," whose treatment "seeks to instill hope through faith in a higher divine power;" and the Synanon Method "of predominantly analytical essence" and based on "self-confidence" and labortherapy (p.53)[39].

Some basic guidelines can be seen in all proposals: the Therapeutic Communities (TC) consist of a structured system with limits, rules, timetable and clear responsibilities; and they are usually located far away from urban areas. The TC is based on discipline and strict rules, such as community remoteness, group work, labortherapy, abstinence from drugs and sex, and imposition of penalties for deviations. Another common characteristic of the TC refers to the "recovered" residents, who have a supporting role in the treatment of the other residents, and to the majority of the work being voluntary[6,9,13,16,38,39,42,43].

Two other noteworthy facts are the religious component and the prevalence of Catholic and Evangelical institutions[16,38,41,43-45].

> There are still a great number of religious communities that [...] [are] mostly and solely faith-based in God. "The encounter with God is the solution against all evils of the spirit and flesh," said an Evangelical pastor, coordinator of a TC (p. 50)[41].

According to Valderrutén[37], the "Teotherapy" is written in Christian conceptions of social life and behavior, in which being a recovering addict means being "convert," that is, seeking salvation in Jesus Christ. The religious discourse is a major theme, organizing both the institutional routine, with activities such as prayers, group meetings and catechesis, and the space, with religious symbols such as crucifixes and images of saints[6,15].

Manguinhos

Manguinhos is a 16-slum complex located in the north of Rio de Janeiro city. It has a population of 50,000 people and alcoholism and other drug addictions as one of its main deficiencies regarding health[46].

Manguinhos had one of the largest "cracolândias" (crackland) - a place for crack cocaine consumption and residence of its users - of Rio de Janeiro city and several points of drug sales. The works of the Federal Government Growth Acceleration Program (PAC), from June 2012, expanded the railway line that runs through Manguinhos, leading to the dissolution of cracolândia and subsequent redistribution of its drug users.

A great number of religious institutions have socially and religiously oriented initiatives, providing care services to drug users. There is an overlapping between these two forms of intervention, being social actions impregnated of a deep religious moralism.

Among government actions with reference to this issue, it is worth mentioning "hosting" drug users and sending them to specialized shelters. This policy has been heavily criticized by social movements fighting for human rights, as well as by professional advisors and health professionals alluding to the resurgence of hygienist practices.

As a healthcare service, there is the project Integrated Healthcare Territory (TEIAS) in Primary Care. It consists of 13 Family Health Teams providing care services for 100% of the families of the area[47].

Manguinhos has the support of Psychosocial Care Centers (CAPS), which are centers offering service of "reference and treatment for people suffering from mental disorders, psychoses, severe

neuroses and other conditions" (p.13)[48]. On the other hand, the region has no CAPS AD – Psychosocial Care Centers specialized in care services for alcohol and other drugs and responsible for harm reduction actions. There are currently only six CAPS AD units[49] in Rio de Janeiro city; therefore, insufficient to serve a population of 6,453,682 inhabitants (IBGE, 2014).

The Polyclinic Rodolpho Rocco is a reference center for emergency mental healthcare. It has a Street Office carrying out "prevention actions, primary care and health promotion, articulating the set of equipment and intersectorial teams inside and outside the territory" [50].

Methodology

This paper is part of the Doctoral Dissertation "Religion, Violence Prevention, Recovery and Rehabilitation of People: a study in Manguinhos." Qualitative data collection methods were used, comprising interviews, participant observation and data collected from institutional materials. Respondents were people converted to religion with drug addiction history and involvement with drug trafficking (3); religious leaders (5); and coordinators of social work provided by religious bodies (4 individual interviews and two groups of 3 and 6 people).

The research was carried out from 2010 to 2012, with respondents from 14 churches and Catholic, Evangelical and Spiritualist associations. Enunciation analysis was used for data analysis process, which considers the word both as meaning and transformation, including historical and social aspects as part of understanding discourse[51]. The discourse, as the product of complex interactions involving the place of discourse and about whom it is spoken, must question the historicity and the social conditions of speaker's utterances[52–55].

The collected data from the interviews were categorized in accordance with the main categories emerged in the respondents' discourse. A first analytical description was made, where the corpus was pre-interpreted in the light of theoretical frameworks, categories, hypotheses, and an inferential interpretation that deepened the analysis of manifest and latent content regarding material, empirical cultural and structural conditions. For this paper, we searched for all occurrences related to drugs and their forms of recovery that were present in the interviews with both "converted" drug users and religious leaders, in the field diaries, and in institutional materials (such as folders on TC).

Participant observation was used extensively in the fieldwork, including activities such as worships, masses and other celebrations, as well as situations involving social work and institutional routine.

Results and Discussion

Some common considerations to all parties

All interviews and informal dialogues in the fieldwork focused on a great concern with drug use and, specifically, with how crack cocaine addiction impacts on the lives of users, their families and the territory. The violence was represented in the discourse as practiced by drug trafficking and promoted by drug addicts who steal and rob in order to get the drugs.

Two quite distinct trajectories were described linking drug abuse to violence. Drug use creates dependence, which, in turn, leads to involvement in theft, robbery and subsequently inclusion in drug trafficking. Trafficking, on the other hand, may lead to the development of drug addiction. Such trajectories are represented as a "destination", which can, however, be changed through religious intervention.

All respondents described the difficulties of access and the poor quality of public health services as preventing the rehabilitation of drug addicts.

The religious-moral treatment in Therapeutic Communities

The main action taken for drug user rehabilitation in Manguinhos is evangelization, which can occur within communities and in Therapeutic Communities.

Two central points guide the moral principles of the TC therapeutic project: firstly, drug addiction considered a sign of sin, weakness, lack of God or demon possession, as well highlighted by Mariz[22], Valderrutén[37] and Rocha[31]; and secondly, the pursuit of abstinence as the only option for undergoing a successful treatment. The drug user under treatment must break with his past life and

embrace a new and religious community, marking his trajectory in terms of before and after conversion. Even alcohol and smoking are condemned, given that they cannot be part of a "converted being."

Some former addicts narrated their personal trajectory related to conversion experiences reorienting their lives and provoking a special bond with faith in God, while others described their return to drugs.

> The man himself cannot win [the struggle for overcoming drug addiction]. I tried several times with my own strength to win this battle, but I couldn't [win it]. I could only overcome it through the Lord Jesus Christ. (R)

> The only thing that keeps me away from drugs is to be sure that God is supervising me. (L)

M.'s rehabilitation occurred in one "unofficial" TC, that is, at the home of a pastor, located far away from his community. According to him, he was "confined, but by free will," and his treatment consisted of prayers:

> I bent my knees, I prayed and asked God [for help], and God was working in my life [...]. And oddly enough, after seven years using crack, I stayed fifteen days in that rehabilitation center – an exceptional thing. No crack user can afford getting rid of drug addiction fortnight.

Having proven the success of the religious method, M. started helping guiding other drug users to "evangelical rehabilitation centers." The rehabilitation of R. and L., on the other hand, occurred through religious conversion in churches. R. also works in a TC welcoming and directing people. Some other former drug addicts have become pastors, as R. and L.

Witnessing has a dual function: it reinforces the condition of freedom and it encourages the individual for playing the role of the example to be followed. After their rehabilitation, M. and R. went back to the cracolândias and drug dens to "speak of God's love for people" (M.), while L. teaches

religious services. Former drug addicts who have undergone a rehabilitation process through religion use their own trajectories as an evangelization strategy.

According to M., "90% of Evangelical rehab centers have no public support;" therefore, churches that fund drug rehabilitation treatments support them. Two evangelical leaders also reported partneships with Therapeutic Communities.

> It's a Therapeutic Community, got it? It's bound by partnership. We send them a monthly budget. Today, we already have a seat there, which is occupied by a representative, and a person that we have sent from here and who is already rehabilitated, a member of the church (the Evangelical church).

According to M., the work has several "Evangelical professionals," mostly volunteers, such as psychologists, lawyers, social workers and doctors, although pastors themselves may also conduct the rehabilitation treatment.

Being "converted" is not an easy task. The "converted", former drug users, and leaders made the following comment about this topic: "from each ten people, three become" (Evangelical leaders). R. tells about the influence of "evil" in spiritual life: "We know that there are spirits that are designed to kill, steal and destroy." An Evangelical leader mentions the challenge of adhering to the "discipline of waking up at a specific time, eating [at that time] and changing habits." Another leader says: "If there is no medicine, we cannot maintain [the person under treatment]."

Although respondents have asserted that Evangelical churches are much more active in rehabilitation actions, a weekly Catholic activity in the old cracolândia could be followed in the fieldwork. It showed us a large group of priests, young missionaries and other Catholics bringing food to the drug users in cracolândia, evangelizing and offering them help to be sent for treatment at a Catholic TC.
According to their official website, that Catholic TC has nine houses working "with completely free admission." A leaflet distributed during their work at cracolânida mentions that one of the objectives of that TC is to "give treatment opportunities for substance abuse, clinical and residential system, with the

aid of a therapeutic program based on Christian principles for providing favorable conditions for abstinence."

Disputes between the psychosocial proposal and the religious treatment

According to the psychosocial perspective, particularly the one from mental health professionals, the treatment offered by religious TC is a form of institutional violence. Many complaints expose the existence of abuse and rights violations in such entities, as stated by the Federal Council of Psychology inspection report[6], placing the TC against the contemporary mental health policies and approaching them of the old asylums.

> They reintroduce the isolation of total institutions, proposing hospitalization and involuntary stay, focusing their actions on religious themes, often disregarding both the right to freedom of religion and the citizens' right to come and go freely (s/p)[6].

According to the document, 78% of them had a religious orientation, distributed in the following way: 29 were Protestant, 9 Catholic, 1 Spiritist, and 14 belonged to unspecified "religions". Participation in religious activities was mandatory, thus disregarding the individual's right to choose to belong to another creed or even to none. In many of those places there were no "employees, [but] only religious people, pastors, workers (mostly former converted members)" (p. 190). On the other hand, when the religious TC had professionals as part of the team, their performance was subjected to moral and confessional principles. Homossexuals and transvesties suffered discrimination, if not also subjected to "healing" actions towards sexual orientation change, due to having a sexuality considered deviant.

Health professionals, human rights defenders organizations, family members and scholars weave a great number of criticisms to the TC model. Among them, they highlight the following: by keeping individuals apart their community, social, educational, employment and health ties are lost; rehabilitation does not lead to a confrontation of the drug user with drugs since he is isolated in the "safe environment" of the TC during treatment; many entities work poorly; medication is administred

without prescription drugs; confinement occur indiscriminately, involuntarily and involving comorbid psychiatric disorders; there are reports of religious fundamentalism, labor exploitation in the name of labortheraphy and pursuit of profit; there are disparities between what is prescribed by public policies and practiced in the Therapeutic Communities, being noticed emphasis on the morality based treatment and the absence of individual therapeutic projects[6,9,15,16,39,56].

The Therapeutic Communities referred to by the "converted" former drug users and religious leaders converge at several aspects, pointing towards the following issues: their therapeutic project is based on religious activities, being dominant the presence of religious professional volunteers; the "religious treatment" is often carried out with medication, as exemplified by the "converts" who narrated their trajectories of care services and work in rehabs. Some "converts", despite holding faith as indispensable to overcome drug addiction, have demonstrated that they also appreciate the intensive prolonged care by health professionals; nevertheless, such care does not occur in those Communities. Hence, it can be seen that there is an overlapping between treatments of "secular basis" and "moral-religious basis," giving a *sui generis* character to the Therapeutic Communities.

Both the respondents' discourse and the registers made in the informal fieldwork contacts have shown that the public sphere services, guided by the philosophy of harm reduction, do not come true. A "converted" former drug user weaves a severe criticism of public services, disqualifying them towards religious entities:

> I do not believe in the work offered by the shelters of the State, the city hall. They actually have no love for fellow human beings, because for you to handle addicts, especially crack users, you have to love the fellow human beings (M.).

With the emergence of crack cocaine as a social issue, there has been an alcohol and other drugs policy review, now including the TC as healthcare services. The "Crack Cocaine, It's Possible to Win" program tops the public discussion[57]. The program also represents a religious entities political dispute for public space, funding and intervention legitimacy regarding the "social issue," as noted by Giumbelli[58], Birman[59] and Montero[60]. Therefore, the public sector maintains its resources transfer project to private entities, thus operating an outsourcing of services.

Failure of providing for the mental health policy, added to the meager amount of Psychosocial Care Centers for Alcohol and Other Drugs (CAPS AD), make the religious TC an easy way out for public managers, who give up their responsibility for the treatment of drug users by offering them counseling for harm reduction therapy.

Placing this discussion in a broader scenario, several authors of the area make allusion to the secularization thesis, referring to the separation between the political and religious spheres and indicating it as an unfinished project[59–62]. As noted by Parente (p. 72)[63], religions "connecting the spiritual to the material guide the political practice, influence the definition of what is ethical, guide interpersonal behavior and affect international relations." Giumbelli[64], adding problematizations to the secularization concept, turns the relations between the State and religions historically more complex, looking back from the State or official religions to the secularization projects in the advent of modernity. The author introduces us to the discussion of new religious movements, which, in turn, win social space, indicating an increase in religious pluralism and jeopardizing religious freedom.

Another author, Mouffe[65], draws attention to the presence of religion in public space as well as to its relation to politics, taking into account that it is not a matter of excluding churches from political integration, providing religious groups respect the constitutional limits.

The Catholic and some Evangelical churches have always been present in various sectors, such as education and care services. Therefore, it is part of their practice to manage social interventions of religious nature. They are also highly politically active in the moral field surveillance when some changes demanded by society contradict their principles. Evangelical political activists in the various government spheres often act towards sanctioning laws that benefit their confessional interests, as stated by Parente[63], Velho[66] and Montero[60].

Giumbelli (p.89s)[58] emphasizes "the impact of Evangelical insertion on Brazilian society in the last decades," the power of Evangelical organization, mobilization and conquering further spaces, including "public policies implementation in partnership with government agencies" for dealing with social issues. Indeed, it is worth noting the multiplication of non-governmenttal organizations of a religious nature that receive huge state fund transfers for healthcare activities. Montero (p.172s)[60] ponders that "it is difficult to distinguish whether we are facing a religious or a business arrangement in this process of

expanding comptences of Evangelical churches," thereupon indicating an overlapping between the public and the religious spheres.

We highlight that it is neither about disregarding the role of religious and spiritual dimensions nor of the religious coping[27] in disease recovery or substance abuse rehabilitation processes nor as a particular counseling or further help in the treatment of drug users. For the "converted" individuals, the most decisive aspect in their rehabilitation is having had the experience of "being in the place of the other" and "serving the other with love." On the one hand, religious and former addicts build a narrative about the "addicts" and their proper way to live. Insistently repeated that narrative becomes part of the religious indoctrination. On the other had, they creat rules to organize the daily life of drug users – a life that must be governed by prayer and work activities through a discipline that shapes users and makes them docile[53], regulating their lives[55].

The State finances churches actions without criticism, letting them impose to individuals a religious creed and a therapeutic project of moral-religious basis, giving up a universal policy that would benefit the whole population. This represents not just a mistake but a government weakness, as if the State would get smaller, giving up both its role and its staff's expertise in favor of a religious creed and a morally based therapeutic project that put at stake the constitutional secularity of Brazilian society.

Conclusion

Religious institutions that manage the Therapeutic Communities decide upon the best way to rehabilitate drug users, thus being up to them to establish their therapeutic project. By using a moral model that faces drug use as a distancing of God, religious institutions point towards a rehabilitation process that only occurs from a rapprochement with Him. Therefore, the changing power of faith is the most relevant element in this process.

A conclusion that can be drawn from the foregoing is that there is a contradiction between the TC defenders and the health and social work professionals we have observed in our fieldwork: the former expressed disbelief regarding public services, qualifying them as unreliable, besides considering that professionals do not get involved in the rehabilitation of drug users, while the latter criticized the

form of religious treatment carried out by prayer, religious activities and withdrawal, defending that they disregard completly both already established mental health policies – which are the result of long technical and political construction, as reflected in the literature of the area – and and the discourses of social and class movements.

Notwithstanding, it is worth adding that, although acknowledging the aforementioned opposition, there is a complementarity between "scientific" and "religious" treatments, given the Therapeutic Communities are integrated into State practices which, by doing so, invest in contradictory and theoretically irreconcilable care policies of care services. As registered in our fieldwork, health professionals either granted by the State or working as volunteers in their spare time work in TC and do not represent an opposition to the institutional treatment project. On the contrary, they cooperate with a treatment that is in accordance with their own beliefs, which makes us question the type of care service they provided for Brazilian public services.

In spite of most religious leaders granting success to the religious proposal, some acknowledged that the instruments at their disposal are insufficient to manage such a complex problem as drug abuse, evaluating their actions as far short of the need.

The religious Therapeutic Communities have popular support and are granted funding as if they were the best option for the recovery and rehabilitation of drug users, particularly crack cocaine users. In a sense, they meet the immediate anxieties of patients and their families who do not find answers in the public infrastructure, notably due to the State withdrawing drug users from their communities and making them undergo a treatment that is often mandatory.

Given that the religious Therapeutic Communities act in the Brazilian context of substance dependence, the State must monitor, inspect and evaluate these entities. Above all, however, as previously recommended, it is urgent to invest in strengthening and expanding the territorial mental health services, notably the Psychosocial Care Centers for Alcohol and Other Drugs (CAPS AD). Instead of embracing a generic therapeutic project based on religious-moral principles, outsourcing TC care services, the State must strengthen individualized treatment proposals, emphasizing a care program approach based on respect to individuals, their right to make choices as well as their inclusion in the health reestablishment process.

Collaborators

Fernanda Mendes Lages Ribeiro has participated in the production, discussion, writing and manuscript review. Maria Cecilia de Souza Minayo has participated in the discussion, writing and manuscript review.

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