The trend toward neoinstitutionalization and religious discourse: elements of analysis for psychiatric reform

A tendência à neoinstitucionalização e o discurso religioso: elementos de análise para a reforma psiquiátrica

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Abstract

Based on the experience of Italian democratic psychiatry, deinstitutionalization became the main axis of the Brazilian psychiatric reform policies. However, the tendency to isolate mental health users persists, leading to recurrent hospitalizations or neo-institutionalization. In the absence of the old asylums, new circuits for the confinement of madness have been created, with therapeutic communities as a paradigmatic example. Considering that the institution is the set of sayings, practices, and moralities that objectify users, translating the dominant rationality, it is necessary to show the ideology of the new asylum strongholds to understand the function they are fulfilling in today's society. Therefore, this study seeks to analyze, by a narrative bibliographical review, what these institutions represent, how they operate, and what questions they pose to the psychosocial care network – especially the in the *Centro de Atenção Psicossocial* (CAPS - Psychosocial Care Center). In discussing the case of Centro Vita and the therapeutic communities, which express a similar logic, we found that if, on the one hand, they are places destined for the death of unproductive people, on the other hand, they embody moralities and mentalities crossed by religious discourse, responding to subjective and existential needs that must be urgently addressed in view of the growing social disaffiliation that plagues mental health users and their families.

Keywords: Neo-institutionalization; Therapeutic Communities; Religion; Psychiatric Reform; CAPS.

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Resumo

A desinstitucionalização, apoiada na experiência da psiquiatria democrática italiana, se tornou o eixo principal das políticas da reforma psiquiátrica brasileira. Contudo, a tendência a isolar usuários de saúde mental ainda persiste, levando a internações recorrentes ou à neoinstitucionalização. Na ausência dos antigos manicômios, vêm se constituindo novos circuitos de confinamento da loucura, que têm as comunidades terapêuticas como exemplo paradigmático. Considerando que a instituição é o conjunto de dizeres, práticas e moralidades que levam à objetificação dos usuários, traduzindo a racionalidade dominante, é preciso revelar a ideologia destes novos redutos manicomiais para entender a função que cumprem na sociedade atual. O presente artigo busca, portanto, analisar, por meio de revisão bibliográfica narrativa, o que estas instituições representam, como operam e quais questões elas colocam para a rede de atenção psicossocial – em particular os Centros de Atenção Psicossocial (CAPS). Ao discutir o caso do Centro Vita e das comunidades terapêuticas, que expressam uma lógica semelhante, constatou-se que, se por um lado são locais destinados à morte dos improdutivos, por outro, encarnam moralidades e mentalidades atravessadas pelo discurso religioso, respondendo a necessidades subjetivas e existenciais que precisam ser tratadas com urgência, diante da crescente desfiliação social que assola os usuários de saúde mental e seus familiares.

Palavras-chave: Neoinstitucionalização; Comunidades Terapêuticas; Religião; Reforma Psiquiátrica; CAPS.

Introduction

Based on the experience of Italian democratic psychiatry, deinstitutionalization has become the cornerstone of Brazilian psychiatric reform policies, seeking not only to remove mental health users from psychiatric hospitals, but also to guarantee their social inclusion with the support of *Centro de Atenção Psicossocial* (CAPS – Psychosocial Care Centers). These services offer a variety of therapeutic resources, such as therapeutic workshops, work, and income generation projects, individual, group and family care, crisis care, home visits, outings and links with family clinics and other services in the local area. It is through these strategies that CAPS seek not only to deconstruct the psychiatric institution as an establishment, but also as a set of sayings, practices, and moralities that lead to the objectification of users, translating the dominant rationality. Nevertheless, the tendency to exclude and isolate madness still persists, leading to recurrent hospitalizations or neo-institutionalization (Fiocruz; Calouste Gulbenkian Foundation, 2015). Between shelters, asylums and private psychiatric clinics, therapeutic communities and prisons, many people are once again being captured by the asylum logic. The family, which has become a key player in caring for a member with a mental disorder, often seeks hospitalization as a way of relieving the physical and subjective burden brought on by the daily relationship with the patient, and also because it still sees hospital treatment as the most effective response to emotional and behavioral changes.

This article seeks to discuss what these institutions represent, how they operate and what questions they pose for psychiatric reform, offering support for CAPS to rethink their work. It is a reflective essay on the subject of the neo-institutionalization of mental health users, based on a narrative bibliographical review that analyzed articles, books, and reports that discuss and map the new institutionalizations, especially in therapeutic communities (TCs), with sociological and philosophical debates that can contribute to broadening the understanding of the phenomenon. By discussing the case of Centro Vita, in Porto Alegre, and then the therapeutic communities, which

express a similar logic, it will be possible to see both the social, political, and economic context that gives rise to the constitution of these institutions, and the meanings that users and their families find there, with religion as the guiding thread. As this is a movement that goes against the grain of psychiatric reform and the work of CAPS, this trend can help to place them under scrutiny and point the way to overcoming obstacles for substitute services.

While there is a vast bibliography on the revolving door[1] investigating its reasons and strategies to alleviate it (Machado; Santos, 2012; Muniz; Nogueira; Guljor, 2014; Sgambati, 1983; Silva; Stefanelli, 1991; Silveira et al., 2016; Solomon; Doll, 1979), there are few studies on the cases that have been institutionalized in other types of nursing homes. In the United States, the percentage of Americans living in institutions of all kinds remained at 1% from 1950 to 1970, of which the proportion of people occupying state hospitals fell from 39% to 20%, while those living in nursing homes increased from 19% to 44%, with conditions in nursing homes being as precarious as those of city wanderers (Talbott, 2004). According to Melman (2001), some patients, especially those whose condition was worsened by a long institutional stay, were transferred to non-psychiatric asylums and private therapeutic communities and a large contingent ended up abandoned on the streets.

According to Marrow and Luhrmann (2012), the presence of schizophrenics on the streets has become almost the norm in the USA. Many people with severe psychotic disorders live nomadically, moving between assisted housing, shelters, hospitalizations, the prison system and homelessness, what Kim Hopper has called the "institutional circuit" (Hopper et al., 1997 apud Marrow; Luhrmann, 2012). Although they offer some mental health treatment, rehabilitation, meals, and beds to those who would otherwise be completely unattended, these institutions also keep them in a situation of marginality, expressing the paradox of care/abandonment. By locking poor people with serious mental illnesses out of conventional housing, in places similar to American refugee camps, the "institutional circuit" ends up corroborating homelessness at the same time as it provides shelter (Marrow; Luhrmann, 2012).

In Boston, only 500 of the 4,000 patients removed from the State Hospital in 1960 were living in the community (Bandeira, 1991). Of the remainder, 200 returned because they were considered incapable of living in society, 1500 were dead by 1977, 800 went to nursing homes, and 1000 to other services, such as board-and-care and transitional housing. For Talbott (2004), what was achieved was not deinstitutionalization, but transinstitutionalization. The patient with chronic mental illness has had their place of life and care transferred from a single bad institution to several miserable ones. In this same perspective, Rotelli (2001) states that deinstitutionalization, understood and practiced as dehospitalization, led not only to the abandonment of significant portions of the psychiatric population, but also to transinstitutionalization (moving to retirement homes, hostels for older adults, "non-psychiatric" chronic wards...) and to other—more obscure—forms of hospitalization. When dehospitalization was carried out according to bureaucratic-administrative procedures and was not accompanied by a complex process of deinstitutionalization, it resulted in the "debasement of meanings" and "a reality made up of squalor and abandonment" (Venturini, 2016, p. 112, free translation).

In Europe, studies indicate that, since 1990, the decrease in the number of beds in psychiatric hospitals has been accompanied by an increase in forensic admissions, places in sheltered housing and people with mental disorders in prisons. Based on an analysis of data from 11 different Western European countries (United Kingdom, Ireland, Denmark, Austria, Belgium, France, Germany, Switzerland, the Netherlands, Spain, and Italy), Chow and Priebe (2016) concluded that the associations and driving factors behind this trend remain unclear. For this reason, the authors indicate the need for further

1 This phenomenon began to be studied in the 1960s and is considered a consequence of the psychiatric reform model, which is still being implemented. The method for defining the revolving door is based on a ratio between the frequency of readmissions and the length of study, which can vary in different proportions: two or more hospitalizations in a one-year period; three or more in a two-year period; four or more in a five-year period; four or more without an interval of more than two and a half years, over the course of ten years (Parente et al., 2007).

research to take into account the characteristics of patients in different institutions, evaluate the effectiveness of care in each of them, and cover a long-term period, with the aim of supporting more appropriate mental health policies.

In India, although a large proportion of people with mental disorders remain subjugated in the family environment, there is a particular institutional circuit to which they are taken when families have financial resources (Marrow; Luhrmann, 2012). Since the 1980s, there have been new private psychiatric hospitals in operation, built as a reflection of Indian deinstitutionalization, which transformed state-funded custodial institutions into units for the care of acute psychiatric conditions. These hospitals encourage abandonment, as they did not require relatives to visit inmates.

In Brazil, setbacks are also being seen with the trend towards neo-institutionalization, with policies regarding social assistance (with shelters for older adults, children, and adolescents), alcohol and other drugs (with therapeutic communities), the expansion of health insurance plans with low state regulation (leading to an increase in psychiatric hospitalizations in private establishments), the socio-educational system (with the hospitalization of adolescents who commit offense), and the penal system (both in psychiatric custody and treatment hospitals and in ordinary prisons, a phenomenon that has still been little studied) (Fiocruz; Calouste Gulbenkian Foundation, 2015). In relation to this last point, Bandeira (1991) states that without drug treatment combined with supportive therapy, the likelihood of worsening acute outbreaks, active symptoms, and drug use increases, leading many patients to commit petty theft and robberies that culminate in the street-prison-hospital cycle. According to Brink (2005), the percentage of prisoners with mental disorders is between 55% and 80% and the rates of psychosis in these environments are often higher than in the community. A series of studies in different countries indicate that the prevalence of mental disorders in the prison population is significant and can be five to ten times higher than in the general population (Andreoli et al., 2014).

In a study carried out in the city of São Paulo by Andreoli et al. (2014), it was found that the lifetime and 12-month prevalence of any mental disorder in the prison population is 68.9% and 39.2% among women, respectively, and 56.1% and 22.1% among men, a significantly higher proportion than outside prison. In relation to serious mental disorders, while the rates vary between 0.4% and 7.7% in the general population, 12-month prevalence rates of 14.7% and 6.9% were identified among women and men prisoners, respectively, results similar to those of other studies.

According to Lefebvre (1987), judicial and legal bodies have contributed to prison becoming an alternative to deinstitutionalization, to the point where psychiatric cases occupy 10%-15% of vacancies in the prison system. The insufficiency and inadequacy of social and care services, as well as the lack of understanding and rejection by both public health units and the community regarding young psychiatric patients, contribute to them being taken by the criminal justice system. The label of dangerousness is used to justify their exclusion and cover up the network's inability to treat them.

Zones of social abandonment

Venturini reports on new ways of isolating patients with serious mental disorders:

> There remains the response of systematizing people who are annoying or unproductive, and various interests are solidifying around this demand. An example of this mechanism is the growing weight placed on prisons, temporary detention centers for immigrants, institutions for the disabled, *assisted living facilities* for older adults, privately-run therapeutic communities for the treatment of alcohol and other drug users [...] in psychiatry, new forms of care have emerged, managed by the private sector, which are more morbid than the old segregating institutions: residences for people suffering from mental illness, sheltered communities, homes for the elderly—veritable ghettos of the 21st century (Venturini, 2016, p. 85-86, free translation).

This shows that a parallel network to the psychiatric reform services persists, reactualizing forms of confinement that have never been overcome. According to Biehl (2005), the demands and strategies of the

anti-asylum struggle were entangled with neoliberal movements in the field of health and even boosted these movements, to the extent that psychiatric patients were evicted from overcrowded and inefficient asylums, but little investment was made in the territorial network. There were more people with mental disorders on the streets than ever before. Amid high rates of poverty, unemployment, drug trafficking, and violence, philanthropic and religious institutions have taken on the role of caring for groups left destitute by an increasingly absent state. These spaces are built in view of the "vacuum of responses" in which the poorest people find themselves.

In the city of Porto Alegre—the site of Biehl's ethnographic research (2005)—while the number of "geriatric homes" was around 25 in 1976, by the early 2000s there were more than 200, 70% of which operated clandestinely, housing older adults, the mentally "ill," and people with severe disabilities. Many of them received state funding and philanthropic donations (Biehl, 2005). In 1997, health inspections identified that between 20% and 30% of the patients in the more than 200 existing institutions were psychiatric.

Since the 1990s, Centro Vita—an asylum/rehabilitation institution for drug users and alcoholics in Porto Alegre—has received not only alcoholics and drug addicts, but also a growing number of people with broken family ties, such as psychiatric patients, the sick, the unemployed, and the homeless, left there by relatives, neighbors, hospitals and the police[2]. Its founder, "Zé das drogas," a former street dweller and narcotrafficker, after converting to Pentecostalism, had a vision in which a spirit told him to open an institution where people like him could find God and regenerate their lives. Some inmates belonged to working- or middle-class families and others came from medical or state institutions from which they had been evicted to the streets or straight to Vita. We see here a process of transinstitutionalization and not deinstitutionalization as the reform policy would advocate. The example of Centro Vita, in this case, aims to contribute to understanding the logic that operates in neoinstitutionalization spaces and what motivates the exclusion of countless mental health users in this circuit, revealing a rationality common to therapeutic communities, as will be seen below.

According to Biehl's ethnography (2005), care at the Center involved a disciplinary routine, with the teaching of civic values, "good" diet, personal hygiene, total abstinence from cigarettes, drugs and alcohol, labor therapy, self-reflection groups, the administration of psychiatric medication, mechanical restraint in certain situations, and religion, which remains present in the institution's trajectory from the beginning. One of the staff members made it the basis of his support in the ward, mediating the religious conversion of his closest colleagues and bringing his friends from the Pentecostal church to work regularly. If, on the one hand, there was no adequate treatment for psychiatric cases, on the other, the patients had nowhere else to go and some even sought out the institution. With no alternative, Vita kept them there, seeking to promote moralization of behavior, control through psychotropic drugs or simply removal from social interaction.

The exclusion is so radical in these spaces, as well as the condition of exception in relation to justice and human rights, that Biehl (2005) uses the notion of "ex-humans" to designate those who are there. Vita did not fit in with the precepts of psychiatric reform, remained exempt from supervision or regulation and was even supported by judges, who praised it and argued that there was nowhere else for the inmates. Large sums of money were allocated to the Center through regional and national funds earmarked for philanthropic and pastoral work that replaced former state institutions. In reality, Biehl's (2005) ethnography reveals that the function of letting people die is what guarantees the institution the most money, because as the state does not take responsibility for older people, the disabled, and people with mental disorders, it is necessary to ensure a place where they can end up.

In 1995, a large number of the 200 patients in the ward had no formal identification and lived

2 All the analysis of the institution in this article, including statements by employees, comes from a critical reading of the ethnography carried out by Biehl (2005) at the establishment, and not from on-site observation.

in a degrading situation. These "zones of social abandonment," which are widespread in Brazil's big cities, "house the mentally ill and homeless, AIDS patients, and new and old unproductive bodies in inhumane conditions" (Biehl, 2005, p. 4, free translation). As well as not intervening in these zones, the authorities direct unwanted individuals to them, ensuring that they remain anonymous, without rights and without anyone to take responsibility for their care. In this way, these institutions are not only sheltering those who do not fit into the political-economic game but also ensuring their exclusion by inserting them into a new social delimitation, capable of maintaining their place of exception and exempting the public authorities from responsibility. Ultimately, these spaces act to accelerate the death of these people.

In this sense, Agamben (2002) proposes the notion of bare life based on *Homo Sacer*, a figure from Roman law that designates someone whose existence is worthless, whose murder would not be punished or even considered as such. It is a prototype of what happens in concentration camps, a typical configuration of states of exception, which, for the author, have become the very mode of operation of democratic power in contemporary times. The body as a biopolitical reality is elevated to the position of a productive instrument of the state to such an extent that the possibility of killing it becomes the main tool of power (Agamben, 2002). It loses its value and meaning in the city beyond the biological attributes that move it to work. As Mbembe (2018) shows with the concept of necropolitics, the capitalist system is intrinsically based on the unequal distribution of the opportunity to live and die. For the author, the logic of sacrifice has always been at the heart of neoliberalism, which could therefore be called "necroliberalism."

In Vita, bodies are killable precisely because they do not fit into the economic game. The "making die," typical of aristocratic sovereignty, is actualized in this permanent state of exception that befalls the insane, drug addicts, the miserable, criminals, among others. Necropower, a structural element of current neoliberalism, operates through practices and devices that manage the death of certain populations (Mbembe, 2018). Therefore, the "make die, let live" of sovereignty is not exactly replaced by the "make live, let die" of national states in the exercise of biopower[3], but "make live and make die" coexist and complement each other to ensure that society is constituted within a certain mold. The government also acts on life through the power of death.

According to Foucault himself (1999), the production of life is linked to the possibility of letting people die, since the elimination of some would ensure the existence of all, in logics such as state racism and wars. Genocide does not only mean physical death, but also political annihilation and expulsion from the social fabric. In the author's words, "The fact that the other dies does not mean simply that I live in the sense that his death guarantees my safety; the death of the other, the death of the bad race, of the inferior race (or the degenerate, or the abnormal) is something that will make life in general healthier: healthier and purer" (Foucault, 1999, p. 305).

By tracing the reasons for abandoning someone in a place like Vita, it becomes possible to understand the social, family, medical, psychopharmacological, and scientific arrangements that determine who deserves to live or die. The family is a central cog in the wheel that decides whether the patient will remain in society or be abandoned to death, and science, with medication, takes on the role of bringing a certain neutrality to this decision.

With the fall in state investment in public sectors in the context of neoliberalism, the family has taken on the role of "psychiatrist by proxy," using medical techniques to carry out functions that would otherwise fall to the state in the form of health services (Biehl, 2005). Based on a logic of control and

3 For Foucault (1999), the King's power to kill his subjects was what guaranteed control over them at the time of sovereignty. With the assumption of modern national states in the 18th century, another type of power was formed, no longer based on the ability to make die, but to make live. Life gains political value because of its productive capacity. Capitalism gave birth to the reality of a new body, which became the labor force of nations. This body-wealth needs to be cared for and optimized in its collective dimension, as part of a whole—the population—crossed by biological processes such as birth, morbidity, mortality, ageing... The state begins to manage these natural processes through biopower, with medicine as one of its main instruments.

productivity, members with mental disorders who do not accept medication and remain outside the order established by the family group are sent to the asylum. For Alverga and Dimenstein (2006), manicomial forms of expression or subjectivity permeate all of space-time, running in our actions. It is the "asylum yearning," that is, the desire to dominate, subjugate, classify, hierarchize, oppress, and control, which are ingrained in the social fabric, that generate the driving force behind the institutions, expressing themselves in the practices and conceptions still present in the field of mental health.

The history of abandonment can be seen as the negative of a photograph, which, if revealed, shows the ways of life endorsed today. The frequent rhetorical questions from family members and staff at the Vita Center asking "what to do?" in a way that indicates that there is no other way out than exclusion, seem to reveal that contemporary ways of being do not intend to reformulate themselves to embrace those who do not fit into the productive daily life. The words of one of the institution's employees are emblematic. According to him, when faced with a sick and unproductive family member, especially in low-income families, there would be no other way out than institutionalization.

Therapeutic communities and the religious paradigm

Although Centro Vita does not call itself a therapeutic community, it has many similarities with these institutions. According to *Relatório da Inspeção Nacional em Comunidades Terapêuticas* (CFP, 2018), while the number of beds in psychiatric hospitals has fallen sharply in recent years, communities have grown in number and have been gaining new uses, taking in not only alcohol and other drug users, but also patients with severe mental disorders, homeless older people and people whose behavior is judged to be morally deviant. This profile shows that these communities have taken on the role of isolating people with socially reprehensible behavior. In the words of the report, "each example ratifies the profile of these spaces as a contemporary expression of segregation" (CFP, 2018, p. 136, free translation). The hospitalization of users with different types of psychological distress reveals that these institutions have become "a renewed expression of mental institutions" (CFP, 2018, p. 139, free translation). Both at the Vita Center and in the communities, psychiatric knowledge only exists in association with other approaches, forming a hybrid that seeks not only psychopathological treatment, but above all the control of bodies through medication, religion, and disciplinary practices.

These institutions have existed in Brazil and other countries since the late 1960s, but have spread more intensely here in recent decades, both through religious organizations linked to numerous Christian churches and private for-profit organizations (Vasconcelos; Cavalcante, 2019). As legal entities, they have adopted various names in Brazil: clinics, treatment centers, religious and secular communities, houses, and welcoming therapeutic communities, both philanthropic and private. They offer services generally located in isolated areas, without legal formalization, many created by former drug addicts in abstinence (Cavalcante, 2019).

The communities gained ground in the public sphere after being included in the Psychosocial Care Network, in the category "Residential Care Services," and defined, according to Ordinance No. 3,088, of December 23, 2011, of the Ministry of Health, in its article 9, item I, as places intended "to offer continuous health care, of a transitional residential nature for up to nine months for adults with stable clinical needs resulting from the use of crack, alcohol, and other drugs" (Brasil, 2011, free translation).

Despite being included in the Psychosocial Care Network (RAPS), many TCs operate in an asylum-like and segregating manner (CFP, 2018), which is even more serious considering that they benefit from public funds. Of the 28 institutions visited by the National Inspection, 18 received some kind of funding or donation from public bodies at municipal, state, or federal levels, although many of them do not have the minimum infrastructure or health conditions. What is striking is that, in practice, the central axis of treatment in most of the communities goes against the logic of psychosocial care. As soon as they enter the TCs, the newcomers are searched in a way that resembles the prison system, having to squat and stand naked. In addition,

they are stripped of their personal documents in 85% of cases, which "limits the possibility of unilateral abandonment of treatment, and exerts a very significant symbolic effect of 'mortification' of the previous self" (Natalino, 2018, p. 47, free translation), as in the total institutions analyzed by Goffman (1961). Another factor that contributes to this subjective mortification is the projection of the architectural space, which makes all spheres of life shared, including rest and leisure time. This indistinction between public and private is typical of total institutions.

Also according to Natalino (2018), inmates are relegated to a situation of social isolation, which is favored by the geographical isolation in which the TCs are located, 74% of them being in rural areas. Other factors that contribute to the restriction of social interaction are the impediment of free range; the use of high and/or electrified fences, surveillance cameras, and constant observation by staff; the application of punishments in the event of attempted escape; restriction of visits; retention of documents, belongings, bank cards or access to social security benefits; the control of telephone calls; violation of correspondence; and the locking of bedroom doors at bedtime and after lunch for "sleep therapy", with no connection to the outside world in case of any emergencies (CFP, 2018).

The infringement of Law no. 10.216 (the Psychiatric Reform Law) is clear in most of the communities, considering the countless obstacles placed in the way when the inmate decides to leave, such as fines for breaking contracts, withholding documents and pressure on family members, which takes away the person's power to decide to end treatment, characterizing deprivation of liberty. Even more serious than violating the principles of psychiatric reform are the human rights violations committed by some of these institutions, with the application of punishments and penalties that could even be classified as torture and degrading treatment under Brazilian law: compulsory performance of repetitive tasks (especially copying biblical passages), increased labor therapy, suppression of food, physical violence (especially in the event of escape attempts, with a punch in the eye or chokeholds), isolation for long periods (in rooms or cubicles within the institution itself), sleep deprivation, and irregular use of mechanical (tie-downs) or chemical (medication) restraint (CFP, 2018).

With regard to the approach adopted in these institutions, Loeck shows that "TCs present hybrid and fluid configurations, sliding between the religious-spiritual and technical-scientific paradigms" (Loeck, 2018, p. 81, free translation). Although non-technical workers still predominate, more linked to the religious side of the model, there has been a "significant professionalization of these entities, which has made the symbolic universe of these institutions increasingly complex" (Loeck, 2018, p. 82, free translation), involving psychologists, social workers, nurses, and doctors. Between individual and group psychotherapy, labor therapy and Twelve-Step meetings (on the model of Alcoholics and Narcotics Anonymous), the communities glide between different approaches that mix medical, psychological and social assistance knowledge, spiritual practices (IPEA, 2017), re-signification of personal history through the absolute condemnation of drug use, appreciation of work and fear of God. Drug addiction is seen both through the prism of medicine, from the notion of chemical dependency—a chronic and incurable disease—and religion—in the form of sin.

Just as in the logic of the asylum, which was based on the idea of a mental illness supposedly independent of situational vicissitudes, the TCs take problematic drug use as an individual issue, whether based on the idea of sin or incurable disease (Loeck, 2018). Identification with this label leads individuals into a spiral of attempts to break free from their "intrinsic deviance," building an institutional career that can involve both coming and going from the TC and choosing to continue working in the area. Numerous inmates spend years in the institution, a time that is prolonged because family members have no interest in coming for them.

Regarding those who leave the communities, it's worth noting that many return, as shown by the high rates of recidivism. In 2015, almost half of the 138,568 people housed in TCs had previously been in similar institutions. The proportion of recidivists is higher than that of those who complete their treatment, with a 55% drop out early (Natalino, 2018). Regarding recidivism rates, Natalino (2018) states

that they are directly proportional to the degree of social isolation and rigidity of the disciplinary regime applied in these institutions. Communities promote the reconstruction of the self, as they instill in the individual the renunciations characteristic of their ideological and social configuration. In this way, they restrict the possibilities of reconstituting ties with the civil world and increase dependence on the moral world and the disciplinary regime of the institution. Furthermore, inmates who leave the TCs and find scrapped and deficient public networks tend to suffer recurrent readmissions, configuring the revolving door phenomenon in the communities (Natalino, 2018).

Cavalcante (2019) points out that during the same period as the expansion of the mental health network, with an increase in the number of CAPS in the country, therapeutic communities became politically stronger. In other words, it was not just the shortage of services resulting from the reform that paved the way for TCs, as they also already had a political force capable of encouraging their spread and helping them to establish themselves as a parallel circuit. Taking up the notion of *hemidern* rationality (Parker, 1995), Cavalcante assumes that the intertwining of religious discourse and the medical and legal paradigms, driven by the driving force of popular tradition, is behind this consolidation. The communities embody the constitutive vectors of our society's hybridity, which has religion as the guiding thread of expectations, moralities, and mentalities. As Maluf (2011) shows, this heterogeneity goes beyond the limits of established knowledge. The author observes the emergence of a field of intersections between new forms of religiosity and spirituality, as well as alternative therapeutic practices of different kinds in large Brazilian cities from the 1990s onwards, which she relates to historical elements of the country's social and cultural configuration, involving the eclecticism of both religious and therapeutic experiences. The way in which these experiences are intertwined in the lives of each individual implies a field of construction of meanings for existence and strategies for self-care that go beyond the scope of formal techniques and biomedical discourses. It is this *sui generis* way of bringing together the therapeutic and the religious that is expressed in therapeutic communities.

Because it is typical of our culture, this tendency is also present in other environments, such as psychiatric clinics, prisons, schools, and churches, with a morality that actively participates in the links between treatment and religion. The logic of self-help, based on group work to normalize conduct, morality, and religiosity as a path to changing lifestyles, is the *modus operandi* that permeates different institutional modalities. In line with the notion of institution used in this work, TCs are not just places with a fixed address, but above all a set of knowledge and practices based on philosophical and theoretical influences that go beyond the walls of the establishment (Cavalcante, 2019). A demonstration of this can be found in the Centro Vita itself, analyzed above; although not a therapeutic community, it has very similar characteristics: new uses, which include people with mental disorders not associated with alcohol and other drug addiction; the strong presence of religion as a form of treatment; discipline in the search for moral correction of the individual; the support of politicians and sectors of the judiciary that have been disregarding the precepts of psychiatric reform.

Although these aspects indicate the social resistance to deinstitutionalization and the moral view that still falls on a large proportion of people with different kinds of mental disorders, they also allow us to see that these institutions play a structuring role, capable of responding to unmet needs in other spheres. As Vasconcelos (2019) shows, many neo-Pentecostal churches[4] provide social and personal support throughout the day and even on night shifts, in contrast to the scarcity of public services for psychosocial care, support for drug addicts, social assistance, and health care as a whole in many of the cities' poor and marginalized neighborhoods. Paradoxically, while religions lead to intolerance towards certain forms of subjectivity, they also play an indispensable role with symbolic and socializing mechanisms (Vasconcelos, 2019). In peripheral and disadvantaged locations, neo-Pentecostal churches

4 Neo-Pentecostalism is the predominant religion in therapeutic communities and similar institutions.

offer spaces for socialization and coping with extreme existential situations, via "faith healing" services and rituals. Evangelical congregations promote a sense of community through a network of solidarity that helps the poorest deal with difficult experiences such as illness, unemployment, and violence. The sense of belonging and identification provided by this network contributes to the structuring of subjectivities weakened by socioeconomic conditions.

The need to reconfigure ties and build references is striking in the contemporary context of growing individualization, vulnerability, and social disaffiliation[5]. With the loss of collective regulations, a "mass individualism" takes shape, which Castel (1998) illustrates with the image of the young drug addict in the suburbs, for whom the lack of ties, job stability, family transmission, and future prospects make their body the only asset and bond. In the sociologist's words, these traits "are found in numerous situations of insecurity and precariousness that are translated into shaky trajectories, made up of restless searches to get by in everyday life" (Castel, 1998, p. 603, free translation). In the current context of advancing neoliberalism, this reality becomes even more overwhelming. The contemporary promise of living individuality freely and independently is fading for people in social positions that lack objective resources and collective protection.

In Brazil, the trajectories of people in situations of social vulnerability are most acutely affected by the following factors: a notable increase in people living alone or single-parent families (especially led by women); domestic overload due to the growing participation of women in the labor market; a reduction in the physical presence of men and women in the home, as well as the precariousness of the symbolic functions of motherhood and fatherhood; a decrease in the ability to provide care for dependent family members; a tendency to occasionally or permanently leave the family home as a way of surviving, leading to more abrupt losses of ties (Vasconcelos, 2019).

In this scenario, religious discourse, particularly neo-Pentecostalism, takes on the role of establishing a collective and shared sense where neoliberalism has generated individual accountability. In the words of Vasconcelos (2019, p. 164, free translation), "current neo-Pentecostal religions offer a shared psychic structure, with their respective intense defense mechanisms associated with rituals of symbolic efficacy that polarize the vicissitudes of life between the extremes God/total good and Devil/total evil." The idea that problems, pain, and addictions are the work of the devil and that a path of devotion and faith can lead to healing helps to relieve the subject of responsibility—relieving stigma in the eyes of family and community—as well as setting a tangible horizon for change. Often, the pastors themselves have life stories marked by drug addiction, crime, trafficking, or other devastating experiences, making them real examples of the possibility of transformation, with whom the faithful identify as they set out to build a new path. In addition to the symbolic offering present in this theology, the social and philanthropic works aimed at the members and the poorest make it possible to make up for the precarious situation in which they find themselves.

Final considerations

This article sought to look at the different forms of neoinstitutionalization, not only as negatives of the deinstitutionalization process, but also as indicative of the needs of users and their families that are not being met by the reform mechanisms, as well as social, economic, and political aspects that require attention. The construction of new institutionalizing circuits and the families' search for these places shows how the institution has been updated in our society. In the absence of the old asylums, moralities, and disciplinary practices permeated by religious discourse drive other forms of confinement of madness, revealing functions that need to be considered in the current deinstitutionalization process. In this scenario, the example of therapeutic communities is an important element of analysis, due to their prevalence and expansion, as well as for catalyzing central elements

5 For Castel (1998 apud Vasconcelos, 2019), social disaffiliation stems from the weakening of social protection - private or public –, work ties and ties with family members and the closest social network.

of the social context, which also operate in other places of neoinstitutionalization, as shown by Cavalcante (2019).

Despite these places acting to accelerate the death of the unproductive, as we saw with Biehl (2005), relegating them to the condition of ex-humans, we must also analyze the meanings that many users and their families find there, with religious faith as the guiding thread. Given the social disruption brought about by the advance of neoliberalism and the consequent deepening of the processes of exclusion of the most vulnerable, religion offers a repertoire of subjectivation devices from which to formulate answers to deep existential questions, a source of precepts for the construction of individual identity and morality or a framework of philanthropic and welfare practices (Vasconcelos, 2019). Understanding the scope of therapeutic communities and other institutions linked to religious discourse, therefore, requires us to shed light on these functions and take them as a means of questioning our practice.

For Cavalcante (2019), it is essential to recognize the Brazilian *hemidernia*, with all its religious knowledge and practices, intertwined with other knowledge, in order to get in touch with the references used by many of our users to make sense of existence. This dimension needs to be not only considered, but also included in clinical practice through coordination with religious organizations that are part of the subjects' support network, seeking to strengthen those that question the violation of rights and the prohibitionist logic. Deinstitutionalization, in its broadest sense, involves this movement of giving way to the references that make up the identity and subjective construction of each user, removing them from the position of object.

In the weaving of this network, in which substitute services need to go beyond the walls of the establishment to connect with the entities that make up the lives of the users they care for, it is clear that the CAPS routine must go beyond carrying out therapeutic activities within the service, deinstitutionalizing the care itself. Participation in strengthening each user's network, as well as welcoming the crisis and listening carefully to these individuals and their families in the face of experiences of extreme psychic disorganization, violence, and social risk—precisely those that give rise to the search for asylums based on religious discourse—are key points in confronting neoinstitutionalization. It is necessary to promote reaffiliation, continuity, and subjective anchoring where "necroliberalism" has produced rupture, disaffiliation, and helplessness. Just as the subject needs to be socially reaffiliated and their mental health condition understood within a social, political, and economic field, CAPS also need to act as a network and, to do so, recognize the network that refers each subject. In order for this circuit to operate with the necessary force, with the necessary resources and professionals to guarantee the mobility of the service towards the existential territory of each user, public investment must be directed entirely towards the substitutive network, with the end of any funding for therapeutic communities or other such institutions.

From this perspective, some questions arise for our practice: how are CAPS relating to religious organizations that provide support and identity references to users? Why is the way some patients' demands are handled not enough for them to understand the service as a place capable of accepting difficult experiences, and so they end up seeking solutions in therapeutic communities or other institutions of this kind? What stance are the CAPS taking with these users, failing to provide the subjective contour and support they need in some situations? This is the challenge for psychiatric reform in the coming years.

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Contribution of the authors

L.M. Corrêa carried out the research and wrote the article. R.C. Lima supervised the research and revised the article.

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