

**Bridging the divide: integrating addiction and mental health care in the Brazilian Psychiatric Reform.** This article examines the complex relationship between mental health care and substance use treatment in Brazil, specifically analyzing how the separation between these fields has evolved within the context of the Brazilian Psychiatric Reform (RPB). Through qualitative research involving in-depth interviews with mental health professionals, legal professionals, and mental health care users in the state of Bahia, the study explores how the historical divide between mental health and drug addiction treatment has shaped care practices and policies. The research argues that the apparent division between mental health and substance use treatment masks a deeper unity in their challenges, as both fields confront similar institutional logics of control and segregation. The article concludes that advancing a truly democratic psychiatric reform requires moving beyond the health-versus-justice dichotomy to address the intersecting issues of racism, social justice, and human rights in both mental health and addiction care.

**KEYWORDS:** mental health policy; anti-asylum movement; drug policy; harm reduction; therapeutic communities; social movements.

**Superar a divisão: integrar o tratamento das dependências e da saúde mental na Reforma Psiquiátrica Brasileira.** Este artigo analisa a relação complexa entre os cuidados de saúde mental e o tratamento do consumo de substâncias no Brasil, examinando especificamente como a separação entre estes campos evoluiu no contexto da Reforma Psiquiátrica Brasileira (RPB). Através de uma investigação qualitativa baseada em entrevistas com profissionais da saúde mental, profissionais de direito e utilizadores de serviços de saúde mental no Estado da Bahia, o estudo explora de que modo a divisão histórica entre saúde mental e tratamento da toxicod dependência moldou as práticas e políticas de cuidado. Sustenta que a aparente divisão entre saúde mental e o tratamento do consumo de substâncias esconde uma unidade mais profunda nos seus desafios, dado que ambos os campos enfrentam lógicas institucionais semelhantes de controlo e segregação. Conclui que o avanço de uma reforma psiquiátrica verdadeiramente democrática exige ultrapassar a dicotomia da saúde contra a justiça, de modo a enfrentar as questões interligadas do racismo, da justiça social e dos direitos humanos, tanto nos cuidados de saúde mental como nos cuidados dirigidos às dependências.

**PALAVRAS-CHAVE:** política de saúde mental; movimento antimanicomial; política de drogas; redução de danos; comunidades terapêuticas; movimentos sociais.

MÔNICA NUNES  
MAURICE DE TORRENTÉ  
TIAGO PIRES MARQUES  
MABEL JANSEN

## **Bridging the divide: integrating addiction and mental health care in the Brazilian Psychiatric Reform**

### **INTRODUCTION: THE ROLE OF JUSTICE IN ADDRESSING CHALLENGES IN (MENTAL) HEALTH**

In many countries worldwide, mental health care and substance use treatment function as separate, relatively autonomous fields. While both areas traditionally fall under the purview of psychiatrists and other mental health professionals, with their theories and treatments included in major clinical compendiums, there has been a marked tendency for the health sector to primarily manage mental health care, while the justice system frequently oversees drug addiction issues.

This separation can largely be attributed to the historical impact of the prohibitionist movement, which began in the United States in the 1960s and rapidly gained global hegemony (Woodiwiss, 2005). This movement criminalized the use of certain drugs, effectively labeling users as lawbreakers. Consequently, even when problematic drug use was recognized as a disease or a manifestation of psychological distress – thus warranting intervention from health professionals – the criminalization of drugs often necessitated involvement from the justice system due to the legal dimension of the transgression.

Over time, drug use evolved into a state-level concern, with governments taking on the task of regulating the issue, often through the “war on drugs” approach. This strategy aimed to reduce drug production, curb trafficking, and decrease user demand. As Andrade (2018) notes, this policy shift, initiated

decades ago, continues to have significant ideological and institutional repercussions today, having “installed in the public a deep-seated belief that psychoactive drugs must be banished from society” (p. 171).<sup>1</sup>

Six decades later, the social role and function of drugs, especially psychedelics, have undergone significant transformations. Their use in the counter-hegemonic hippie culture of the 1960s, aimed at “widening the doors of perception” and challenging the status quo, stands in stark contrast to patterns of drug use in the 1990s yuppie milieu. Cocaine and amphetamines, for instance, have become increasingly aligned with the productivity demands of high-performance capitalist culture (Birman, 2014). More recently, psychedelics have been reassessed as potential therapeutic tools (Aronov, 2019; Beserra and Vieira, 2020). While drug use may differ across historical periods, we are discussing hegemonic symbolic dimensions. Contemporary uses can also take on meanings of resistance (or “re-existence”, as social movements in Brazil term it) in situations of extreme adversity, notably among highly vulnerable populations like the homeless (Flach, 2019). In addition, drug use has been linked to new forms of group sociability and spirituality, another facet of the psychedelics’ resurgence (Ribeiro, 2022).

This preliminary delineation of the separation between mental health and drug addiction fields – particularly based on the meanings acquired by the phenomenon of (illicit) drugs and their users – reveals complex layers that illuminate the social and historical dynamics governing intervention and care practices for these groups.

Brazil’s Psychiatric Reform (*Reforma Psiquiátrica Brasileira*, or RPB) is a multi-dimensional social deinstitutionalization movement, initiated in the late 1970s and significantly influenced by Italian Democratic Psychiatry, which aims to replace the traditional hospital-centric model of mental health care with a community-based, psychosocial model that emphasizes patients’ rights and social inclusion. Embedded within and running parallel to a broader Health Reform (*Reforma Sanitária*), it extends beyond its legal and institutional frameworks, whose landmark is the passing of Federal Law 10.216 in 2001, and encompasses original cultural and theoretical features (Amarante and Nunes, 2018; Amarante, 2007).

Our research investigates the historical dynamics of the Reform in Bahia, a state in Northeastern Brazil, which has significantly contributed to RPB’s advancement, in particular as far as substance use treatment is concerned, while also exemplifying broader national dimensions and structural tensions.

1 All quotations originally in languages other than English have been translated by the authors.

As already stated, one of the main objects of our inquiry has been the relationship between the mental health and drug addiction fields. The emergence of so-called therapeutic communities has rendered their interaction particularly problematic, bringing into sharp relief the tensions between health-based and justice-oriented approaches to substance use. These institutions exemplify how the complexities outlined above – the criminalization of drug use, the dual medical and legal framing of addiction, and the evolving social meanings of drugs – converge in concrete institutional practices. According to our research interlocutors, “therapeutic communities” began appearing in Brazil in significant numbers around the mid-2000s, spreading rapidly across the country. Operating primarily as religious institutions – both Protestant and Catholic – or as private clinics, these establishments positioned themselves as decisive solutions to the problem of psychoactive substance use. Over time, despite operating at the intersection of health care, religious rehabilitation, and what often amounted to custodial confinement, they gradually gained legitimacy and became institutionalized within public policy frameworks, raising critical questions about the role of justice, health, and rights in addressing drug-related issues. In this article, we will explore some of these complexities, drawing on relevant literature, our field experience and research, and insights from our interlocutors in a research project focusing primarily on mental health and human rights.<sup>2</sup>

Our analysis is empirically grounded in the state of Bahia. While Bahia presents distinct regional characteristics – including its pioneering role in harm reduction initiatives such as the *Centro de Estudos e Terapia do Abuso de Drogas* (1985) and the *Consultório de Rua* (1999), about both of which more later, as well as its trajectory of fragmentation between mental health and addiction fields – these very specificities make it an invaluable observatory for understanding Brazil’s broader psychiatric reform dynamics. Bahia’s experiences anticipate and crystallize tensions that would later emerge nationally: the precarious institutionalization of innovative projects operating as temporary “fireworks” rather than sustainable policies; the delayed recognition of harm reduction work as integral to the Brazilian movement known as *Luta Antimanicomial* (“anti-asylum struggle”, in a literal translation); and the contested terrain between progressive reform and regressive therapeutic communities targeting drug users. Moreover, the state’s dual status as both a laboratory for experimentation and a site of structural contradictions –

2 PSYGLOCAL. *Psychic Suffering and Human Rights: Mental Health Epistemologies, Policies, and Activism in Psychiatry* (Lisbon, Portugal and Salvador, Brazil, c. 1950 – c. 2020). PTDC/FER-HFC/3810/2021.

where groundbreaking practices coexist with institutional fragility and where anti-asylum innovations occurred alongside persistent marginalization of the most vulnerable populations – mirrors the paradoxes inherent to Brazil’s psychiatric reform as a whole. Thus, examining Bahia’s trajectory offers not merely a regional case study but rather a lens through which the challenges, achievements, and ongoing struggles of Brazilian psychiatric reform become visible in their full complexity.

**THEORETICAL FRAMEWORK:  
THE NEW BRAZILIAN DRUG POLICY AS A REFLECTION  
OF CAPITALIST INTERESTS AND POLITICAL POLARIZATION**

In examining treatment within “therapeutic communities”, it becomes apparent that many of the practices employed by these institutions are reminiscent of those found in the early reports on moral treatment for the mentally ill during the beginnings of psychiatry (Foucault, 2005). One might assume, therefore, that these methods are simply being applied to contemporary drug users without requiring new analysis. However, drugs cannot be dismissed as a mere addition to this framework, as they reflect significant social changes that warrant attention. This distinction highlights a shift from what was once described as the “social status of madness” (*lugar social da loucura*; Birman, 1992) to what we would now refer to as the “social status of drug addiction.”

From the 18<sup>th</sup> century through much of the 20<sup>th</sup> century, madness was largely associated with an inability to be productive (Castel, 2015), in a capitalist system that relied on a free, able-bodied workforce to sustain the market economy and drive industrialization. Under these conditions, the insane were infantilized, deemed incapable and irresponsible, and often considered dangerous. As a result, they were placed under medical supervision in the segregated space of psychiatric hospitals (Castel, 1978).

In contrast, the world of drugs, their users, and associated dynamics reflect the contemporary context of financial and consumerist capitalism, characterized by the commodification of social relations. Drugs have become a consumer good that fuels a significant chain of production and power across various spheres of society. Drug users are frequently perceived as “manipulative” (Petuco and Medeiros, 2010), unemployed, indolent, and uncontrolled, driven by cravings (Lancetti, 2020) and considered dangerous. Consequently, they are viewed as requiring removal from social life to undergo treatment.

This impulse toward segregation aligns with the reality of today’s capitalism, where wealth is increasingly generated through financial capital, producing larger segments of the population deemed disposable in an economic

context of “labor non-requirement”. However, it remains important that these marginalized groups remain somewhat integrated into the capitalist system. In the case of drug users, even when efforts to reintegrate this “mass of unproductive people and troublemakers” are limited, the enforcement of social order through their segregation still generates profits for the system. As health-care is one of the most commercialized and profitable sectors, the predominantly private nature of “therapeutic communities” – largely financed by the Brazilian state, which thereby diverts significant resources from public health services – fits within this capitalist framework. Furthermore, there is a political dimension to this system, as many of these institutions are operated by (neo-)evangelical groups connected to an expanding number of elected politicians. These groups leverage their constituencies of faithful voters as political capital, forming a powerful lobby in the Brazilian Parliament (Doudement and Conceição, 2018).

Thus, the theoretical framework adopted here positions contemporary drug policy in Brazil within transformations in the development of capitalism and social control. The shift from industrial to financial capitalism has reconfigured both who is deemed socially disposable and the mechanisms through which marginalized populations are simultaneously excluded and economically exploited. In this context, the expansion of “therapeutic communities” emerges as a convergence point where economic interests (the commodification of treatment), political power (evangelical parliamentary lobbies), and social control (segregation of “undesirable” populations) intersect, revealing therapeutic segregation as both a technique of social ordering and a profitable enterprise embedded within contemporary political-economic structures.

## METHODOLOGY

Our research sought to describe and analyze the oral history of Brazil’s Psychiatric Reform (RPB) in Bahia, focusing on milestones identified by key protagonists and how they perceive their own central roles in this process. We conducted in-depth individual interviews with seven mental health professionals, two legal professionals, and one mental health care user who is also president of the main regional activists’ association (*Associação Metamorfose Ambulante de Usuários/as e Familiares do Estado da Bahia* – AMEA).<sup>3</sup> In addition,

3 Founded in 2007 but with historical roots in previous decades, AMEA is the emblematic group of *antimanicomial* activism by mental health service users in Bahia. More than a formal association, this collective is a group of militants whose action identity is to overcome total institutions and associated practices and mentalities (Santos, 2012).

we held a focus group with nine users from the *Comunidade de Fala* collective<sup>4</sup> in Bahia, a group dedicated to recovery and mutual aid activities.

The selection of interviewees, all relevant witnesses to the RPB process in Bahia, was based on criteria of heterogeneity: pioneers and new generations; users and professionals; managers and intellectuals; representatives from the health sector and of the judiciary; women and men; etc. The interviews were recorded in full, transcribed verbatim, and thematically analyzed with the aid of the NVivo software.

Through the accounts of mental health experts and activists, we examine how the psychiatric reform in Bahia reshaped fundamental concepts: from the meaning of human dignity and personal autonomy to the very definition of rights and identity for individuals living with mental illness. These transformations can only be observed by connecting micro and macrostructural scales, revealing the interweaving of macro and micropolitics. Based on our interviews, we highlight key reform milestones while connecting the practical and theoretical aspects supported by the evidence. The unveiling of this history offers us knowledge and understanding, diachronically produced, and altered, that inform the ways of conceiving and acting in the fields of mental health and problematic substance use at different times in the Bahian context, establishing direct dialogues with national and transnational trends.

Notably, the distinctions and congruities between the mental health and substance use fields emerged as a prominent theme in the discourse of interlocutors primarily affiliated with the “alcohol and other drugs” (*álcool e outras drogas* or AD) field when discussing RPB’s history in Bahia. These considerations aligned with discourses we had encountered in other spaces and specialized literature, suggesting their potential relevance to RPB as a whole and possibly to psychiatric reforms worldwide. We interpret these emic readings as analyzers of how biomedical and psychological languages about (mental) suffering are socially and historically reconfigured in concrete realities. Regarding the proposition of mental health and AD as separate fields, this article will analyze the legitimacy or artificiality of this “fracture” through the lens of “Collective Health” (*Saúde Coletiva*)<sup>5</sup> and RPB as socio-historical constructions and dynamics.

4 Brazilian adaptation of a North American peer support program called “In Our Own Voice” (Weingarten et al., 2021).

5 Since the 1970s, Latin American *Saúde Coletiva* has established itself as an “area of knowledge [that] seeks to understand health/disease as a process that relates to the structure of society, man as a social and historical being, and the exercise of health actions as a social practice permeated by a technical practice that is simultaneously social, subject to economic, political and ideological influences” (Vieira-da-Silva et al., 2014, p. 7).

Since all the interviewees are publicly known for their involvement in the process of psychiatric reform in Bahia, it would be nearly impossible, and even undesirable, to guarantee their anonymity. For this reason, we sought formal permission from those who wished to have their real names included in the publications, especially for those mentioned in the story we are narrating, which was consented to by all of them. The project was submitted to the National Research Ethics Committee of Brazil (CONEP) and received approval.<sup>6</sup>

### HOW DRUGS, “JUNKIES” AND COUNTER-REFORM MOVEMENTS ARE RESHAPING THE BRAZILIAN PSYCHIATRIC REFORM

RPB is simultaneously a social movement and a political-legal, institutional, cultural, and theoretical-conceptual process (Amarante, 2007). It seeks to transform the care system for individuals experiencing “biopsychosocial suffering” or “ethical-political suffering” (Sawaia, 2007) from a hospital-centric, asylum-base model to a biopsychosocial, territorial model. RPB is also committed to the deinstitutionalization, de-stigmatization, and social reintegration of people living with mental disorders.

Originating in the 1970s as a workplace struggle within psychiatric hospitals, spearheaded by the Mental Health Workers’ Movement (MTSM), RPB gradually took shape as a model over the following decades. A series of legal regulations established a comprehensive Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS), composed of a range of services designed to replace psychiatric asylums. These include Psychosocial Care Centers (CAPS), Therapeutic Residential Services (SRT), Reception Units (UA), Community Centers (CECO), Primary Care Units (UAB), emergency services, and solidarity economy centers. RPB is bolstered by the organization and capillarization of a significant cultural and political movement in Brazil, known as *Luta Antimanicomial* (Amarante and Nunes, 2018).

RPB adopted a harm reduction approach to alcohol and substance use disorders, based on pioneering initiatives in the city of Santos, in 1989. Under Health Secretary David Capistrano’s leadership, the reform advanced through a pivotal intervention at Casa de Saúde Anchieta psychiatric hospital – a watershed moment in RPB’s history. By incorporating harm reduction principles into addiction treatment, this administration achieved a significant breakthrough: bridging the previously separate fields of mental health care and substance use treatment under a shared anti-asylum philosophy.

6 Research registered under no. CAAE 58900122.0.0000.5030 (CONEP, Brazil; report no. 6.215.461).

Casa de Saúde Anchieta became what Petuco and Medeiros (2010, p. 5) described as “a laboratory for experiments that would profoundly influence what would become sus [acronym of *Sistema Único de Saúde*, the Unified Health System]”. According to the authors “harm reduction did more than prevent HIV – it fundamentally challenged long-held assumptions and practices considered unquestionable truths in drug policy and theory” (p. 5). Their observation captures the transformative spirit of the harm reduction policy that would become central to RPB. Abstinence was no longer a prerequisite for accessing healthcare services. This paradigm shift enabled interventions across three territorial dimensions – spatial, temporal, and affective. Healthcare workers could now engage with substance users in their own environments, during moments of active use, creating opportunities to discuss self-care practices. Furthermore, harm reduction strategies could be developed collaboratively, drawing on the collective knowledge and lived experiences of the user community (*ibidem*, pp. 5-6).

Over time, the Brazilian Psychiatric Reform movement has increasingly incorporated the field of addiction into its discourses and practices, promoting harm reduction approaches and advocating for community-based treatment, particularly through the creation of the first CAPSad (Psychosocial Care Center for Alcohol and Other Drugs Users) services in 2002.

However, the integration of substance use treatment into psychiatric reform remained challenging, as our interviews made clear. Dr. Antonio Nery Filho, a pioneering psychiatrist in harm reduction and prominent figure in the Brazilian anti-prohibitionist movement, offered a telling observation about the situation in Bahia: “I think we were working on the reform without recognizing that this reform was happening.” This statement reflects a relationship of estrangement from the Reform, that Nery has expressed on multiple public occasions. Despite being a highly sought-after lecturer on alcohol and drug-related issues, he often claims to have insufficient familiarity to comment on RPB and its policies.

This discomfort, evident in our research in Bahia, has been shared by experts and activists in the AD field across Brazil, especially until around 2002. Recognizing this unease, officials in the National Mental Health department introduced substantial changes, bringing the two fields together within a single mental health, alcohol, and other drugs policy. As Gallassi (2018, p. 65) notes:

Recognizing the problematic use of alcohol and other drugs as a significant public health issue and seeking to keep it within the mental health field, the National Program for Integrated Community Care for Users of Alcohol and Other Drugs was launched in 2002. This later evolved into the Ministry of Health’s Policy for Comprehensive Care for Users

of Alcohol and Other Drugs. The policy's central strategy supports expanding treatment access, promoting a comprehensive and dynamic understanding of the problem, advocating for rights, and implementing a harm reduction approach.

While this change might suggest a resolution, the “drug issue” continues to maintain a complex relationship with the mental health field, despite moves towards convergence. A strong indicator of this tension is the inclusion of *comunidades terapêuticas* – often “therapeutic” and “communities” in name only, but religious total institutions in reality – in mental health policy, primarily targeting individuals with problematic alcohol and drug use. This incorporation began in 2011, under President Dilma Rousseff's administration, through Ordinance No. 3,088, which paradoxically also established RAPS.<sup>7</sup> It expanded significantly from 2018 onwards with the psychiatric counter-reform accelerated by President Jair Bolsonaro's government. For the anti-asylum movement, these developments symbolize a damaging regression in RPB and the resurgence of the asylum model at the center of mental health policy (Costa, 2023; Passos et al., 2020).

Drug users have become the primary target of a re-institutionalization shift undertaken by counter-reformist groups, overshadowing the position traditionally held by “the mad”. This shift involves the medical and social legitimization of “junkies” as subjects whose treatment should occur in segregated, monovalent institutions, excluding them from social integration. While part of the “mad” continue to be admitted to psychiatric hospitals, and people with problematic drug use have been treated there for decades, in the last decade the drug issue has acquired unprecedented prominence as a social concern.

To better understand this issue, it is crucial to consider its historical and sociological context. Roberto Tykanori, a psychiatrist partly trained in Trieste who served as Mental Health Coordinator during most of Dilma Rousseff's government (2010-2016), explains:

The great challenge during my tenure was reconciling the country's enormous pressure regarding the crack issue. The crack phenomenon needs to be understood sociologically because, quantitatively, crack users represent a small population. Initially, it was difficult to clearly understand the alcohol and drugs field. Many actors compete to address the issue, but these are not isonomic oppositions; they are different things competing as if

7 RAPS operates within Brazil's Unified Health System (SUS) as an integrated network of mental health services. Developed during the RPB process, RAPS coordinates various treatment facilities, including Psychosocial Care Centers and Therapeutic Residential Services, to serve individuals experiencing mental health challenges and substance use addiction.

they were the same. Crack exposed a central problem: urban poverty and misery. In many municipalities, destitute people using drugs appeared in public spaces for the first time. Prohibited drugs have always been consumed by those with money, especially cocaine among the middle and upper-middle classes. Marijuana consumption has a long history, but in Brazil, this association between poverty and drug use happened with crack. [Desinstitute, 2022]

We would rather argue that the association between poverty and drug consumption has resurfaced with crack. Studies by authors such as Edward MacRae (2016) have clearly highlighted the long-standing relationship between illicit drugs, poverty, and racism in Brazil since the colonial period, when marijuana was associated with “Black culture” (*coisa de preto*) and criminalized, making its users targets of repression and imprisonment. This association has re-emerged forcefully in Brazil’s recent history, marked by escalating neoliberal policies, with at least three lines of attack:

1. The moralization of a social issue, with drug use viewed as being a moral weakness.
2. The “punishment of the poor”, a phrase coined by Wacquant (2003), which in Brazil is strongly linked to racism against the most vulnerable social strata, particularly Black people.
3. The upsurge in incarceration, whether in prisons or “therapeutic communities”.

These elements are exacerbated by the reduction of social protection policies, characteristic of a rapidly shrinking state under the governments of Michel Temer and Jair Bolsonaro.

Tykanori correctly points out that the hyper-dimensioning of the crack problem is a sociological issue. The reductionist image of homeless people using crack in city center streets, portrayed in various campaigns as a “drug epidemic”, lacks epidemiological relevance, given its low prevalence in Brazil (Fiocruz/MS, 2017). This imagery presents illicit drug use as correlated with marginalized people, suggesting that hard drugs with antisocial consequences are the prerogative of disadvantaged social classes. It becomes necessary to delimit this Other that lies beyond the “abyssal line”, to borrow Santos’ (2007) decolonial concept, on the opposite side of the civilized, on the reverse side of the metropolis.

This segregation strategy aligns with the public portrayal of the “junkie” as a potentially dangerous thug or, at a minimum, a weak-willed person dominated by addiction. Sociologically, this sustains a dynamic of exclusion, producing

what Castel (2015) called “disaffiliation”, a mechanism whose consequences range from potential dehumanization to the annihilation of the Other. The drug addict is not just any drug user, but one who carries intersectional markers of social oppression: being poor / Black / Indigenous (increasingly, given the significant increase in illicit drug consumption and trafficking in Brazilian Indigenous territories) / a woman, especially a Black woman (Pinheiro and Nunes, 2023).

Human rights violations in these “communities” are increasingly reported, as evidenced by inspections carried out by agencies such as the Federal Council of Psychology (Conselho Federal de Psicologia, 2018). These violations include physical abuse, moral humiliation, excessive use of psychotropic drugs for disciplinary and punitive purposes, or, conversely, the complete absence of psychiatric medication to manage withdrawal. One of our interviewees, Priscila Coimbra Rocha, a nurse, university professor, and *anti-asylum* activist, provides a stark account of these conditions:

In 2008, we received a complaint about a therapeutic community [...] run by [an Evangelical Christian organization]. We made an unscheduled visit with the OAB [Brazilian Bar Association], university representatives, mental health interns, and social movement members. By then, we already knew where the situation with therapeutic communities was heading. We found cell-like rooms with closed grills, water served in buckets on the floor, cement beds, and pit-like holes instead of toilets. Users reported physical violence, beatings with sticks, food insecurity (being forced to eat chicken carcasses or go hungry), and daily violence starting from wake-up time. There was also the violence of mandatory prayer and rituals disguised as care processes. We didn’t witness it, but it was reported that people had to dig holes and stay in them to deal with abstinence or cravings. There was an absence of both medicinal drugs and psychiatric medications that could address the biological aspects of chemical dependency and psychoactive substance use. It was all very striking. [Priscila Coimbra Rocha]

Illicit drugs are also prominent in public discourses and common-sense representations due to their perceived agency, often seen as capable of surpassing human agency: “drugs kill”; “people become slaves to drugs”. In these representations, drugs are “the destroyer of homes/families”, establishing a causal relationship in which the problem supposedly lies in the substance rather than in its relationship with individuals in socio-historical contexts that shape social determinants of health. Thus, drugs are believed to dominate subjects, fracturing their conscience, reason, and will (Fiore, 2008).

Consequently, there are calls to resume moral treatment “outside the world”, a world that incites passions, weakens will, and undermines virtue.

It is no coincidence that most *comunidades terapêuticas* are religious, exploiting users' quest for conversion and capitalizing on the idea of salvation from sin and perdition. This approach is coupled with "edifying work" (labor therapy), based on the belief that work occupies the mind (Mângia, 1997) and that, as the saying goes, "an idle mind is the devil's workshop", often resulting in unpaid, slavery-adjacent labor (Conselho Federal de Psicologia, 2018).

#### BAHIA'S PIONEERING ROLE IN THE ANTI-ASYLUM AND ANTI-PROHIBITIONIST MOVEMENTS

The notion of a "laboratory of experiences" is compelling, as it strongly resonates with what we found in the accounts of the Reform's history in Bahia, based on the interviews we conducted with local protagonists. However, whereas in the city of Santos initiatives from both fields seemed to converge organically into a unified policy, our interlocutors in Salvador conveyed a sense of two parallel worlds coexisting, each operating in separate fields without meaningful communication. This disconnection, in fact, appears to better reflect the broader national reality. Yet this does not diminish the innovative and avant-garde nature of the AD field in Bahia (as will be discussed further), nor does it negate the pioneering elements present in certain mental health initiatives in the state, which would later be adopted more widely across Brazil.

Several accounts of the Reform's history in Bahia and Brazil highlight this fracture between the two fields. Analysis of these narratives reveals that the separation between fields was deeply entrenched, especially during RPB's early period. Mental health professionals working in the AD field did not identify as reformers, nor did they recognize their work as part of what would later become the *Luta Antimanicomial* movement.

In the field of drug addiction, Bahia was home to trailblazers such as psychiatrist Nery and the multidisciplinary team that gathered around him at the CETAD outpatient clinic in Salvador. This group advocated viewing individuals with problematic illicit drug use not merely as subjects of legal or police intervention, but as patients to be cared for within the health sector, focusing on their physical and psychological suffering. This advocacy was ahead of its time and later became a cornerstone of a broader anti-prohibitionist social movement. This campaign, aligned with the cultural dimension of RPB – whether or not they were fully aware of it in the mid-1980s – sought to decriminalize drug use and reclaim the socio-cultural and historical contexts surrounding it, with the goal of reducing stigma. This theme remains central to the thinking of theorists and activists in the AD field. For example, anthropologist MacRae (2007)

argues that any meaningful intervention in this field must challenge drug policies based on legal and biomedical “heterocontrols,” which rely on prejudice by equating drugs with “social scourges” and misconceptions that ignore the multidimensional nature of actual drug use (p. 4).

A shift of this kind must coincide with non-criminalizing portrayals of drugs, and with the establishment of care practices compatible with territorialized and open treatment approaches. In this regard, our interviewees highlight the pioneering role of the AD mode of care in introducing key pillars of RPB. As João Mendes de Lima Júnior explains, a psychologist, university professor, health sector manager and anti-asylum activist:

In other words, the Psychiatric Reform provided even this: a foundation for experimentation and testing for the Brazilian Health Reform as a whole. In '93, there was the Users' Meeting,<sup>8</sup> then the Harm Reduction Programs with needle exchange, followed by the *Consultório de Rua*,<sup>9</sup> which was also piloted and launched in Bahia, based on experiences in the Bahian context. The Mad Pride movement, which started in Bahia and later gained traction and spread throughout the country as a whole. [João Mendes de Lima Júnior]

Among the interviewed AMEA's activist members, all emphasized the interconnection between mental health and substance use issues in RPB. Girlene Almeida was particularly vocal about this relationship, and her views were representative of the group as a whole.

I am a harm reduction worker, I'm taking the course offered by the Run for a Hug program [dedicated to homeless people]. [...] When AMEA was born, I met Lucia at the movement's door. Lucia is the founder of the *Movimento de Rua* [“Street Movement”, in defense of homeless people], and they didn't want to let either of us in – her because she was from the Street Movement, considered a vagrant, and me because I was considered crazy. This was at a Human Rights conference at the Convention Center, but we stood our ground and entered. On that day, both the Street Movement and the Mental Health Movement were born, and this was for the better. [Girlene Almeida]

8 What is alluded to here is the *Encontro de Piatã*, the first national meeting of the *Luta Antimanicomial* movement, which happened in a neighborhood of Salvador.

9 The *Consultório de Rua* (“Street Consulting Room”) “is recognized by SENAD as a successful model for care, prevention, and harm reduction in relation to drug use among children, adolescents, and young people living on the streets. A key feature of this methodology is its direct engagement with users in their own environments, addressing their living conditions while facilitating access to municipal services. It offers multi- and interdisciplinary support, fostering citizenship and dignity” (Nery Filho et al., 2011, p. 11).

Girlene's activism for mental health rights intertwines naturally with her work supporting those struggling with substance addiction, with CAPSad serving as the bridge between these two interconnected struggles:

I am a mental health service user; I am an activist, and I will advocate wherever I feel I should advocate. So, for me, there's this story that there's a CAPS for alcohol and drugs and a CAPS for "normal people" – which is a lie, it's all mixed together. [Girleane Almeida]

In sum, professional and user activists alike view harm reduction approaches embodied in CAPSad as part of the anti-asylum movement, given that, as early as the 1980s, by providing outpatient care for vulnerable individuals and defending their human rights, these initiatives prevented the confinement of patients in total institutions such as psychiatric hospitals, prisons, or, more recently, "therapeutic communities". As Eduardo Calliga, one of Bahia's most prominent user-activists, vehemently states, the latter represent a worrying regression to asylum rationales to which RPB is strongly opposed:

To say "no more asylums" – asylums are dysfunctional in society, and therapeutic communities even less so, right? There's no objectivity to these therapeutic communities. I can't understand what the hell kind of therapeutic community this is. Suffering. And therapeutic communities are offshoots of asylums, and we know who's behind this and what the real objectives are behind what we're talking about. [Eduardo Calliga]

State-sanctioned therapeutic communities stand in stark contrast to Bahia's groundbreaking work in harm reduction. The pioneering CETAD in Salvador, the state's first outpatient clinic, was established in 1985 to provide care for people struggling with illicit drug use. A decade later, CETAD expanded its services to include alcohol, tobacco, and prescription drug addiction, widening its scope to address both licit and illicit substance use. Despite this broadening of focus, some early advocates felt a degree of "alienation" from the Psychiatric Reform movement, not participating directly in its militancy and only later recognizing that their work fit within the broader reformist framework. This perceived divide between mental health and drug addiction – seen as distinct areas of activity for decades – is still reflected, to some extent, in the political and bureaucratic realms, where different government bodies are responsible for each field.

In the realm of alcohol and drug addiction, CETAD was doubly innovative. Not only did it adopt an outpatient model, as opposed to the traditional clinic or hospital-centered approach, it also developed new care modalities for people experiencing homelessness who were using drugs problematically.

Beginning in 1999, Bahia stood out with the creation of the *Consultório de Rua*, a project institutionally linked to CETAD. This innovation coincided with the advance of the Brazilian Psychiatric Reform, which was formalized with Ordinance 336/99, regulating Psychosocial Care Centers (including CAPSad).

Nationwide, the AD field was incorporated into mental health policy only in 2002. A decade later, under Tykanori's management at the Ministry of Health's *Coordination for Mental Health, Alcohol, and Other Drugs*, the *Consultório de Rua* evolved into the *Consultório na Rua*, integrated into primary health-care, and both became formally part of federal policy. This timeline highlights Bahia's role in spearheading innovations that preceded – and in many ways anticipated – shifts in national policy.

However, despite these innovative approaches, many initiatives in Bahia were precarious and lacked long-term sustainability, as they were funded through temporary grants rather than permanent government programs. As a result, these projects often functioned as “pilot programs”, achieving great success but ultimately being discontinued due to a lack of financial support. A useful metaphor is that of “fireworks” – projects that shone brightly but quickly faded without the opportunity to mature and consolidate, a clear indicator of the limited political understanding of their significance. Examples of such projects include *Consultório de Rua* (discontinued after five years but later resumed as part of federal policy), *Saúde de Cara na Rua* (2010-2011), *Ponto de Encontro* (2012-2013), *Ponto de Cidadania* (2014-2019), and *Girassóis na Rua* (2019-present).

Despite the transient nature of these programs, there has been a deepening of expertise in Bahia, reflected in the ongoing development of care technologies tailored to homeless populations. People experiencing homelessness are among the most marginalized and stigmatized groups, often excluded from healthcare and vulnerable to extreme risks, including violence and death. Their difficult-to-reach status requires highly engaged and specialized forms of care. Nery, a key figure behind these innovations, has observed that non-specialized professionals, such as those in primary healthcare, may feel unprepared to work with these populations, sometimes sidelining or rejecting them. This has led to reservations about the newer models proposed by the Ministry of Health:

I've said this: *Consultórios de Rua* enter through the soul and find the body; *Consultórios na Rua* enter through the body and rarely find the soul. [They] treat the wound, treat tuberculosis, but don't create a connection, don't establish a bond that allows the person to accept care. This care is very occasional, very circumstantial, because the soul is not reached. [Antônio Nery Filho]

While these observations highlight the value of specialization, they are somewhat controversial, as the psychosocial care model depends on a network to function properly, guiding patients through multiple RAPS services. Primary healthcare units, alongside Psychosocial Care Centers, are intended to be the gateways to this system, and their teams should be trained (or “matrixed”)<sup>10</sup> to care for all users within the network, including those who are drug users, homeless, or suffering from psychosis – no matter how challenging this may seem.

Another innovative approach developed by CETAD involved providing care for drug users in conflict with the law, including children and adolescents under court-ordered socio-educational measures. Nery now describes this as an anti-asylum intervention, as it helped prevent hospitalization or enabled more appropriate treatment for psychological suffering linked to drug use. This was a groundbreaking approach, particularly in the 1990s, given the strong taboos surrounding open care interventions settings with people in conflict with the law:

Since 1995, we began caring for boys and girls referred by FUNDAC [Foundation for Children and Adolescents] because they conflicted with the law. We created a system to take in these boys and girls... without handcuffs. Sometimes they came in handcuffs, and the staff were worried, but we removed the handcuffs at the entrance to CETAD. For many years, we cared for people in conflict with the law, not just children, but adults too. Because, again, we didn't see their conflict with the law as our problem. Our issue was to provide care for the person, treating them because of their consumption of a psychoactive substance. [Antônio Nery Filho]

The issue of individuals suffering from mental illness who commit crimes, whether related to illicit drug use or other actions classified as criminal, has recently re-emerged as a central topic in Brazil. This is particularly relevant following the promulgation of National Justice Council Resolution No. 487 in February 2023, which mandates the closure of all *Hospitais de Custódia e Tratamento Psiquiátrico* (judicial psychiatric hospitals) in the country and calls for the social reintegration of inmates, with their care being incorporated into the RAPS network.

10 “Matrix support represents a new approach to healthcare, where two or more teams collaborate to develop a pedagogical-therapeutic intervention through a process of shared construction. In Brazil, this model has guided the integration of mental health into primary care, shaping initiatives implemented in various municipalities over recent years” (Chiaverini, 2011, p. 13).

## DECriminalization and Harm Reduction in the Era of “Therapeutic Communities”

“Therapeutic communities” gained significant traction during President Dilma Rousseff’s administration, driven by political interests within the government – notably those of the Evangelical Caucus, then an emerging political force in Parliament. The subsequent administrations of Michel Temer and Jair Bolsonaro further strengthened this trend, revitalizing asylum-style institutional approaches. A notable shift occurred with Technical Note No. 11/2019, issued by the Ministry of Health’s *Coordenação-Geral de Saúde Mental, Álcool e Outras Drogas*, which allocated significantly more funding to these institutions compared to community services, as illustrated in the table below.

In line with the current political landscape and the ongoing influence of evangelical groups, financial support for “therapeutic communities” has continued even after Lula da Silva’s victory in the 2022 federal elections. However, this funding is no longer managed by the Ministry of Health but is now overseen by the Ministry of Social Development, which provides a dedicated line of credit and has a specific department responsible for administering these institutions. Similar funding mechanisms exist at the state level. In Bahia, for example, they are financed through the Superintendence for Drug Policies and Reception of Vulnerable Groups (SUPRAD). Interestingly, SUPRAD also funds the *Corra pro Abraço* (“Run for the Hug”) program, which supports homeless populations, focusing on disease prevention, health promotion, and political education from an anti-prohibitionist and human rights-oriented perspective. Despite this, the financial resources allocated to *comunidades terapêuticas* in Bahia are considerably larger and have a more significant impact on the health budget (Lima Júnior, 2022).

The resurgence of asylum-based institutions as central to mental health policy during the Bolsonaro government (beginning in 2018) was marked by

TABLE 1  
2019 Funding Announcements for Mental Health (in Brazilian Reais)

Asylum-type and Non-community Services		Community Services	
Psychiatric hospitals	60 million	All RAPS	70 million
Therapeutic communities	100 million	Therapeutic residences	50 million
Outpatient clinics and new CAPSad IV (for “cracklands”)	33 million		
<i>Total Announced</i>	<i>193 million</i>		<i>120 million</i>

Source: Technical Note No. 11/2019, Brazil’s Ministry of Health; our elaboration.

the proliferation of religious, abstinence-based institutions and the broader psychiatric counter-reform (Nunes et al., 2019; Pitta and Guljor, 2019). This trend led anti-asylum movements in both the addiction and mental health fields to unify in defense of open-door, community-based treatment. A key outcome of this resistance was the creation of alliances between various sub-groups of Brazilian anti-asylum activism, such as the *Rede Internúcleos da Luta Antimanicomial* (RENILA) and the *Movimento Nacional da Luta Antimanicomial* (MNLA). This coalition represents what sociologist Leonardo Pinho, former president of the Brazilian Mental Health Association (ABRASME), termed “unity in diversity.”

These developments reflect the idea that changes in conceptions and models of care are driven by social struggles and power disputes between groups with differing interests. The outcomes of these struggles mirror the balance of power in contexts that are constantly shifting. Andrade (2018) offers a similar analysis, noting the coexistence of conflicting drug policies in various societies – not only in Brazil, but also in the us and Europe. On the one hand, laws criminalizing drug use appeal to conservative interests; on the other, harm reduction laws offer therapeutic alternatives, representing a reformist shift in drug policy that focuses on managing the consequences of drug use rather than combating it. While harm reduction policies have been shown to improve public health and reduce problematic drug use (Fonseca et al., 2006; Gomes and Dalla Vecchia, 2018), Andrade warns of the significance of their ambivalent coexistence with anti-drug policies.

Since none of the groups involved possess enough power to impose their vision of the drug problem – whether through the criminalization of use and commercialization or the legalization of both – a compromise emerges. This compromise tightens criminal law against supply and demand while offering depenalization, or even decriminalization, for consumption. The expectations of interest groups are partially met, reducing tensions (Andrade, 2018, p. 180).

In Brazil, this ambivalence results in a persistent oscillation between viewing drug use primarily as a public health issue or as a criminal justice problem. Treatment approaches also reflect this divide, with psychosocial health services promoting harm reduction – which may include abstinence as one option – while other institutions, such as psychiatric hospitals and religious spaces like “therapeutic communities”, offer exclusively abstinence-based, socially isolating care.

For Andrade, the lack of a more radical push for drug decriminalization in Brazil merely delays the resolution of “social conflicts,” as the dual approach of criminalizing traffickers and caring for users, including through harm reduction, “ultimately perpetuate[s] the impasse” (Andrade, 2018, p. 184).

This ideological tug-of-war has intensified since the period leading up to the impeachment of President Dilma Rousseff, continued throughout Bolsonaro's presidency, and persists under Lula da Silva's third administration. It mirrors the deep political polarization within Brazilian society, one prominent example being within the justice system.

As previously mentioned, the field of AD gained recognition within national health policy after 2002. However, it remains closely tied to the justice sector, both at the federal and state levels. Nationally, drug policy falls under the responsibility of the *Secretaria Nacional de Política sobre Drogas e Gestão de Ativos*, part of the Ministry of Justice and Public Security (SENAD/MJSP). The official National Drug Policy, presented as an improvement on the 2002 *Política Nacional Antidrogas*, was established in 2005 and is based on the premise that “a drug policy is the set of efforts by the country to reduce the supply and demand of drugs” (Brasil, 2005). In 2006, Law no. 11.343 sanctioned the creation of a system of Drug Policy Councils at the municipal, state, and federal levels, including the influential *Conselho Nacional de Políticas sobre Drogas* (CONAD).

It is worth noting that these reforms marked progress in the effort to decriminalize the status of illicit drug users, redefining them as individuals in need of care within the mental health care network, thus separating them from the category of dealers/traffickers. However, in a regressive move, the Senate Justice Committee recently approved an “Anti-Drugs Constitutional Amendment” (PEC 45/2023) in March 2024, which criminalizes the possession and carrying of any amount of drugs. If this amendment is passed by Parliament, sanctioned by the President, and upheld by the Supreme Court, it would represent a significant setback for Brazil, as it would once again criminalize illicit drug users. This ongoing tension between political factions (and the societal groups they represent) with divergent views on the issue continues to generate cycles of conflict. Each side seeks to assert its dominance over the other, creating a constant state of impasse. Draconian measures such as PEC 45 have sparked intense mobilization from anti-asylum and anti-prohibitionist movements – just as occurred in response to the counter-reforms of the Bolsonaro government – challenging conservative onslaughts that tend to dominate in Brazil's Parliament but retreat under public pressure.

Against this backdrop, various social movements have long advocated for the decriminalization of small quantities of marijuana for personal use,<sup>11</sup> while clarifying that this does not equate to full legalization – a stance intended to

11 One of the most symbolic markers of pro-cannabis activism in Brazil is the *Marchas da Maconha* (Cannabis Marches), which have been held since 2002 (Reed, 2014).

make the proposal more palatable to Parliament. Proponents of the anti-prohibitionist movement argue that criminalizing drug users, particularly in contrast to the liberalization seen in many Western countries (or even decriminalization, as in Portugal (Cabral, 2017), only hinders access to health services and social assistance. They accuse political actors of exploiting the issue to create moral panic, distracting society from pragmatic and rational policies.

In this context, the comparison with the Portuguese case proves itself to be particularly significant. Portugal has gained international recognition for its pioneering drug policy reform, rooted in profound social transformation. Throughout the late twentieth century, illicit drug consumption in marginalised urban spaces became one of the most striking manifestations of poverty and social suffering in the country, with the 1980s and 1990s marked by a widespread “heroin epidemic” in heavily stigmatised neighbourhoods. In response, Portugal undertook a comprehensive shift in its political, legal, and therapeutic frameworks, culminating in landmark 2000 legislation that decriminalized all drug consumption and reframed it as a public health concern rather than a criminal justice issue.<sup>12</sup> This “Portuguese model”, accompanied by the rehabilitation of drug-affected areas and a significant decline in heroin use, has attracted substantial international attention and has been credited with reducing drug-related deaths, incarceration rates, stigma, and HIV transmission (Cabral, 2017; Transform Drug Policy Foundation, 2021).

Ultimately, the arguments supporting PEC 45 and other similar proposals that frequently surface in public debate expose the paradox at the heart of the “drug issue”: pseudo-scientific rhetoric concealing historical and sociopolitical roots. The drug issue in Brazil is intertwined with structural racism – another narrative used to justify the punishment and incarceration of poor and Black people (Lima and Montenegro, 2024). More recently, this pattern has extended to include Indigenous populations, particularly the poorest among them, as observed in research conducted in the mid-2000s among the Pataxó people in Coroa Vermelha, in southern Bahia (Pedrana, 2018). Additionally, a growing body of evidence demonstrates that, historically, those incarcerated in Brazilian mental institutions have disproportionately been poor and Black (Barros, 2014). This evidence brings to light the markers of oppression that preordain

12 Law 30/2000 established the Commissions for the Dissuasion of Drug Addiction, replacing the courts and transforming the user from a criminal into a patient. Harm reduction was implemented radically, with free distribution of syringes, supervised consumption rooms, and mobile methadone teams. Social reintegration completed this policy, guaranteeing free treatment within the National Health Service, housing support, and employment programmes. This legislation came into force in 2001.

violations of certain social groups' rights, calling for new analyses and a rewriting of the history of the anti-asylum and anti-prohibitionist movements. These movements now need to adopt an explicitly anti-racist stance, recognizing the social determinants that compound injustice and inequality.

Much of the criticism from various authors and central figures focuses on discomfort with the delayed or partial incorporation of the Alcohol and Drugs (AD) field into the concerns and policies regarding psychosocial care advocated by the Brazilian Psychiatric Reform. This often revolves around the distinction between care for individuals with mental disorders and care for those who use drugs problematically. However, a deeper analysis is necessary, collapsing these dichotomies into broader arguments and reflections. Rosa and Pinto (2019), in their discussion of the governmentalization of drugs within the health and criminal justice systems, support this interpretation by highlighting the connection, rather than the separation, between the logics operating in both systems. They assert that the judiciary's approach to drugs and drug users aligns closely with both the health sector's perspective and dominant common-sense notions. The authors argue that "[the] conjunction between medical knowledge and legal practices [is] an important vector for the governmentalization of truths that instrumentalize intervention on the so-called drug issue from the perspective of population management" (p. 1).

This notion of conjunction, rather than dissociation, echoes arguments put forth by other scholars, as it underscores that "the health and justice game" relies on the "public representation of the drug user as a societal risk" (Rosa and Pinto, 2019, p. 3). This representation, in turn, calls upon the state to act in the name of public safety, underpinning the governmentality of this issue, including its moral dimensions.

#### CONCLUSION: REFRAMING THE DRUG POLICY DEBATE BEYOND THE HEALTH VS. JUSTICE DICHOTOMY

From this analysis, it becomes evident that both the health and justice systems reinforce each other to perpetuate the asylum logic, which have historically evolved to act more decisively on illicit drug users, who are purged from capitalist society while symbolizing the vulnerability of marginalized groups. The economy of drugs, meanwhile, reveals the *modus operandi* of a highly profitable consumerist capitalist system that violently occupies peripheral urban and rural territories, including Indigenous lands. In this context, the war on drugs and the criminalization of drug users function as a smokescreen that distracts from deeper issues and legitimizes ineffective actions.

Drawing a parallel between the social status of madness, which marked the cultural shift of the 18<sup>th</sup> century, and the social status of drug addiction in the 20<sup>th</sup> century, it becomes clear that these two phenomena are historically linked. Madness, in the era of industrial capitalism, was associated with those deemed incapable of labor, rendering them “useless”. By contrast, the drug addict of the 20<sup>th</sup> and 21<sup>st</sup> centuries represents the failures of consumerist capitalism, which discards individuals unable to consume productively, eventually recycling them as commodities within the incarceration industry. Both issues mirror one another, grounded in the segregation and violation of bodies.

Thus, addressing the drug issue is not essentially different from the historical *Luta Antimanicomial*'s and the *Reforma Psiquiátrica*'s defense of the human rights of those suffering from mental illness. It requires dismantling the institutional logics that govern the control of Black and poor bodies, as well as those who do not conform to societal norms. The suffering experienced by individuals, along with their disruptive or non-normative behaviors, must be understood in a situated and complex way within both the health and justice systems, without being appropriated by regimes of truth that reinforce subordination.

In this context, the fields of AD and mental health are not so distinct. Tensions or convergences between them should focus on the paradigms that guide their practices: whether they adhere to asylum or anti-asylum logics; are racist or anti-racist; sexist or feminist; exploitative or oriented toward social justice. Ultimately, the struggle that must unite these fields is the advancement of a democratic and emancipatory psychiatric reform – one that is culturally sensitive and responsive to the existential and symbolic challenges that arise in each historical moment, expressing the myriad ways in which humans experience suffering and resistance in society.<sup>13</sup>

#### ACKNOWLEDGMENTS

The authors gratefully acknowledge financial support provided by FCT, Fundação para a Ciência e a Tecnologia (Foundation for Science and Technology, Portugal), through the project PSYGLOCAL, <https://doi.org/10.54499/PTDC/FER-HFC/3810/2021>.

13 This article was proofread by Latife Karadag in fulfillment of the curricular internship for the Translation degree at the School of Arts and Humanities (FLUL), University of Lisbon.

## REFERÊNCIAS BIBLIOGRÁFICAS

- AMARANTE, P. (2007), *Saúde Mental e Atenção Psicossocial*, Rio de Janeiro, Editora Fiocruz.
- AMARANTE, P., NUNES, M. O. (2018), “A reforma psiquiátrica no sus e a luta por uma sociedade sem manicômios”. *Ciência & Saúde Coletiva*, 23 (6), pp. 2067-2074.
- ANDRADE, O. H. A. F. (2018), *O Caráter Simbólico da Criminalização das Drogas*. Doctoral thesis, Brasília, Universidade de Brasília.
- ARONOV, M. (2019), “(Micro-)’Psychedelic’ experiences: From the 1960s creativity at the workplace to the 21st-century neuro-newspeak”. *Ethnologie française*, 49 (4), pp. 701-718. Disponível em: <https://doi.org/10.3917/ethn.194.0701>.
- BARROS, S. (2014), “Censo psicossocial dos moradores em hospitais psiquiátricos do estado de São Paulo: Um olhar sob a perspectiva racial”. *Saúde e Sociedade*, 23 (4), pp. 1235-1247.
- BAUMAN, Z. (2005), *Identidade: Entrevista a Benedetto Vecchi* (trad. C. A. Medeiros), Rio de Janeiro, Jorge Zahar.
- BESERRA, F., VIEIRA, T. (2020), “Desafios para uma psicoterapia aliada ao uso de psicodélicos no Brasil”. In F. Beserra, S. Rodrigues (eds.), *Psicodélicos no Brasil: Ciência e saúde*, vol. 1, Curitiba, CRV, pp. 123-139.
- BIRMAN, J. (1992), “A cidadania tresloucada”. In B. Bezerra, P. Amarante (eds.), *Psiquiatria sem Hospício. Contribuições ao Estudo da Reforma Psiquiátrica*, Rio de Janeiro, Relume-Dumará, pp. 71-90.
- BIRMAN, J. (2014), “Drogas, performance e psiquiatrização”. *Ágora (PPGTP/UFRJ)*, 17, pp. 23-37.
- BRASIL. Ministério da Justiça (2005), Resolução CONAD n.º 3, de 27-10-2005. Disponível em: <https://www.legisweb.com.br/legislacao/?id=101642>.
- CABRAL, T. S. (2017), “The 15th anniversary of the Portuguese drug policy: its history, its success and its future”. *Drug Science, Policy and Law*, 3. Disponível em: <https://doi.org/10.1177/2050324516683640>.
- CASTEL, R. (1978), *A Ordem Psiquiátrica. A Idade de Ouro do Alienismo*, Rio de Janeiro, Graal.
- CASTEL, R. (2015), *As Metamorfoses da Questão Social: Uma Crônica do Salário*, Petrópolis, Vozes.
- CHIAVERINI, D. H. (ed.) (2011), *Guia Prático de Matriciamento em Saúde Mental*, Brasília, Ministério da Saúde, Centro de Estudo e Pesquisa em Saúde Coletiva.
- CONSELHO FEDERAL DE PSICOLOGIA (2018), *Relatório da Inspeção Nacional em Comunidades Terapêuticas*. Disponível em: <http://site.cfp.org.br/wp-content/uploads/2018/06/Relat%C3%B3rio-da-Inspe%C3%A7%C3%A3o-Nacional-em-Comunidades-Terap%C3%AAuticas.pdf>.
- COSTA, P. H. A. (2023), “Comunidades terapêuticas no distrito federal: ‘Controle’ social e saqueio do fundo público”. *Revista de Políticas Públicas*, 27 (1), pp. 341-360.
- DESINSTITUTE (2022, 3 de junho), “Entrevista com Roberto Tykanori Kinoshita”. Disponível em: <https://desinstitute.org.br/noticias/roberto-tykanori-a-reforma-psiquiatrica-e-um-processo-civilizatorio-e-uma-antipoda-do-jogo-neoliberal/>.
- DOUDEMANT, M., CONCEIÇÃO, V. N. M. (2018), “Frente Parlamentar em defesa das Comunidades Terapêuticas”. In M. P. G. Santos (ed.), *Comunidades Terapêuticas: Temas para Reflexão*, Rio de Janeiro, IPEA, pp. 167-186.
- FIOCRUZ e MINISTÉRIO DA SAÚDE (2017), *III Levantamento sobre o Uso de Drogas pela População Brasileira*. Disponível em: <https://portal.fiocruz.br/noticia/pesquisa-revela-dados-sobre-o-consumo-de-drogas-no-brasil>.

- FIGORE, M. (2008), “Prazer e risco: uma discussão a respeito dos saberes médicos sobre uso de ‘drogas’”. In B. C. Labate et al. (ed.), *Drogas e Cultura: Novas Perspectivas*, Salvador, EDUFBA, pp. 141-153.
- FLACH, P. (2019), *Experiências de Sofrimento Social e Movimentos de Resistência entre Trabalhadores e Gente de Rua (Usuários de Álcool e Outras Drogas), na Praça das Duas Mãos – Salvador-Bahia*. Doctoral thesis, Salvador, UFBA, Instituto de Saúde Coletiva.
- FONSECA, E. M., RIBEIRO, J. M., BERTONI, N., BASTOS, F. I. (2006), “Syringe exchange programs in Brazil: Preliminary assessment of 45 programs”. *Cadernos de Saúde Pública*, 22 (4), pp. 761-770. Disponível em: <http://ref.scielo.org/t4kkxt>.
- FOUCAULT, M. (2005), *História da Loucura na Idade Clássica*, São Paulo, Perspectiva.
- GALLASSI, A. (2018), “A política do Ministério da Saúde na atenção às pessoas em uso problemático de álcool e outras drogas: Avanços e retrocessos”. *Boletim de Análise Político-Institucional*, 18, pp. 63-69.
- GOMES, T. B., DALLA VECCHIA, M. (2018), “Estratégias de redução de danos no uso prejudicial de álcool e outras drogas: Revisão de literatura”. *Ciência & Saúde Coletiva*, 23 (7), pp. 2327-2338.
- LANCETTI, A. (2020), *Contrafissura e Plasticidade Psíquica*, São Paulo, Hucitec.
- LIMA, L. S., MONTENEGRO, D. P. (2024), “Proibicionismo-racismo na política brasileira sobre drogas a partir do encarceramento”. *Em Pauta: Teoria Social e Realidade Contemporânea*, 22 (54), pp. 84-98.
- LIMA JÚNIOR, J. M. (2022), *Análise da Implantação da Política de Saúde Mental na Bahia: O Processo de Transição do Modelo Assistencial entre 2001 e 2021*. Doctoral thesis, Salvador, UFBA, Instituto de Saúde Coletiva.
- MACRAE, E. (2016), “Cannabis, racismo, resistência cultural e espiritualidade”. In E. Macrae, W. C. Alves (eds.), *Fumo de Angola. Cannabis, Racismo, Resistência Cultural e Espiritualidade*, Salvador, Edufba, pp. 23-58.
- MACRAE, E. J. B. N. (2007), “Aspectos socioculturais do uso de drogas e políticas de redução de danos”. In *Anais do XIV Encontro Nacional da Associação Brasileira de Psicologia Social*, Fortaleza, ABRAPSO, pp. 3-12.
- MÂNGIA, E. F. (1997), “Psiquiatria e tratamento moral: o trabalho como ilusão de liberdade”. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 8 (2-3), pp. 91-97.
- NERY FILHO, A., et al. (2011), *Guia do Projeto Consultório de Rua*, Brasília, SENAD, CETAD.
- NUNES, M., MENDES, J., PORTUGAL, C., TORRENTÉ, M. (2019), “Reforma e contrarreforma psiquiátrica: Análise de uma crise sociopolítica e sanitária a nível nacional e regional”. *Ciência & Saúde Coletiva*, 24 (12), pp. 4489-4498.
- PASSOS, R. G., FARIAS, J. S., GOMES, T. M. S., ARAUJO, G. C. L. (2020), “Comunidades terapêuticas e a (re)manicomialização na cidade do Rio de Janeiro”. *Argumentum*, 12 (2), pp. 125-140.
- PEDRANA, L. (2018), *Atenção Básica Diferenciada às Comunidades Pataxó da Bahia. Uma Etnografia Polifônica das Práticas de Cuidado na Perspectiva Intercultural*. Doctoral thesis, Salvador, UFBA, Instituto de Saúde Coletiva.
- PETUCO, D. R. S., MEDEIROS, R. G. (2010), *Saúde Mental, Álcool e Outras Drogas: Contribuição à IV Conferência Nacional de Saúde Mental – Intersetorial*, Brasília.
- PINHEIRO, C. M., NUNES, M. O. N. (2023), “Tratamento para usuárias de drogas: Uma revisão sob a perspectiva da colonialidade do gênero”. *Psicologia & Sociedade*, 35, e259943.
- PITTA, A. M. F., GULJOR, A. P. (2019), “A violência da contrarreforma psiquiátrica no Brasil: Um ataque à democracia em tempos de luta pelos direitos humanos e justiça social”. *Cadernos do CEAS*, 246, pp. 6-12.

- REED, A. M. (2014), “*Não Tenha Vergonha, Vem pra Marcha da Maconha*”: *Ação Coletiva, Política e Identidade em Um Movimento Social Contemporâneo*. Doctoral thesis, Rio de Janeiro, Universidade do Estado do Rio de Janeiro.
- RIBEIRO, S. (2022), *Sonho Manifesto*, São Paulo, Companhia das Letras.
- ROSA, P. O., PINTO, G. S. S. (2019), “Quando a experiência é capturada pela representação: Governamentalização das drogas na saúde e no sistema de justiça criminal”. *Interface (Botucatu)*, 23, e180103.
- SANTOS, B. S. (2007), “Para além do pensamento abissal: Das linhas globais a uma ecologia dos saberes”. *Novos Estudos CEBRAP*, 79, pp. 71-94.
- SANTOS, M. R. P. (2012), *A Trajetória de Uma Associação de Usuários e Familiares dos Serviços de Saúde Mental na Cidade de Salvador, Bahia*. Master’s thesis, Salvador, Universidade Federal da Bahia.
- SAWAIA, B. B. (2007), “O sofrimento ético-político como categoria de análise da dialética exclusão/inclusão”. In B. B. Sawaia (ed.), *As Artimanhas da Exclusão: Uma Análise Ético-Psicossocial da Desigualdade*, 7.ª ed., Petrópolis, Vozes, 97-119.
- TRANSFORM DRUG POLICY FOUNDATION. (2021), *Decriminalisation in Portugal: Setting the Record Straight*. Disponível em: <https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight>.
- VIEIRA-DA-SILVA, L. M., PAIM, J. S., ALMEIDA-FILHO, N. (2014), “O que é saúde coletiva?”. In J. S. Paim, N. Almeida-Filho (eds.), *Saúde Coletiva: Teoria e Prática*, Rio de Janeiro, MedBook, pp. 3-12.
- WACQUANT, L. (2003), *Punir os Pobres: a Nova Gestão de Miséria nos Estados Unidos*, Rio de Janeiro, Revan.
- WOODIWISS, M. (2005), *Gangster Capitalism: The United States and the Global Rise of Organized Crime*, Londres, Constable.

---

Received on 30-01-2025. Accepted for publication on 28-11-2025.

---

NUNES, M., TORRENTÉ, M., MARQUES, T. P., JANSEN, M. (2026), “Bridging the Divide: Integrating Addiction and Mental Health Care in the Brazilian Psychiatric Reform”. *Análise Social*, 258, LXI (1.º), e40087. <https://doi.org/10.31447/40087>.

---

Mônica Nunes » [monicatorrente11@gmail.com](mailto:monicatorrente11@gmail.com) » Instituto de Saúde Coletiva, Universidade Federal da Bahia » Rua Basílio da Gama, s/n, Campus Universitário Canela — CEP 40110-040 Salvador, BA, Brasil » <https://orcid.org/0000-0002-5905-4199>.

Maurice de Torrenté » [mdetorrente@hotmail.com](mailto:mdetorrente@hotmail.com) » Instituto de Saúde Coletiva, Universidade Federal da Bahia » Rua Basílio da Gama, s/n, Campus Universitário Canela — CEP 40110-040 Salvador, BA, Brasil » <https://orcid.org/0000-0001-8804-4961>.

Tiago Pires Marques » [tomarques@fch.unl.pt](mailto:tomarques@fch.unl.pt) » CHAM – NOVA-FCSH » Avenida de Berna, 26 C — 1069-061 Lisboa, Portugal » <https://orcid.org/0000-0002-5266-6539>.

Mabel Jansen » [mabeljansen1@gmail.com](mailto:mabeljansen1@gmail.com) » Instituto de Saúde Coletiva, Universidade Federal da Bahia » Rua Basílio da Gama, s/n, Campus Universitário Canela — CEP 40110-040 Salvador, BA, Brasil » <https://orcid.org/0000-0001-6800-1876>.

---