Public funding in Brazilian Therapeutic Communities between 2017 and 2020

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This executive report is based on a study carried out by CEBRAP researchers in a partnership with Conectas Direitos Humanos and with support from the Open Society Foundation. It presents the consolidation of data and the main findings of the study and proposes some topics for the discussion on the public funding of Therapeutic Communities in Brazil.

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1. SUMMARY OF RESULTS

A. Therapeutic Communities (TCs) are private entities that provide temporary residential care for people with problem drug use. After being created as a community concept of mental health treatment in the 1950s, TCs have had a very peculiar development in Brazil, where their operating model is based on isolation, abstinence and, in most cases, association with religious denominations.

B. It is difficult to access data on the public funding of TCs in Brazil. The issues include the opacity of the budgetary instruments and the violation of the statute of limitations of the Access to Information Act. Some of these obstacles seem to be specific to this relationship between the government and TCs.

C. Even though it has been growing in terms of volume and can already be considered a public policy at the federal, state and municipal levels, the type of service contracted by the State with the TCs takes place within a grey zone, varying between different sectors of government: health, social assistance, public safety, among others, which reinforces the ambiguity pointed out by the literature when characterizing the work performed by these entities.

D. In recent years, the amount of public funds spent on TCs has increased. The amount of federal investment between 2017 and 2020 went up to BRL 300 million and, considering the amounts transferred by state governments and capital city halls, it reached BRL 560 million. The most likely trend is that the investment will continue to grow, especially on the part of the federal government, which makes the funding of TCs the main axis of its care policy for people with problem drug use. Additionally, with the enactment of Complementary Law 187/2021, TCs now have the right to seek tax immunity and thus receive indirect public funding.

E. The study identified that 14 states and the Federal District funded openings in TCs, totaling, in the studied period, an expense of around BRL 250 million, with a tendency to increase; payments to TCs were found in nine city halls of capital cities, reaching a total volume of around BRL 19 million invested in the period, also with a tendency to increaseo.

F. The public funds invested in TCs are concentrated at two levels: regionally, with some states receiving proportionally more funds than others, and among the entities themselves. Some are recipients of a high percentage of federal, state and municipal funds.

G. The study did not attempt to measure, with the same precision, the federal parliamentary amendments destined to TCs, limiting itself to estimating their general impact. A total of R$ 30 million of federal amendments raised were effectively paid in the period, which corresponds to about 10% of federal investments.

H. From the perspective of some public policy assessment theories, the funding of TCs can be considered a policy with deficits in terms of planning, control, and evaluation. There is no clarity on the type of service contracted, the composition of its cost, its inputs, the expected outputs and, mainly, its impact and effectiveness.

I. In international literature, the treatment offered to people with problem drug use by TCs is controversial, with moderate evidence of effectiveness found only in specific contexts, quite different from those found in Brazil. Regarding the effectiveness of the treatment of Brazilian TCs, evidence is scarce and, when characterized as a public policy, non-existent.

J. In view of the data and critical points raised, the study highlighted the urgency of an in-depth and democratic discussion regarding the public funding of TCs and its role in the Brazilian policy of care and attention to people with problem drug use.

2. INTRODUCTION

The Therapeutic Community was proposed as a new model of community treatment in the 1950s by the Maxwell Jones in England. Initially, it was presented as an alternative to the asylum model for the care and treatment of people under mental suffering. It was in the United States, however, that the TCs became more intensely spread, already adapted to a new target audience: people with problem drug use or drug addicts. With presence in dozens of countries, TCs have taken on new configurations and adapted their treatment model, as will be discussed in the last section of this report.

The TC's "performance model" is based on a few pillars. In brief, its main aspect is temporary residential isolation – not necessarily short-term –, strict enforcement of abstinence, and the support of "peers" who may or may not have some kind of technical qualification. Its goal is a personal transformation that involves radical changes in habits related to drug use. In Brazil, TCs have been operating since the late 1960s and are non-profit private entities, with direct and indirect links to churches or religious groups, and provide safe housing, shelter or internment – the definition of a term for the the kind of work they offer is part of the controversy of their performance – of problem drug use. The number of entities that refer to themselves TCs has never stopped growing and, in the latest nationwide survey, nearly 2,000 of these institutions were counted in all states (IPEA, 2017).

The growth in the number of TCs occurred concomitantly with the strengthening of their political capital. Federations and Confederations were created both to represent them and to, in some way, attempt to establish common operating parameters, in a process that also presents a certain level of internal divergence (Barroso, 2021). Since the beginning of this century, TCs have been included in the Brazilian policy of care for people with problem drug use and, as Resende (2021) points out, the normative orders that govern their performance contain ambivalences that allowed them to grow without conceptually precise definitions.

2011 was an important year for the inclusion of TCs in official Brazilian regulations. They were included, without an extensively defined function, in the Psychosocial Care Network (RAPS) through Ordinance 3088, issued by the Ministry of Health, and had their general sanitary operation rules defined by the Resolution of the Collegiate Board of Directors (RDC) 29 of the Brazilian Health Surveillance Agency (ANVISA)[1]. Since then, the regulation of TCs as care providers for people with problem drug use has become more robust and the funding of these entities through public funds, after some initial setbacks, was consolidated in the second half of the decade. While discussions among experts until the end of the first decade of the century

1 https://bvsms.saude.gov.br/bvs/saudelegis/anvisa/2011/res0029_30_06_2011.html

referred to the acceptance or rejection of the TCs' actions, given their possible violations of the anti-asylum precepts of Law 10.216/2001[2] – known as the Psychiatric Reform Law – , from the 2010s onwards, the discourse began to encompass the controversies regarding the public funding of these entities.

Two recent regulations demonstrate the progress of TCs. The first, Resolution 3 of the National Drug Policy Council (CONAD)[3], allows and regulates the sheltering of adolescents by these entities[4]; the second, Complementary Law 187, approved by the National Congress[5] and sanctioned in December 2021 by the President of the Republic, grants tax immunity to TCs – provided they meet certain requirements –, which considerably increases the public support to these entities[6].

The expansion of TCs in Brazil has been the subject of numerous academic papers. Most of them are critical of the performance of these entities and, in a very summarized way, their main arguments are[7]:

- TCs are asylum institutions that reproduce the asylum structure of isolation and segregation. Even though, in theory, they only welcome individuals who attend them voluntarily, TCs impose a series of limitations on the freedom of individuals who undergo their treatment;

- The TCs are not, in fact, connected to the community-type psychosocial care that underpins the work of the RAPS;

- There are countless reports of human rights violations in TCs, with different levels of severity.

- Their direct relationship with Christian denominations and the mandatory practice of religious activities diminish the freedom of those who are sheltered and, in the case of entities that receive public funding, violate the principle of State secularism;

- TCs are exclusively abstinence-based, with no flexibility to serve people who could benefit from different approaches;

- There is no evidence that treatment or sheltering at TCs is effective for the recovery of people with problem drug use or drug addicts.

This last point – referring to the evidence of the effectiveness of the treatment offered by TCs – will be further explored at the end of this report. It is important to note, on the other hand, that there are also papers that point out positive aspects of the work carried out by TCs, especially

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2 http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm
3 https://www.in.gov.br/web/dou/-/resolucao-n-3-de-24-de-julho-de-2020-268914833
4 Some entities that saw a clear disregard for the Child and Adolescent Act in this resolution made an appeal for its suspension to the Federal Courts. There is no final decision yet, but the regulation remains in force.
5 https://www.camara.leg.br/proposicoesWeb/fichadetramitacao?idProposicao=2203957
6 For further details see ANNEX I – Legal Opinion on Complementary Law no. 187/21
and the nature of therapeutic communities
7 For further details on various topics involving TCs in Brazil, we suggest the collections organized by Gomes dos Santos (2018) and Rui & Fiore (2021).

for people who would be deprived of other forms of care. TCs act within a grey zone between protection, treatment and social assistance, being perceived as a path – sometimes the only one – for the poorest segments of the population (Fiore & Rui, 2021). This is one of the reasons why, in practice, it is difficult to define, beyond the established regulations, the differences between a TC and a Clinic (IPEA, 2017, Duarte & Glens, 2021). One of the examples of how TCs exist within a grey zone is the progressive abandonment of the term "internação" (inpatient care) and the adoption of "acolhimento" (sheltering). This was one of the TCs' strategies[8] to differentiate themselves from healthcare establishments – which must follow much stricter regulations – and to characterize themselves as support and care entities for people with problem drug use. In practice, many users are not able to identify the difference (Rui et al. 2016).

Specific issues regarding the evidence of effectiveness of TCs will be discussed in the last section of this report. For now, it should be noted that, even in the face of relevant controversies, the data produced by this study reinforce the hypothesis that public funding of TCs can already be considered a perennial public policy at various levels of government, especially in the Federal Government. National Secretariat for Drug Care and Prevention - SENAPRED, which, in the administrative reform carried out by the current administration, was responsible for the area of "Reduction of demand and care and attention to drug users", considers the contracting of TCs its main axis of action, as can be quickly found in their own public disclosure materials available in their digital media channels.

Federal public investment in the RAPS has alternated between stability and reductions in recent years and, although the funds for TCs do not have the same origin – the Ministry of Health, in the case of RAPS, and the Ministry of Citizenship, in the case of TCs (Weber, 2021) – the fact is that this latest policy has been increasingly important. It is a costly and relevant public policy, still opaque in its design and criteria and, as will be discussed in the last section of this report, lacking evidence of effectiveness in the treatment of people with problem drug use. Unlike recently, this policy needs to be discussed with the depth and democratic openness it deserves, encompassing various sectors of academia and civil society, which, of course, includes the TCs and the associations that represent them.

8 For further details see ANNEX I – Legal Opinion on Complementary Law no. 187/21 and the nature of therapeutic communities.

3. METHODOLOGY: OBSTACLES AND WHAT THEY INDICATE ABOUT THE PUBLIC FUNDING OF TCs

Based on studies that pointed to the growth of public funding for TCs, a four-year period – 2017 to 2020 – was established as a segment that helps identify the recent trajectory of the phenomenon. The methodology used to raise federal funds will be more detailed so that they are presented with some transparency issues involved in this funding.

Initially, a study was carried out on the federal government's budget planning instruments – particularly the Multi-annual Plan (PPA) and the Annual Budget Law (LOA) of the current Ministry of Citizenship – to the extent that the funding of openings in TCs is a policy that is explicitly promoted by this secretariat. Featuring interviews and promoted events, actions related to TCs are the main theme of the contents on the website of the National Secretariat for Drug Care and Prevention (SENAPRED). The website also presents a map of therapeutic communities in Brazil[9] with georeferenced data from the TCs funded by the Secretariat; however, this tool does not allow data to be fully analyzed, nor does it allow access to *metadata*. The study of budget planning instruments, in turn, allowed for a standardized search with measurements and general classifications, ensuring more reliability to the data collected.

The structure of the PPA 2016-2019[10] would allow the extraction of information corresponding to expenses with TCs by the federal government, should there be a direct alignment between the objectives, actions, and individualized initiatives for this purpose. In the document "Reducing the social impact of alcohol and other drugs" (Program 2085), there is an emphasis on this funding, being one of the 54 thematic programs[11] of the federal PPA and one of 20 within the topic of social affairs. Program 2085 articulates actions for the protection of "children and adolescents and their families with problems resulting from drug use", the prevention drug use, and the promotion of mental health and social reintegration. Coordination was sometimes performed by the Ministry of Justice and Public Security, sometimes by the Ministry of Citizenship; the Ministry of Health and the Ministry of Women, Family and Human Rights are also involved.

The goals of the Program, which totals 23 initiatives, range from the implementation of Psychosocial Care Centers for Alcohol and Drug Users (CAPS-AD) – types I and III – to the increase in beds dedicated to mental health and the restructuring of communication channels

9 https://aplicacoes.mds.gov.br/sagi/app-sagi/geosagi/localizacao_equipamentos_tipo.php?tipo=comunidades_terapeuticas&rcr=1
10 This reference was chosen because it is closer to the temporal universe of the study. The PPA information in this report was taken from the PPA Monitoring Dashboard – PPA Dashboard: http://painelppa.planejamento.gov.br/. Accessed on 01/12/2021.
11 According to the PPA Panel, "Thematic programs portray government agendas, organized by public policy subsets that guide government actions. Its scope represents the challenges and informs the management of the plan, with regard to the monitoring and evaluation of its tactical dimension." PPA Monitoring Dashboard – PPA Panel: http://painelppa.planejamento.gov.br/. Accessed on 01/12/2021.

for the “prevention of alcohol and other drugs”. Amidst the variety of initiatives[12], emphasis may be placed on “07FW - Funding of, at least, 4,000 openings, per year, in entities providing shelter services for disorders resulting from the use, abuse or dependence of psychoactive substances (therapeutic communities)”. With this structure, it would be possible to identify the planned, committed and effectively paid amounts for each of the years (2016 to 2019). However, the amounts of the initiative are not individualized, and it is only possible to identify the expenses related to objective 1071 “Strengthening the prevention of the use of alcohol and other drugs, with emphasis on children, adolescents and youth”, which compromises the accuracy of the amounts studied.

This difficulty in obtaining data allows us, at first, to point out three relevant characteristics of this policy:

- Funding for TCs was part of the federal government’s multi-annual planning as early as 2015, when it was approved;

- This expense was located at the lowest level of detail of the instrument (initiatives) and, therefore, was one of the actions within an extensive menu, with reduced centrality in the set of initiatives;

- The absence of disaggregated information on this initiative indicates an opacity with regard to the monitoring and evaluation of the public policy within the scope of the multi-annual plan.

In this sense, it is important to highlight that the PPA is the space for planning and guiding state action and, therefore, it would be important that, for each public policy implementation, the funds, their respective applications and, mainly, their results and impacts expected social benefits were detailed. As a result, both the Federal Constitution and the Fiscal Responsibility Law (Law No. 101, 2001) establish the need to publish indicators that allow for the monitoring of the evolution of a program and its results. Thus, the proposed list of indicators shows a high degree of genericness (minimum care network) and a near absence of measurement of the expected impacts of the sheltering service at TCs.

The correspondence between the Multi-annual Plan and the Budget Laws takes place within the scope of the “Programs”. It was possible to locate the expenses with the 2085 Program, but again, the data can only be read at a generic level, since the said program includes many other expenses in addition to those carried out with TCs. In order to specify the expenses within the Program, it was found that the public call notice of SENAPRED No. 17, of September 12, 2019, indicated the programmatic function under which the current hiring expenses should occur and, thus, it was possible to detail the budgetary action 215S “Networks of care and social reintegration of people and families who have problems with alcohol and other drugs”.

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12 According to the federal government, an initiative “declares the means that make the objectives and goals viable, explaining ‘how it is done’ or the delivery of goods and services resulting from state action”. PPA Monitoring Dashboard – PPA Panel: http://painelppa.planejamento.gov.br/. Accessed on 01/12/2021.

With the path for extracting the effective budget data, the funds applied can be measured in the Federal Government's Transparency Portal, highlighting not only the values, but also the way in which the expenditure was planned and classified each year. It was also possible to assess the relative position of the TC treatment policy within the scope of the SENAPRED. The results are shown in Table 1. It identifies some important aspects of SENAPRED's budget policy:

- Budgetary priority: the program under which the expenses with the TCs are included – "Networks of care and social reintegration" – consumed 89% of the expenses of the Secretariat. Within it, residential care services represented 81% of the funds used.

- Great commitment to services performed in the previous year: the column "Paid Remains Payable", which refers to services performed and measured in 2018, represented 76% of the Secretariat's budget. Furthermore: shelter services consumed 78% of the BRL 87 million in outstanding payments paid in 2019. The execution data also indicate that all of these remaining payable funds originated from the National Anti-Drug Fund.[13]

- When adding expense element information[14], it was also found that 100% of expenses with Sheltering Services are classified as "other third-party services", that is, they were unequivocally spent on outsourced contracts.

Out of the BRL 103 million allocated to the "Care Networks" action in 2019, BRL 94 million were paid in residential care services, fully spent on contracts with third parties. However, from the budget execution, it is not possible to find the precise amount passed on to the TCs, only to dimension it. In other words, the budget execution base does not allow for details beyond the budget action "networks of care and services", which is generic. A portion of these payments may have been destined to other activities and other actions may have subsidized the sheltering services. In this sense, only the analysis of the payment base, that is, the one that identifies each bank order made by the Federal Government to its suppliers, allows for a more precise quantification.

13 On the first day of 2019, Provisional Measure 870 transferred a portion of the attributions of the National Drug Policy Secretariat (SENAD), which is part of the structure of the Ministry of Justice, to the SENAPRED, thus initiating the process of transferring FUNAD resources to the Ministry of Citizenship.

14 The expense element is the classification that "attempts to identify the objects of expenditure" (GESP, 2019, p. 6). This is what allows us to identify how much is spent on salaries and staff remuneration, retirements and pensions, interest and charges, acquisition of real estate, consumables, consulting services, and third-party services. By default, services provided by therapeutic communities are classified as third-party services; in some federal states, there is a more detailed specification, identifying that they are services provided with OSS, which is more appropriate from the perspective of expenditure transparency. This is not the case for the Federal Government.

Table 1 - Total amounts and "remaining amounts payable" paid by SENAPRED in 2019

Program/Action/Budget Plan	Amount Paid (BRL)	Remaining Amounts Payable Paid (BRL)	Total
COORDINATION OF PREVENTION, CARE, AND REINSERTION POLICIES	**0**	**2.832.850**	**2.832.850**
NATIONAL DRUG POLICY MANAGEMENT	0	0	0
NATIONAL PUBLIC SAFETY AND CITIZENSHIP PROGRAM - PRONASCI	0	0	0
REDUCTION OF THE SOCIAL IMPACT OF ALCOHOL AND OTHER DRUGS	28.061.673	84.914.385	112.976.058
PUBLIC DRUG POLICY	1.096.144	6.945.433	8.041.577
PREVENTION OF DRUG USE, CARE, AND SOCIAL REINSERTION OF PEOPLE AND FAMILIES WHO HAVE PROBLEMS WITH ALCOHOL AND DRUGS	700.00	795.706	1.495.708
NETWORK FOR CARE AND SOCIAL REINSERTION OF PEOPLE AND FAMILIES WHO HAVE PROBLEMS WITH ALCOHOL AND OTHER DRUGS	26.263.529	77.175.244	103.438.773
INDIVIDUAL AMENDMENT	395.600	5.718.610	6.114.210
TEMPORARY RESIDENTIAL SHELTERING SERVICES AND CARE NETWORKS	25.867.929	68.438.234	94.306.163
SOCIAL REINSERTION	0	3.018.400	3.018.400
NO INFORMATION	0	100.00	100.00
GRAND TOTAL	**28.061.673**	**87.847.235**	**115.908.908**

Source: Federal Government; Comptroller General of the Union. Transparency Portal / Budget Execution Expenses

Access to the data on each payment process made the study more complex, considering the millions of annual records, but also more accurate. Therefore, payment records, in the impossibility of filtering by their programmatic functional classification, were selected from the executing agencies, the Ministry of Justice (2017 and 2018) and the Ministry of Citizenship and Social Development (2019 and 2020).

Study methodology in state, district, and municipal governments

Unlike the methodology used for data at the federal level, the study of expenditures on TCs in states, the Federal District and city halls of capital cities was based on two concomitant stages: 1. The submission of a set of questions supported by Law 12.527/2011 – known as the Access to Information Law (LAI) – through the respective official government channels; and 2. Queries in the transparency portals that allow access to budget data. This methodological option aimed to ensure that the study could be compared using two data sources, given the impossibility of reaching the level of detail of the federal study in more than 53 different government entities.

As expected, the study encountered a number of obstacles. In the case of the questions submitted under the LAI, in addition to some more general obstacles in some systems, a peculiar characteristic of public funding for TCs drew attention: the lack of uniformity regarding their place in the budget and in the government's organizational chart. The process of choosing the addressee of the questions followed the same operation: first, an exploratory search took place on the websites and in the official journals for information about the funding of TCs and, if it were found, which secretariat or organ of government was responsible for executing it, with said entity being the direct addressee of the questions, if possible[15]. When it was not possible to identify the funding of the TCs or to have any other more concrete information from the secretariat or the agency executing the policy, the questionnaire was sent either to the planning secretariats or equivalent entities with budget coordination responsibilities.

The questions sent varied according to the limitations imposed by each system or with the addition of information that had already been collected previously, but their standard format is available in the Annex of this report.

The pattern of responses was quite varied, ranging from quick and technically accurate responses to ignored requests or appeals that had not yet been answered or were answered outside the legal deadlines and could not be included in the study. Chart 1 presents the consolidation of the types of responses obtained from states, federal district and city halls of capital cities.

Chart 1 - Responses to the request for information on TC funding via the Access to Information Law

Type of response	States and the Federal District	City Halls of Capital Cities
Complete information	4 (15%)	---
Partial information	8 (30%)	7 (27%)
Informed that it does not fund TCs	7 (25%)	9 (35%)
Did not respond or answered after the deadline	8 (30%)	10 (38%)

15 Some governments' information systems impose limitations on the choice of recipient and the format of questions that can be sent.

The search for budgetary data to locate public expenditure on TCs at the state, district and municipal levels was carried out regardless of the answers obtained from the questions via the Access to Information Act (LAI). Inconsistencies between the official responses and the queries on budget transparency portals occurred mainly among governments that did not respond or partially responded, even though payments made to TCs were identified in the investigated period. In cases where there was a disparity between the amounts obtained via LAI and those found in the budgets – which were residual cases – an option was made for the LAI data. This procedure maintained a conservative goal in the attempt to consolidate the data collected, namely: the possibility that errors in the values presented are due to their underestimation, not the opposite.

In addition to the problems related to efficiency and transparency in accessing public data, which are evidently not restricted to the TC funding policy, it is important to highlight two points learned with the study process that indicate peculiar characteristics:

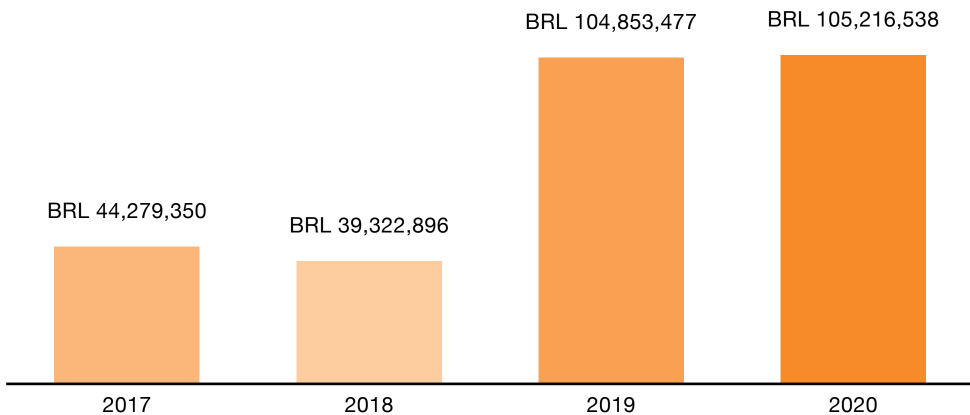
- There were countless cases in which those responsible for responding to inquiries via LAI had difficulty directing the claim, since they were unclear on which secretariat, agency or program the funding of TCs could be linked to.

- Among the state and municipal governments in which the funding of TCs was identified, the agencies that execute the policy belong to very different areas, encompassing entities such as health, social assistance, justice, urban security, and social development secretariats, etc. This is yet another indication, already pointed out in the literature, of a grey zone regarding the type of work provided by the TCs to the State.

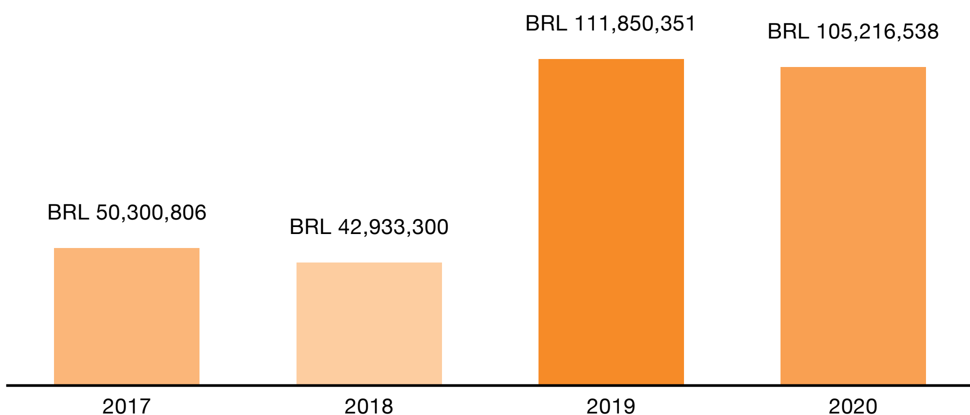
4. VOLUME AND TYPE OF PUBLIC FUNDING OF TCs BETWEEN 2017 AND 2020

The data that will be presented herein refer to the payment that was effectively made for residential care openings for people who experience problems with their drug use by the National Secretariat for Care and Drug Prevention (SENAPRED) between 2017 and 2020 (until the beginning of 2019, the openings were funded through the National Drug Policy Secretariat, which is under the purview of the Ministry of Justice).

Graph 1 – Federal funding of TCs (2017-2020)
In millions of current reais



Graph 2 – Federal funding of TCs (2017-2020)
In millions of reais adjusted for their 2020 value



Within the period, the total nominal amount invested was BRL 293 million; corrected by the currency value for the last year of the study, 2020, the amount reached BRL 309.3 million. The expressive growth in annual investment between 2017 and 2020, in corrected values, was at around 109%. It is important to consider that the SARS-CoV-2 pandemic has altered some government spending habits and may have interrupted this growth pattern in 2020. However, it must be taken into account that the hiring of new sheltering openings through another public notice launched in 2020 and more openings announced by SENAPRED throughout 2021, in addition to the payment of current contracts, indicates that federal funding for TCs will grow at least until the end of the current federal administration.

Once again, it should be noted that all amounts presented here are those effectively paid within the period, even if they refer to contracts, agreements or "payables" from previous years.

Regional distribution of federal funds

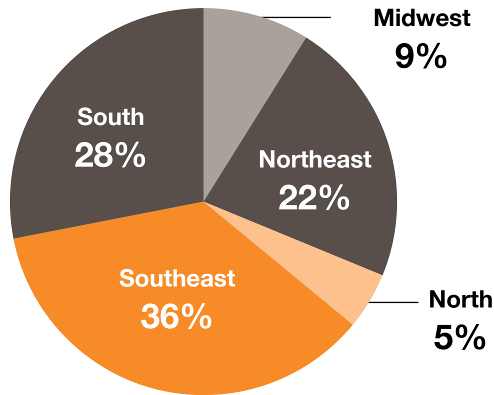
Table 2 and Graph 3 present the absolute distribution of federal funds by state, in addition to the number of funded TCs.

Table 2 – Federal funding of TCs by region and state (2017-2020)

REGION	STATE	TCs FUNDED	MOUNT INVESTED (millions of current reais)	
NORTH	Acre	4	BRL 1.0	BRL 13.0
	Amapá	--	--	
	Amazon	4	BRL 2.5	
	Pará	8	BRL 4.3	
	Rondônia	5	BRL 1.5	
	Roraima	2	BRL 1.9	
	Tocantins	5	BRL 1.9	

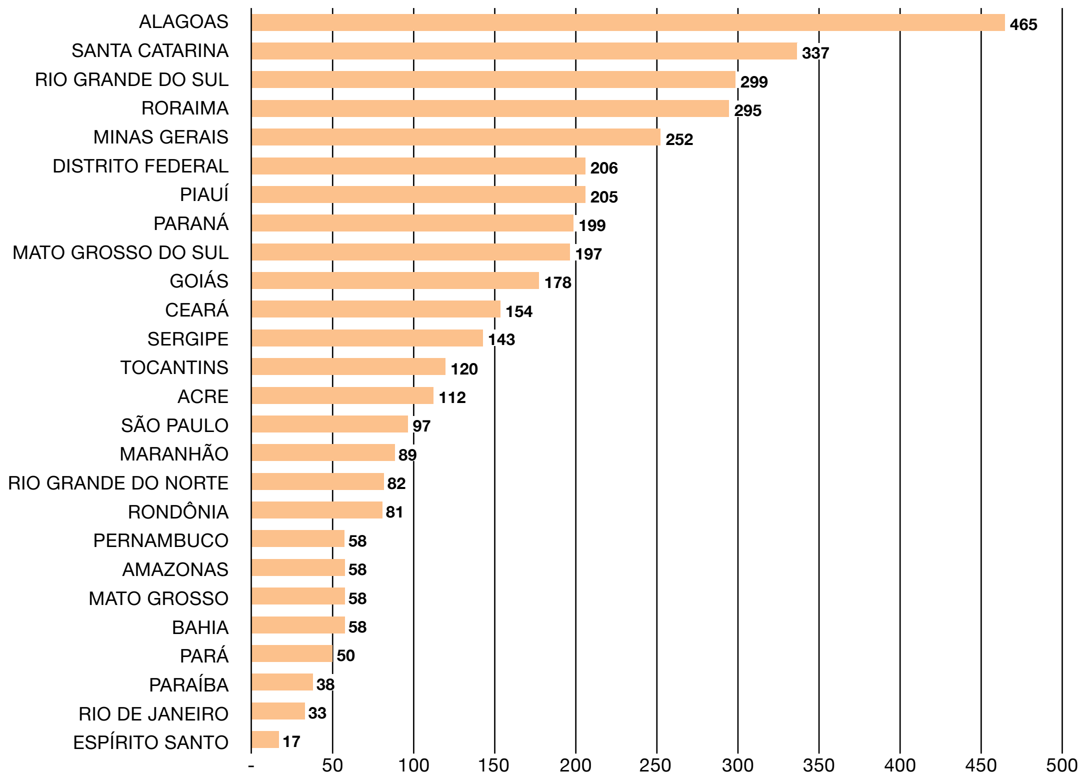
REGION	STATE	TCs FUNDED	MOUNT INVESTED (millions of current reais)	
SOUTH	Paraná	48	BRL 22.9	BRL 81.6
	Rio Grande do Sul	75	BRL 34.2	
	Santa Catarina	61	BRL 24.4	
SOUTHEAST	Espírito Santo	4	BRL 0.7	BRL 105.0
	Minas Gerais	102	BRL 53.7	
	Rio de Janeiro	9	BRL 5.7	
	São Paulo	76	BRL 44.9	
MIDWEST	Federal District	9	BRL 6.3	BRL 26.5
	Goiás	29	BRL 12.7	
	Mato Grosso	4	BRL 2.0	
	Mato Grosso do Sul	9	BRL 5.5	
NORTHEAST	Alagoas	25	BRL 15.6	BRL 64.8
	Bahia	19	BRL 8.6	
	Ceará	21	BRL 14.1	
	Maranhão	11	BRL 6.3	
	Paraíba	3	BRL 1.5	
	Pernambuco	11	BRL 5.6	
	Piauí	9	BRL 6.7	
	Rio Grande do Norte	5	BRL 2.9	
	Sergipe	5	BRL 3.3	
TOTAL	**593 CTs**		BRL **293.7**	

Graph 3 – Regional division of federal funds paid to TCs (2017-2020)

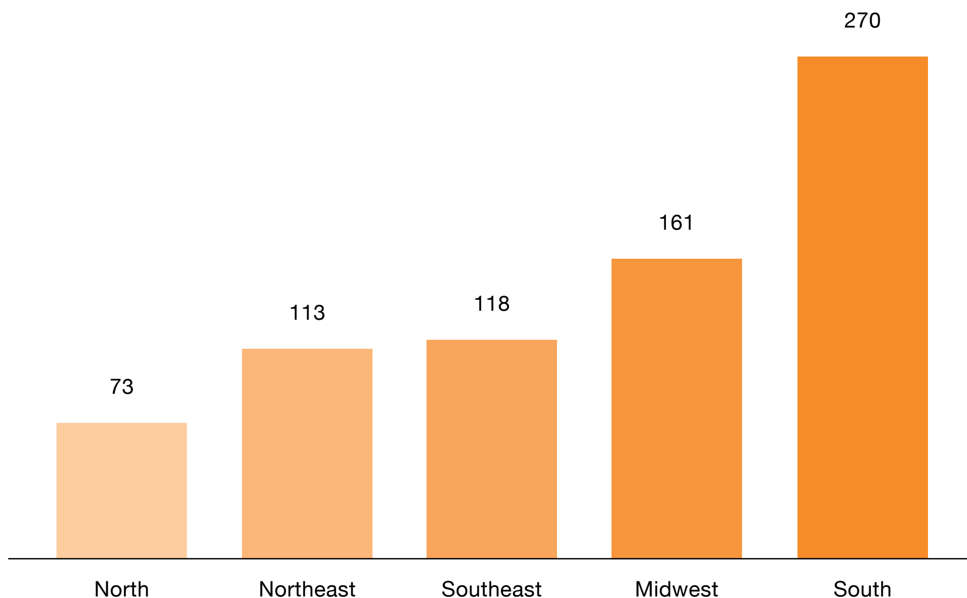


In order to measure the unequal distribution of funds, graphs 4 and 5 present the amounts invested per 100 thousand inhabitants – a traditional criterion for the evaluation of public policies. In them, one can observe that there is no demographic proportionality in the application of funds, at least at its most general level (states have different age pyramids, which could, in theory, have some impact on the target audience of the policy).

Graph 4 – Federal funds transferred to TCs by state (2017-2020)
In thousands of current reais per 100,000 inhabitants

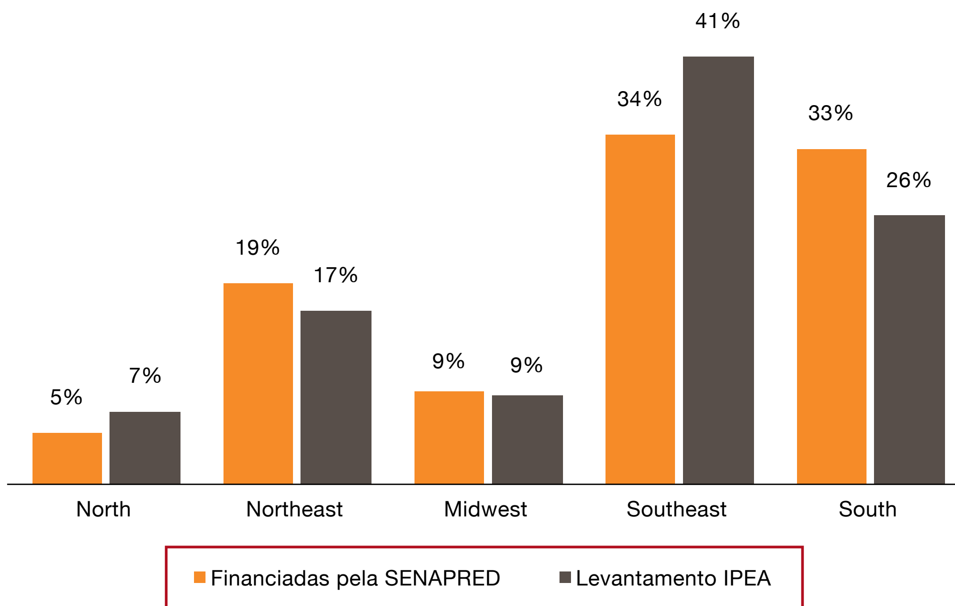


Graph 5 – Federal funds transferred to TCs by region (2017-2020)
In thousands of current reais per 100,000 inhabitants



One of the hypotheses to be explored in the future to explain the concentration of federal funds in some regions is that they would concentrate, through peculiar historical processes, a greater number of TCs. When this study is compared to the only recent nationwide investigation on these entities, carried out in 2014 (IPEA, 2017), it appears that there is, in fact, an important association between the regional distribution data on funded entities (Graph 6).

Graph 6 - TCs funded by the federal government (2017-2020) vs. TCs surveyed by IPEA (2017)



State, district, and municipal funding of TCs

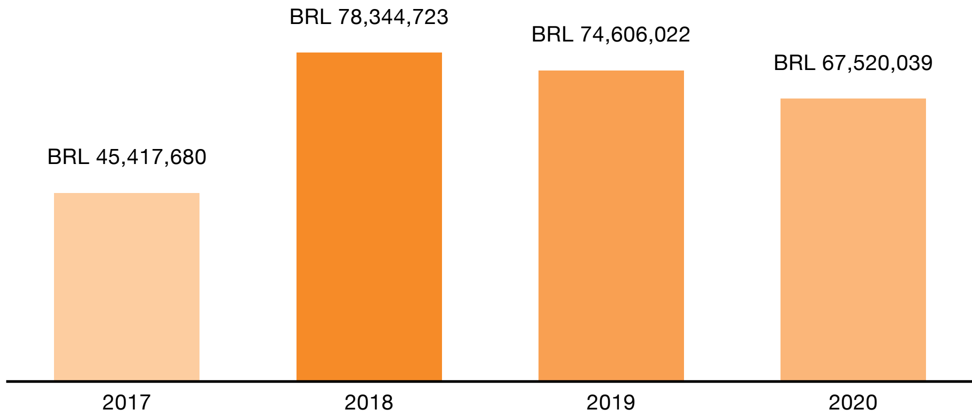
As already discussed in the section dedicated to the research methodology, data were collected on the public funding of TCs in all 26 states, the Federal District and the 26 city halls of state capitals. The data are presented with an adjustment to the currency value of 2020, in order to correct distortions in the analysis of the investment evolution.

Table 3 – State funding of TCs (2017-2020)
In millions of reais adjusted for their 2020 value

STATE	2017	2018	2019	2020	TOTAL
Amazonas	BRL 1.0	BRL 1.5	BRL 1.2	BRL 2.6	BRL 6.3
Rondônia	-	BRL 0.6	BRL 0.5	BRL 0.5	BRL 1.7
Rio Grande do Sul	BRL 0.9	BRL 1.7	BRL 7.3	BRL 4.8	BRL 14.7
Santa Catarina	BRL 1.2	BRL 9.8	BRL 6.1	BRL 7.5	BRL 24.4
Federal District	BRL 3.0	BRL 3.3	BRL 4.0	BRL 3.6	BRL 13.9
Goiás	BRL 0.1	BRL 3.3	BRL 3.8	BRL 1.6	BRL 8.9
Mato Grosso do Sul	BRL 0.7	BRL 0.1	BRL 0.2	BRL 0.3	BRL 1.3
São Paulo	BRL 3.9	BRL 23.5	BRL 22.5	BRL 24.6	BRL 74.5
Espírito Santo	-	BRL 1.0	BRL 1.8	BRL 1.5	BRL 4.1
Minas Gerais	BRL 8.6	BRL 5.5	BRL 4.2	BRL 3.9	BRL 22.2
Bahia	BRL 8.3	BRL 10.5	BRL 6.2	BRL 2.2	BRL 27.1
Piauí	BRL 4.3	BRL 7.2	BRL 7.3	BRL 7.6	BRL 26.4
Alagoas	BRL 9.9	BRL 9.6	BRL 8.0	BRL 6.0	BRL 33.5
Ceará	BRL 0.9	BRL 0.4	BRL 0.7	BRL 0.8	BRL 2.8
Maranhão	BRL 0.9	BRL 0.3	BRL 0.8	BRL 0.1	BRL 2.1
TOTAL	**BRL 43.7**	**BRL 78.3**	**BRL 74.6**	**BRL 67.5**	**BRL 264.1**

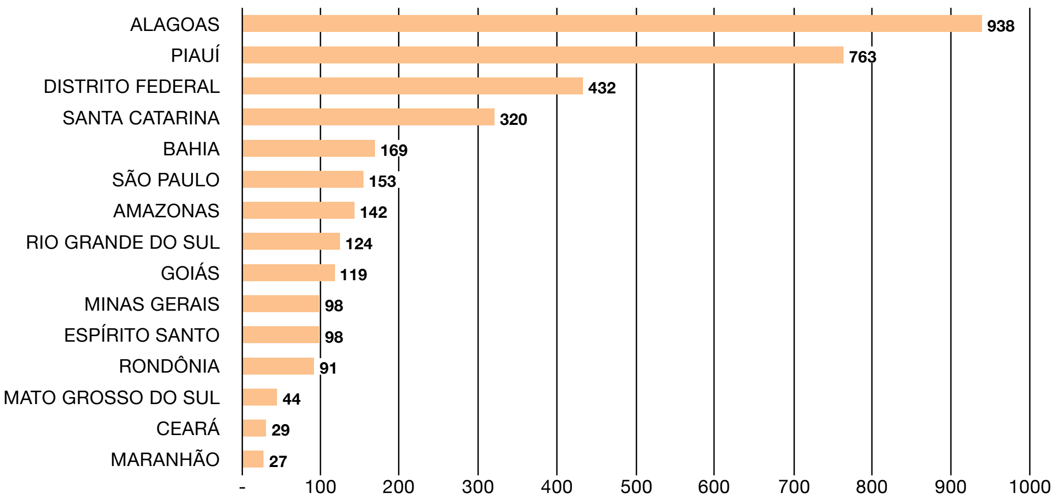
In states where there was public funding in TCs, there was significant growth in that spending until 2018, followed by a period of stabilization. The volume of investments is, in some states, comparable to the federal investment.

Graph 7 – Funding of TCs by states and the Federal District (2017-2020)
In millions of reais adjusted for their 2020 value



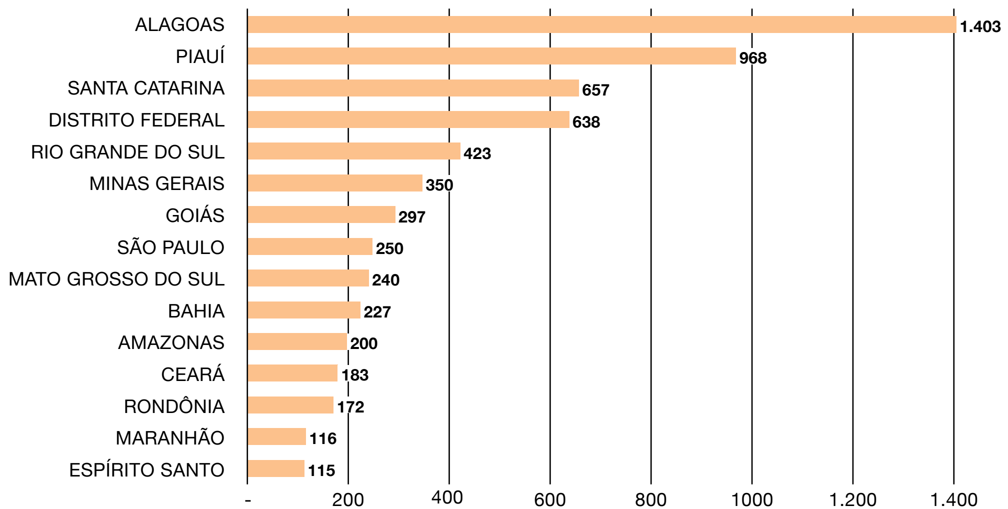
To measure the distribution of investments among state governments, the reference of amounts spent per 100 thousand inhabitants was also used. From this perspective, investment disparities between states are evident.

Graph 8 – Funding of TCs by states and the Federal District (2017-2020)
In thousands of current reais per 100,000 inhabitants



When funding from the federal, state and district governments is jointly measured, the concentration is even more evident and the hypothesis that there would be some sort of state-level compensation to cover the lack of federal investment in TCs is ruled out. In fact, the data reinforce the hypothesis raised in the previous section that there is an accumulation of political capital and know-how of the TCs of some states in order to obtain public funds at different levels of government. States with TCs that received significant state funding, such as Alagoas, Piauí, Santa Catarina, Rio Grande do Sul and the Federal District, also received a sizable amount of federal funds (Graph 9). There is no indication, therefore, that there was any kind of compensation state to cover the lack of federal funding in TCs.

Graph 9 – Sum of TC funding by federal, state, and district governments by state (2017-2020)
In thousands of current reais per 100,000 inhabitants

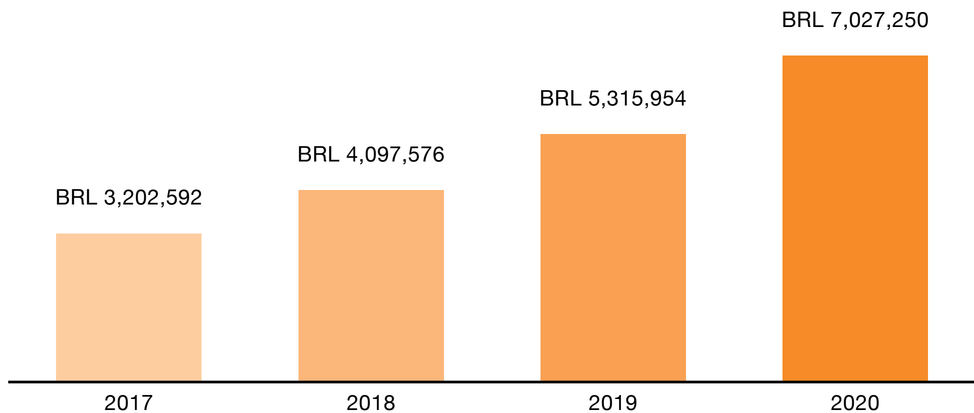


With regard to city halls in state capitals, only 10 out of 26 funded openings in TCs between 2017 and 2020 and the volume of funds was much less expressive than that raised at the federal and state levels. Nevertheless, there is a growth trend, even when the amounts are corrected for 2020.

Table 4 – Funding of TCs by City Halls of State Capitals (2017-2020)
In millions of reais adjusted for their 2020 value

CAPITAL CITY	2017	2018	2019	2020	TOTAL
Porto Alegre	BRL 0,598	BRL 0,690	BRL 1,256	BRL 1,499	BRL 4,044
Rio Branco	BRL 0,177	BRL 0,509	BRL 0,246	BRL 0,150	BRL 1,083
Salvador	---	---	BRL 0,122	BRL 2,156	BRL 2,278
Recife	BRL 0,118	BRL 0,282	BRL 0,357	BRL 0,278	BRL 1,036
Teresina	BRL 1,526	BRL 1,898	BRL 3,083	BRL 2,399	BRL 8,906
Cuiabá	BRL 0,741	BRL 0,700	BRL 0,243	BRL 0,015	BRL 1,699
Campo Grande	BRL 0,043	BRL 0,019	BRL 0,008	---	BRL 0,070
Fortaleza	---	---	---	BRL 0,302	BRL 0,302
Rio de Janeiro	---	---	---	BRL 0,225	---
TOTAL	**BRL 3,203**	**BRL 4,098**	**BRL 5,316**	**BRL 7,027**	**BRL 19,643**

Graph 10 – Funding of TCs by City Halls of State Capitals (2017-2020)
In millions of reais adjusted for their 2020 value

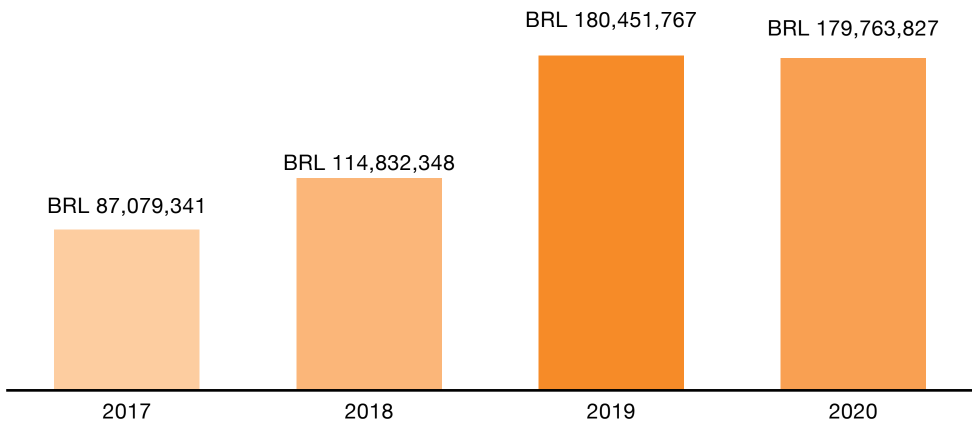


One can observe the perennial and robust funding of TCs by the municipalities of three capitals whose state and federal governments already provide many funds: Teresina, Salvador, and Porto Alegre.

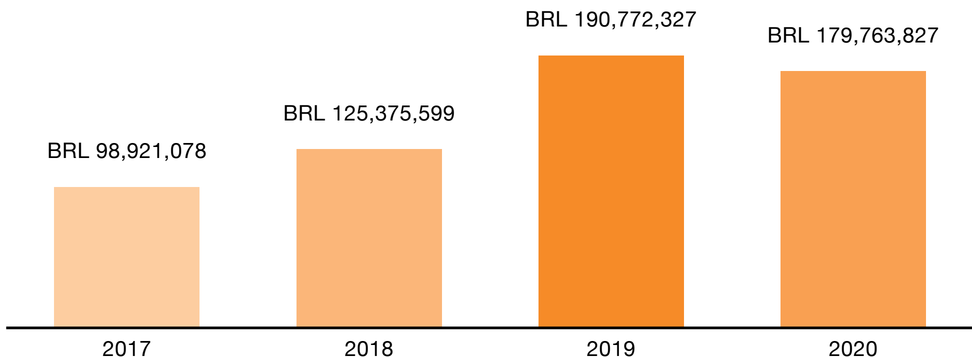
Total public investment in TCs and concentration patterns

Graphs 11 and 12 present the total amounts paid to TCs at the federal, state, district, and municipal levels. We emphasize that these are the amounts calculated within the methodological framework that was already explained and are, therefore, a conservative estimate of what was effectively paid each year. Even so, between 2017 and 2020, direct public funding of TCs reached, in 2020-adjusted values, almost 600 million reais, with a growth trend that stabilized in 2020, probably due to budget restrictions related to the SARS-Cov-2 pandemic.

Graph 11 – Total public funding of TCs (2017-2020)
In millions of current reais



Graph 12 – Total public funding of TCs (2017-2020)
In millions of reais adjusted for their 2020 value



The average total public expenditure on TCs between 2017 and 2020, adjusted for the value of the Real in 2020, is approximately **BRL 148 million per year**. The data reveal a clear concentration of funds in a few entities that share the same business name. When combined with the perennial investments of some states and municipalities, the concentration scenario deepens. The most obvious example is that of the Obra Social Fazenda Esperança therapeutic community, an entity that received, in the period under investigation, BRL 35.6 million in federal funds and BRL 7.4 million in state fudnds, in addition to BRL 8.8 million paid by federal parliamentary amendments (not directed to the funding of openings, as will be seen later).

The funds are not concentrated solely within entities with great national capillarity. It was found that a considerable proportion of entities received, simultaneously, federal, state and, in some cases, municipal funding.

Charts 2 and 3 present data referring to the concentration of receipt, by the same TC, of public funds from more than one government entity. Some states have a high level of concentration regarding these entities. It is noteworthy that the concentration percentages were based on transfers made to TCs with the same Corporate Taxpayer ID (CNPJ), thus reducing inaccuracies resulting from coincident names. Some TCs that have several headquarters with their own CNPJ were not considered as a single recipient. Therefore, if the data had been aggregated for similar business names, the level of concentration of funds would be even higher, especially for entities with greater capillarity, such as the Obra Social Fazenda Esperança, Desafio Jovem, and Amor Exigente.

Chart 2 – Concentration of public funding for TCs by state (2017-2020)

State	Total public funding (Current reais)	Total funding for TCs that receive funds from more than one public entity (Current reais)	Proportion of funds concentrated with TCs that receive funds from more than one public entity
Rondônia	BRL 3,080,948	BRL 2,784,265	90%
Amazonas	BRL 8,436,284	BRL 7,352,256	87%
Alagoas	BRL 47,035,174	BRL 34,988,198	74%
Federal District	BRL 19,594,165	BRL 14,432,222	74%
Goiás	BRL 21,094,599	BRL 15,210,323	72%
Piauí	BRL 40,171,605	BRL 28,342,534	71%
Santa Catarina	BRL 47,627,946	BRL 31,106,556	65%
Rio Grande do Sul	BRL 53,813,334	BRL 34,850,772	65%
São Paulo	BRL 108,995,604	BRL 66,496,543	61%

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State	Total public funding (Current reais)	Total funding for TCs that receive funds from more than one public entity (Current reais)	Proportion of funds concentrated with TCs that receive funds from more than one public entity
Ceará	BRL 17,085,798	BRL 8,969,396	52%
Maranhão	BRL 8,286,946	BRL 4,208,446	51%
Minas Gerais	BRL 73,656,046	BRL 33,532,745	46%
Bahia	BRL 36,125,640	BRL 15,227,020	42%
Acre	BRL 2,008,557	BRL 526,771	26%
Pernambuco	BRL 6,609,787	BRL 1,022,942	15%

Chart 3–- TCs that receive public funding from multiple sources by state (2017-2020)

State	Total TCs that received public funding	TCs that received funds from more than one public entity
Rondônia	5	4 (80%)
Minas Gerais	50	38 (76%)
Alagoas	38	23 (61%)
Federal District	15	8 (53%)
Goiás	35	17 (49%)
Santa Catarina	91	41 (45%)
Rio Grande do Sul	95	41 (43%)
São Paulo	98	40 (41%)
Ceará	31	10 (32%)
Bahia	26	8 (31%)
Maranhão	12	3 (25%)
Piauí	30	7 (23%)
Acre	10	2 (20%)
Amazonas	5	1 (20%)
Pernambuco	13	1 (8%)

5. CONSIDERATIONS ON THE PAYMENT OF PARLIAMENTARY AMENDMENTS

The 1988 Federal Constitution dedicated a specific chapter to deal with the budget issue and, within the logic of recovering the attributions of the legislative power, it strengthened the role of Congress in the approval of budget instruments, including parliamentary amendments (Machado, 2002). As in any ordinary law, the processing, consideration and approval process involves the possibility of modifying the project of the executive branch. The particularity here is that these changes directly involve the production of public goods or services and the expenditure of funds for this.

Since they generate the dedication of a direct benefit (usually a visible one) through public spending to a certain segment of the population, the approval of an amendment can contribute to strengthening the bond between parliamentarians and their constituents. This characteristic clearly places amendments in an important place in the negotiation and bargaining processes of the budget process, a phenomenon that is already broadly studied by several areas of the humanities (Kramon & Posner, 2013; Machado, 2002; Niskanen, 2007; Wildavsky, 1964, 1992).

In the context of budget negotiations, one may also identify alliances between parliamentarians and public bureaucracy to ensure budget space for public policies that meet the interests of both parties (Brubaker, 1997; Rubin, 2015; Wildavsky, 1964). In this sense, it is not surprising that government structures can be mobilized to articulate the insertion of amendments with parliamentarians. In the specific case of the funding of TCs, SENAPRED has actively sought the destination of amendments for this purpose and has even prepared a guide to facilitate request from parliamentarians. In this text, SENAPRED provides guidance on the programmatic functional classification, the items that can be funded within the budget actions and the resulting products, with special emphasis on:

Purchase of vehicles, including cars, vans and minibuses

Training of therapeutic community staff members

Direct support for the maintenance of TCs

Material for workshops, the so-called KITs that include, for instance, the implementation of an industrial kitchen for bakery purposes

The information in the guide was used to locate amendments intended for the TCs, since it was possible to identify the expenses from the budget bases. Thus, the study also focused, as in the case of the executive branch, on payments that were actually made, but on this basis, there is no element that allows for an individual association of each payment with the amendments.

The collaboration terms can either be used in the aforementioned items or be intended to fund sheltering openings. The amount of amendments effectively paid in the period was small when compared to the amount of direct federal executive funding. If we consider all the amendments actually paid between 2017 and 2020, those that passed through SENAD and SENAPRED – and there is a chance that part of them were not directly destined to the TCs, as explained below –, the total amount is slightly above BRL 30 million, which corresponds to about 10% of the total federal funding.

Chart 4 – TCs that received the most funds from federal parliamentary amendments (2017-2020)

Therapeutic Community	Amount received (In current reais)
Obra Social N S da Glória Fazenda Da Esperança	BRL 9,150,000
Casa do Menor São Miguel Arcanjo	BRL 6,788,000
Rede Crista de Acolhimento e Recuperação do Dependente Químico do Estado de Alagoas	BRL 1,500,000
Desafio Jovem Ebenezer do Estado do Rio de Janeiro	BRL1,250,000
Fundação Centro de Recuperação Feminino Missão Resgate	BRL 1,191,000
Cruz Azul no Brasil	BRL 650,000
Transforme - Ações Sociais E Humanitárias	BRL 600,000
Associação de Acolhimento Aos Dependentes Químicos e Familiares – ADQF	BRL 400,000
Ceami - Reabilitação Para A Vida	BRL 400,000
Comunidade Terapêutica Caverna De Adulao - CTCA	BRL 398,000

Chart 5 presents the eight congress members who most managed to have amendments effectively paid to TCs. It should be noted that some of them are no longer in office.

Chart 5 – Federal congress members who had the most amendments paid to TCs (2017-2020)

CONGRESS MEMBER	PARTY	STATE	TOTAL AMOUNT OF THE AMENDMENTS (In current reais)
Eros Biondini	PROS	MG	BRL 3,347,129
JHC (not in office)	PSB	AL	BRL 1,200,000
Jose Maranhão (not in office/deceased)	PMDB	PB	BRL 1,191,224
Flavinho	PSC	SP	BRL 1,178,500
Cabo Daciolo (not in office)	Patriotas	RJ	BRL 1,000,000
Rosangela Gomes	Republicanos	RJ	BRL 950,000
Maria do Carmo Alves (senator)	DEM	SE	BRL 850,000
Hugo Leal	PSD	RJ	BRL 800,000

Eros Biondini (PROS-MG), the congressman who had the most amendments aimed at TCs that were effectively paid, has a strong role in the defense of these entities, being the leader of the Mixed Parliamentary Front for the Support of Therapeutic Communities. Although it may be noticed that some of the parliamentarians who dedicate amendments to the TCs are evangelicals, the data do not reveal a pattern that could define a typology of the authors of this type of amendment.

As previously explained, there is a risk of imprecision when determining that an amendment has actually been paid to a TC. For example, a major recipient of funds is the entity Casa do Menor São Miguel dos Arcanjos, which is headquartered in more than four states and has received amendments from parliamentarians from very different political spectra. This entity performs a series of social services, including sheltering in TCs, but the data collected regarding the agreements do not allow us to categorically state that this was the final destination of the funds.

The topic of the allocation of parliamentary amendments to TCs must be further explored in future research that also considers the role of legislative assemblies, the Legislative Chamber of the Federal District and City Councils in the allocation of resources to these entities. In any case, the present study pointed out that their participation in the face of the growing amount of federal government investments between 2017 and 2020 is relatively small.

6. TC FUNDING AS A PUBLIC POLICY: PLANNING AND CONTROL

The different government levels that funded TCs between 2017 and 2020 have their own criteria and models when it comes to implementing this policy. Despite the impossibility of a detailed study in the cases of state and municipal governments, there are examples of well-structured and transparent models as well as very opaque policies. The state of São Paulo, with a TC funding program that began to be implemented in 2013, is an interesting model that points to the importance of future work dedicated to understanding, in a detailed manner, how the transfer of public funds to these entities is organized. Recomeço – the name of the São Paulo program that funds openings in TCs – is a well-structured policy with general criteria available for public access; at the same time, in order to implement it, the São Paulo government hires one of the entities representing the TCs, the Brazilian Federation of Therapeutic Communities (FEBRACT), so that it may organize and perform general control over the program.

Keeping within the scope of this study, we will now discuss some of the problems identified in the public funding policy for TCs within the federal government, as carried out by SENAPRED.

SENAPRED, through Ordinance No. 1 of 2019[16], establishedthe Electronic Management System for Therapeutic Communities (SISCT) to organize transfers TCs that are described in the various public notices for opening funding. This is a control system that is compulsorily fed by the entities themselves with the documentation and information required by SENAPRED. SISCT is another factor that indicates that the funding of TCs is a perennial policy for the transfer of public funds based on a few points:

- Simplified contracting: the service contracting model is agile, with no need for competitions or public tenders, and is based on compliance with accreditation requirements. Once the fulfillment of these requirements is proven, the TCs are considered able to perform the sheltering and to receive funds for it;

- Concentration of funds: As discussed in Section 4, there is a concentration of funds received among large entities. They have the executive and bureaucratic capacity to obtain these funds. These institutions, from what can be ascertained from the material provided in the electronic media channels of the entities themselves, offer technical support for the accreditation process, models of terms of reference, public notices, and service operation manuals.

16 https://www.in.gov.br/en/web/dou/-/portaria-n-1-de-12-de-novembro-de-2019-228394305

- Stable source of funding: the current federal administration has ensured that the TC funding policy has an advantageous position in intra-government budget disputes. This condition allowed the expansion of an expenditure even under a severe fiscal regime, with an effective public spending cap. This space has been granting this public policy its continuity, since it actually increases the political cost of a reduction or interruption.

- Partnership with the legislative branch: By proactively offering a procedure for the signature of parliamentary amendments from a service visible to constituencies, as discussed in Section 5.

According to the literature on public budgets, two points are still relevant to analyze the policy of funding TCs at the federal level. The first is the relevance of these mechanisms for obtaining budget space in a context of intensified intra-governmental competition for funds. Understanding this conflict from the perspective of dispute spaces (Lowi, 1964) and the tendency of, under the spending cap, distributive conflicts becoming redistributive (Silva & Couto, 2017), the observed growth in funding indicates a relevant political advancement in TC funding.

Analyzed from the perspective of incrementalism, there is reason to assume that the TC funding policy will continue to be part of public budgets at least in the medium-term horizon of the federal government and, in some cases, of state governments. The literature points to a characteristic of inertia and aversion to change in the public budget over the years, with a strong tendency of reproducing previous budgets (Rubin, 2015; Schick, 1972, 2003; Wildavsky, 1964).

This scenario makes it even more relevant for there to be a well-structured accountability system, which would transcend internal bureaucratic control mechanisms and allow citizens to have control over public policy (Abrucio, 1998; Campos, 1990; Mosher, 1968). Such control must take into account a comprehensive analysis of the evaluation dimensions of public policies, considering not only the ability to achieve their goals, but also the means by which they will be carried out, and the relationship between their inputs and their outputs (Marinho & Façanha, 2001).

Thus, we can use three dimensions of analysis of public funding policy for TCs as parameters: efficiency, efficacy, and effectiveness (Castro, 2006; Marinho & Façanha, 2001; Sano & Filho, 2013):

1. **Efficiency:** measures that establish links between inputs and outputs, that is, how budget resources are used to deliver outcomes. In the context of TC funding, the difficulty of directly obtaining information on the relationship between openings available and funds used are obstacles to the evaluation of their efficiency and, in addition, the concentration of funds in a few entities, without constituting a competitive price formation scenario, appears as a tendency towards a less efficient use of public funds.

2. **Efficacy:** the availability of the service and, specifically, the way in which it is distributed and allocated in the territories. In this sense, the data collected indicate that: (i) the service distribution criteria, both from the perspective of priority territories and of concentration of target audiences, are not made explicit; (ii) interfederal coordination is not clear, and it is possible to identify an imbalance in funding between the federal government, states and municipalities (excess funding for some states and absence in others).

3. **Effectiveness:** the impact of the policy and its ability to achieve the desired goals. In other words, since it is a temporary residential care for people with problem drug use, which results would be expected? Are there general evaluation policies or policies specific to each entity? The answers to these questions are not included in the regulatory framework for this policy. As we will see in the next section of this report, within the scope of the specialized literature, there is little international evidence of the effectiveness of sheltering in TCs, and this evidence is non-existent at the national level.

In short, a comprehensive control system could only be achieved if there was clarity in the policy regarding inputs, outputs, outcomes, and impacts. In multi-annual plans, such as budget laws, this rationale is not presented, nor is a clear relationship established between "therapeutic community services" and "reduction of the social impact of alcohol and drugs". As a result, even if impact assessments were available, the policy for funding openings in TCs could not yet be considered transparent and open to social control proportionally to the growing volume of public funds invested.

In light of these findings and without going into the merits of the policy's ultimate goal, the hiring of openings for sheltering in TCs, we present some specific recommendations regarding its transparency, monitoring, and social control:

- Evaluation of the Therapeutic Community contracting model, from the perspective of its administrative procedures and of market conditions and effective costs. If the justification of the costs of a service is constructed from the conditions in which they are offered, the concentration of resources in a few institutions increases likelihood of distortions;

- Greater control over the multi-annual planning, in order to make actions, goals, indicators and, mainly, the monitoring of expenses explicit and individualized. A policy that has already reached the level of BRL 100 million per year must provide, in a more adequate and direct manner, the inputs for the analysis of efficiency, efficacy, and effectiveness;

- In terms of annual budget planning and execution, a set of short and medium-term measures could be carried out:

    a. Adequacy of the functional-programmatic classification to allow the direct identification of expenditures with Therapeutic Communities;

    b. Complementing the information on the relationship between individualized payments and the functional-programmatic classification;

    c. Annual presentation of quantitative data related to care provided, openings maintained, and new openings created;

    d. Update of the map of Therapeutic Communities in Brazil, indicating, for each entity, the government agreements, the public sponsorship terms, and the current contracts.

The adoption of these measures would at least make the parameters of planning and budgetary execution of the financing of TCs clearer and more accessible, which is already common in other public policies. Parameters, criteria and information about this increasingly onerous policy would be accessible without civil society having to spend so many resources, and this would enable a qualified debate on such a sensitive topic.

7. OPINIONS IN THE LITERATURE ABOUT THE EFFECTIVENESS OF TCs[17]

Finally, with hope that the growing importance of TC funding as a public policy in Brazil and some of its main problems have been well demonstrated, a brief discussion is appropriate, from the mental health care perspective, on the effectiveness and impacts of the treatment offered by these entities to people with problem drug use. Evidently, our intention is not to deplete the numerous controversies regarding the performance of TCs, starting with their guiding principles, which have abstinence and temporary isolation as their two core foundations. As discussed in the introduction to this report, there are many other subjects raised in the literature on, for example, the fundamental rights of drug users, the threat to the secularity of the State in the face of the religious orientation of most TCs, and the contradictions experienced in the integration of these devices to the RAPS network (Souza et al., 2013; Kurlander Perrone, 2014; Tófoli, 2015; Carvalho & Dimenstein, 2017; CRP-SP, 2016; Gomes dos Santos & Pires, 2020, Fiore & Rui, 2021).

Firstly, one can emphasize the lack of attention given to some of the most important parameters for the evaluation of public policies, such as 1. the definition of a specific target audience for this type of intervention amidst the broad universe of drug users; 2. the evaluation of the effectiveness of this intervention; 3. the analysis of its implementation in terms of costs and processes; and 4. the understanding of the possible therapeutic benefits and the social impact subsequent to its implementing.

Thus, this section seeks to present a synthesis of evidence regarding therapeutic effectiveness and other outcomes associated with sheltering in TCs through a narrative review. It is a brief "state of the art" that particularly highlights the gaps that still remain in the specialized literature.

The changes and the diversity within TC approaches

Since a treatment option can only be evaluated using recognized standards, in order to assess data on the effectiveness of TCs, it is necessary to take a brief look at the foundations, evolution, and modifications incorporated to this form of care over the years (Reif et al., 2014; Vanderplasschen et al., 2014).

The therapeutic community can be considered a space and a form of treatment for the problematic use of psychoactive drugs – an issue with a term defined in contemporary psychiatric classifications

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17 This section was originally written by Dr. Debora Gomes Medeiro, under the supervision of Prof. Dr. Luís Fernando Tófoli, both psychiatrists and researchers at Unicamp. The final edition was arranged by the general coordination.

and included under the construct of Substance Use Disorder (SUD). Conceptually created in Europe, this approach to temporary residential care for those with people with problem drug use was initially implemented in the United States in the late 1950s, and has since been adopted in at least 65 countries worldwide (NIDA, 2015). Its orientation – based on the understanding of dependence as a chronic and relapsing condition – aims to produce broad and long-term changes in the lives of people who are sheltered, with complete abstinence from the use of the drug(s) related to the primary dependence situation. In addition, the TC approach is based on the concept of "community as a method", developed through the participation of sheltered individuals in a structured routine in which they commit to their own recovery and that of their peers (social learning) (NIDA, 2015).

In its original version, treatment programs in TCs were directed only by peers, that is, by people who had already experienced problematic drug use and who were in more "advanced" stages of recovery. However, over the last five decades, TCs began to progressively incorporate health professionals into their staff (such as psychiatrists, psychologists, nurses, and other professionals with training in mental health) and to add new techniques and forms of intervention, notably originating from the health sciences and psychology (Vanderplasschen et. al., 2014.; IPEA, 2017). Nevertheless, a relevant portion of the TC staff continues to be composed of users in recovery (NIDA, 2015).

It is worth mentioning that, in the process of spreading TCs around the world, there was an intense adaptive process in the approaches. In Europe, for example, the behaviorist approach of North American TCs was complemented by educational theories and psychoanalytic theory, as well as by bringing families to the community and hiring more technically qualified staff (Vanderplasschen et. al., 2014).

Recently, TCs have undergone changes regarding their target audience and duration of treatment (REIF, S. et al., 2014). As the demographic characteristics of those seeking treatment changed, TC programs began to welcome people with psychiatric comorbidities, who were homeless and who were convicted of a crime (NIDA, 2015). Budgetary pressures have also led to changes in treatment programs, notably in terms of their duration (Vanderplasschen et. al., 2014).

In Brazil, TCs are characterized as entities that provide residential care for people with problem drug use and the only available census data indicate that they are predominantly installed on large plots of land in rural areas or on the outskirts of urban centers, with the capacity to receive a maximum of 30 people (almost half of the institutions have this profile). Its approach is based on the work-discipline-spirituality tripod, with the adoption of labor therapy (exercise of work as a way to achieve therapeutic goals) and the cultivation of spirituality, notably of a Christian denomination, a constant of its therapeutic project. Likewise, the link between Brazilian TCs and churches and religious organizations is highly prevalent (IPEA, 2017).

Also in the Brazilian context, there was an increase in the hiring of professionals with some technical training and the incorporation of knowledge and technologies specific to the health area. Likewise, the accumulation of internally produced data has been growing, which is a means of enabling accountability and public justification of the work that is carried out (IPEA, 2017).

Summary of evidence of the effectiveness of TCs in an international context

In the last three decades, studies have investigated the therapeutic effectiveness and other outcomes of the type of care offered by TCs (Vanderplasschen et. al., 2014). All of them recognized relevant methodological obstacles. Attempts to systematize findings into systematic or narrative reviews have repeatedly indicated weaknesses that limit the development of consistent conclusions (Smith et al., 2006), or even that lower the level of evidence down to moderate (Reif et al., 2014). Among the limitations of the studies, the relative scarcity of controlled, double-blind, and randomized trials (De Leon et al., 2021) stands out, as well as the deficiencies regarding the design of these trials – especially those related to the adequacy of the samples and the control group equivalence (Reif et al., 2014).

In addition, the differences in the interpretation of the data are noteworthy. There are works that, even though they acknowledge the methodological reservations, defend the effectiveness of the TC treatment model for specific target audiences (De Leon, 2010, 2021). On the other hand, other studies posit that there is not enough evidence to support the superiority of TCs in relation to other less expensive forms of treatment, emphasizing the need for more rigorous studies (Fiestas & Ponce, 2012).

Despite the evident limitations, there are some relevant convergences. Firstly, with regard to the impact of the treatment provided by TCs, the most consistent data indicate that the length of the stay and the way in which the follow-up was carried out after leaving are the most relevant predictive factors for the maintenance of drug abstinence for determined periods. (Maliver et al. 2012; Vanderplasshen et al, 2013, Kurlander Perrone, 2019).

A body of more recent literature – particularly in the last decade – acknowledges moderate evidence of reduced drug use after periods of stays at TCs (Magor-Blatch et al., 2014; Vanderplasschen et. al., 2014; NIDA, 2015; De Leon, 2010, 2021). This evidence is stronger for individuals with more severe conditions who seek treatment (NIDA, 2015; Janeiro et al., 2018). However, issues related to sustaining this impact in the medium and long term are less clear (Malivert, et al., 2012). When comparing the set of residential-type treatments, which include TCs and other types of temporary inpatient care, with other approaches, the results are not consistent. Although some studies suggest positive impacts of residential treatment, most of the literature does not provide evidence of superior levels of effectiveness (Reif et al., 2014).

Furthermore, in general, there is little evidence of the effectiveness of treatments for people with problematic drug use based solely on detoxification (control of sensations linked to discontinuation of use) and short-term stabilization, without maintenance therapy approaches. As in other clinical conditions, difficulties related to adherence to drug treatment, early dropouts and high relapse rates are common, especially when factors such as poverty, lack of family support, and psychiatric comorbidities are present. Thus, one may observe that only 40 to 60% of users remain abstinent one year after discharge from the inpatient care process (McLellan et al., 2000).

There has been a growing interest in studies that assess the effectiveness and impacts of modifications to the original treatment proposal in TCs (modified therapeutic community) for subgroups of users with specific needs, such as adolescents, users with psychiatric comorbidities, women, mothers, and people in some kind of conflict with the law or deprived of their freedom by the penal system. Likewise, outcomes that are not directly related to drug use have been investigated, such as quality of life, employability, and criminal behavior (Vanderplasschen et. al., 2014; NIDA, 2015; Kurlander Perrone, 2019).

Furthermore, part of the literature began to encourage new avenues of research attempting to answer other questions about the TC treatment model: how this type of intervention works in detail, which users could benefit from it, and in which contexts it could be effective, are all pending questions that invite further investigation (Magor-Blatch et al., 2014, Janeiro et al., 2018).

In the regulatory framework that defines the performance of TCs in Brazil, the sheltering of people with severe psychiatric comorbidities is prohibited. However, there are relevant indications of non-compliance with this and other prohibitions. International research indicates that psychiatric comorbidities are not associated with increased risks of relapse or treatment dropout (Maliverta et al., 2012) and a review of four studies on the outcomes of treatment offered by TCs for people with problem drug use and individuals with other types of psychiatric conditions showed positive outcomes (improvement in terms of substance use, mental health, illegal acts, risk of HIV infection, employment and housing) when compared to those who received standard care. However, in addition to the methodological limitations that require a careful interpretation of these findings (Sacks et.al, 2008), it is important to mention that the way in which most Brazilian TCs operate differs greatly from those located in countries where the studies were carried out.

There is a particularly controversial point in the international literature on people deprived of their liberty sheltered in TCs. In some countries, being sheltered at TCs is one of the options for those who respond to the criminal justice system and are people with problem drug use, and some results were positive when compared to other types of care offered in the prison environment or to this same environment without any type of care being implemented (Smith et al., 2006; Fiestas & Ponce, 2012). Equivalent results were obtained for people with illicit behaviors and with personality disorders (Richardson & Zini, 2010). Still with regard to the TCs' interface with the criminal justice system, studies have shown a positive impact of this form of treatment with regard to different legal outcomes, especially the reduction of recidivism (Vanderplasschen et al., 2013; Magor-Blatch et al., 2014; Vanderplasschen et. al., 2014; NIDA, 2015). However, the literature also draws attention to the fact that, in the case of users protected by the criminal justice system, different motivating factors for treatment are present – such as the possibility of staying outside the prison environment –; as such, these services and their outcomes are not directly comparable to other residential treatments (Reif et al., 2014). In addition, once again, it is important to emphasize that these studies were carried out in prison contexts that are radically different from the Brazilian ones and, therefore, their findings cannot be extrapolated without great caution.

There are also studies that suggest that being sheltered at a TC can have a positive social impact, later influencing entry into the labor market, promoting social bonds and improving the general mental health of its patients (Vanderplasschen et. al., 2014).

Finally, the international literature presents moderate evidence of the effectiveness and positive impacts of being sheltered at TCs when the evaluation criteria are expanded to include quality of life, social bonds, mental health, employability, and legal outcomes, which is aligned with a broader understanding of recovery beyond abstinence (Sacks et al., 2008, Kurlander Perrone, 2019; De Leon, 2021). This evidence, however, has important methodological limitations and can hardly be extrapolated beyond its original research context.

National evidence

In Brazil, there are few investigations on the effectiveness and impact of being sheltered at TCs. Although this type of entity has operated in the country since the 1960s and public funding has, as seen throughout this report, grown substantially, the systematic description of the set of these care establishments in Brazil is very recent in itself (IPEA, 2017).

However, in recent years, some studies have investigated outcomes associated with being sheltered at TCs in Brazil (Kurlander Perrone, 2014; Barreto et al., 2021). The results tend to reinforce some data from international literature, such as the association between the sheltering period without early dropouts with positive outcomes, such as an overall improvement in quality of life. The maintenance of abstinence was, likewise, associated with indicators of better quality of life and this specific work discussed the feedback loop between these two evaluation criteria, abstinence and quality of life (Kurlander Perrone, 2019).

With regard to predictive factors for dropping out of the treatment, the study that evaluated users sheltered at a particular Brazilian TC pointed to practices considered "dysfunctional", especially those related to labor therapy and the obligation of religious practices, which contributes to treatment dropout and, in some cases, to relapses (Kurlander Perrone, 2014).

Based on an analysis of a dataset relating to 18 TCs in the Northern region of Brazil, Silva et. al (2018) stated that

> *"[T]hese establishments lack coordinated interventions that range from the mapping and registration of TCs to training, planning, evaluation and monitoring – prioritizing the effectiveness of clinical protocols and the provision of humanized services – just as any health services should be"*
>
> (Silva *et.al*., 2018).

Regarding the shortcomings identified by this study, it is important to note that it was only in 2021 that an investigation was published attempting to describe the implementation of a monitoring system in TCs funded by the state government of São Paulo, as well as to evaluate the results obtained between 2014 and 2016. The evaluation allowed for the characterization of the users sheltered at these facilities, their structure and the treatment programs they developed (Barreto et al., 2021).

In said analysis, the observed outcome of returning to the family with conditions to support oneself was relevant, considered by the authors as an important indicator of a successful social reintegration. Regarding this variable, the authors highlighted the fact that the 21% rate exceeds a series of longitudinal studies with populations undergoing treatment for problematic stimulant use, where rates between 15 and 20% would be expected (SINHA, 2015, apud Barreto et al., 2021). However, the possibility of a confirmation bias in this interpretation is noteworthy, since the difference of 1% is not usually considered relevant. Additionally, the authors recognized the possibility of a selection bias in the sample, since the study analyzed TCs that are in a different regulatory process and that would not, therefore, be necessarily representative of the universe of these entities operating in the country (BARRETO et al., 2021).

Given the above, it is evident that the body of knowledge regarding the effectiveness of sheltering at TCs in Brazil is quite incipient, influenced by regional aspects, and limited by the different levels of institutionalization of this type of facility. Therefore, in spite of data obtained in incipient studies and which must be further studied, there is no rigorous evidence of the effectiveness of sheltering people with problem drug use in TCs in Brazil.

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9. ANNEX - LEGAL OPINION ON COMPLEMENTARY LAW Nº 187/21 AND THE NATURE OF THERAPEUTIC COMMUNITIES

I. SUMMARY OF THE OPINION

A Complementary Law No. 187/2021 brought innovations to the Brazilian legal system by including, among the charitable entities eligible for the Certificate of Charitable Social Assistance Entities (CEBAS), "institutions that act in the reduction of drug demand" (art. 32), specifying in its item I that these institutions encompass "I – therapeutic communities";

B Upon analysis of the rules that involve therapeutic communities (TCs), one may notice that these organizations receive special legal treatment based on their nature and their activity profile, with a distinction being established between "Therapeutic Communities meant for Treatment" and "Therapeutic Communities meant for Sheltering";

C The Therapeutic Communities meant for Treatment are health entities of a medical nature that act as a health institution, as such, they are part of the RAPS - Psychosocial Care Network and must be registered with the CNES/MS - National Registry of Health Establishments, of the Ministry of Health, observing the rules of the Brazilian Health Surveillance Agency (ANVISA) and the Federal Council of Medicine (CFM) pertaining to health establishments;

D The Therapeutic Communities meant for Sheltering are entities that operate under the National Drug Policy and are not characterized as a health or social assistance institution; rather, they are considered services of interest to health, and must be registered with the Therapeutic Communities Management System (SISCT) at the National Secretariat for Drug Care and Prevention (SENAPRED) of the Ministry of Citizenship, observing ANVISA rules that pertain to the sheltering of drug users in non-health services and the Resolutions of the National Drug Policy Council (CONAD);

E TCs are not characterized as organizations that operate in the area of social assistance, since the activities they develop are not expressly provided in the list of sheltering services recognized within the scope of the Unified Social Assistance System, pursuant to the Resolution of the National Social Assistance Council (CNAS) No. 109/2009;

F The inclusion of institutions that work to reduce drug demand by art. 32 of LCP No. 187/2021 as entities that are eligible for CEBAS represents, in practice, the creation of a fourth category of organizations that are exempt from social contributions, subverting the purpose of the LCP,

contrary to what is established in art. 2 of LCP No. 187/2021 and § 7 of art. 195 of the Federal Constitution; and

G The creation of this new category of organizations eligible for CEBAS by Complementary Law No. 187/2021 creates an unequal legislative treatment in regards to other types of non-profit legal entities operating in related areas, but that are not recognized as charitable for certification purposes in the areas of social assistance, health or education.

II. THERAPEUTIC COMMUNITIES AND THE BRAZILIAN NATIONAL DRUG POLICY

TCs are part of the National Drug Policy as expressed in Decree 9,761/2019[1], which establishes its coordination and implementation as attributions of SENAPRED of the Ministry of Citizenship and by the National Secretariat for Drug Policies of the Ministry of Justice and Public Safety (SENAD/MJ), within the scope of their respective jurisdictions.

As a general guideline, the Decree establishes that the goals of this policy include promoting and assuring the articulation and integration of interventions for treatment, recovery, social reintegration, through the distribution of technical and financial resources by the State, and, especially, stimulating, improving and supporting, including through financial means, the work of TCs.

In 2015, CONAD published Resolution No. 1/2015, characterizing TCs as “entities that provide voluntary care for individuals who have problems associated with harmful use or dependence of psychoactive substances”. According to Art. 2 of this resolution, TCs are non-profit legal entities that have the following characteristics:

I. voluntary adhesion and permanence, formalized in writing, understood as a transitory stage for the social, familiar, and economic reintegration of the sheltered individual;

II. residential environment, of a transitory nature, conducive to the establishment of bonds, with conviviality among peers;

III. sheltering program;

IV. provision of activities in the entity’s sheltering program, as described in art. 12; and

V. promotion of personal development, focused on sheltering people in vulnerable situations with problems associated with abuse or dependence of psychoactive substances.

1 Decree No. 9,761, APRIL 11, 2019 - National Press (in.gov.br)

Pursuant to the CONAD rule, entities that offer health care services or that perform procedures of a clinical nature different from the services described in the Resolution are not considered TCs – which must observe specific health standards and protocols (art. 2, §1). Furthermore, the sheltering referred to in the aforementioned Resolution is not to be confused with the services and programs offered by the SUAS network (art. 2, §1).

Regarding the admission of new residents, the rule requires prior diagnostic evaluation, involving medical assessment and the characterization of harmful use or dependence on psychoactive substances, issued by the health care system or by a qualified professional, preferably with technical qualification for said assessment (article 6, II , and § 4[2]).

These entities must also annually send updated information to CONAD regarding their operations, number of vacancies and profile of the people they shelter (art. 25), and the Council is responsible for systematizing the information passed on by the entities in its separate, public database, assuring that it georeferences the entities[3].

III. THERAPEUTIC COMMUNITIES AND HEALTH SERVICES

Ordinance No. 3.088/2011, issued by the Ministry of Health, established the Psychosocial Care Network – RAPS, establishing its purpose aimed at the creation, expansion and articulation of health care establishments for people in suffering or with mental disorders and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the Brazilian Public Health System (SUS), specifically aiming at reducing the damage caused by the consumption of crack, alcohol and other drugs and the rehabilitation and reintegration of these individuals through access to work, income and housing.[4]

Regarding this spcific approach, it is essential to highlight that the RAPS was created based on Law No. 10.216/2001[5], which consolidated the psychiatric reform in the country, and provided a new direction regarding mental health care, favoring the provision of treatment in community-

2 The Resolution also establishes that the entities that promote the sheltering of people with problems associated with abuse or dependence of psychoactive substances, characterized as therapeutic communities, have the following obligations, among others: (article 6), Singular Assistance Plan – PAS; clearly informing the admission, stay and discharge criteria, as well as the entity's sheltering program, which must receive the prior written consent of the sheltered individual; assuring the participation of the family or person indicated by the sheltered individual in the sheltering process; communicating each sheltering procedure to the health establishment and the social protection system in the entity's territory; encouraging familial and social bonds, allowing family visits; not practicing or allowing actions of physical or medication containment, isolation or restriction of the sheltered individual's freedom, keeping the environments used by the sheltered individuals free from locks, keys or bars; not practicing or allowing physical, psychological or moral punishment; not subjecting the sheltered individual to forced or exhausting activities, subjecting them to degrading conditions.

3 Another interesting aspect is that the TCs must communicate the start and end of their activities and their sheltering program to other bodies, such as federal, state and municipal drug policy management bodies, Municipal Health, Social Assistance and Education Departments and Councils (the latter in the case of Adolescents). The TCs that shelter adolescents must register the entity and its programs, specifying the service regime, at the Municipal Council for the Rights of Children and Adolescents (CMDCA). It will be up to the CMDCA, pursuant to § 1 of art. 90 and art. 91 of the Child and Adolescents Act, to keep a record of registrations and their changes, which will be communicated to the Guardianship Council and the judicial authorities. The sheltering of adolescents in TCs is pending trial – ACP 0813132-12.2021.4.05.8300/TRF5

4 Available at: https://www.gov.br/saude/pt-br/acesso-a-informacao/acoes-e-programas/caps/raps. Accessed on 03/21/2022.

5 Available at: http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm.

based services, as well as determining the protection and rights of people with mental disorders – although it has not established clear mechanisms for the progressive extinction of asylums[6].

TCs are regulated by the Ministry of Health Ordinance no. 3,088, of 2011, as a "temporary residential health care service for admissions of up to nine months for adults with stable clinical needs resulting from the use of crack, alcohol and other drugs", playing an important role in the deinstitutionalization strategy of the RAPS.[7] According to this ordinance, the TCs are included as part of the RAPS Residential Care Services.[8]

The Residential Care Services work in coordination with the basic health care system, which supports and reinforces the general clinical care of its users, and with the Psychosocial Care Centers (CAPS), responsible for the referral to sheltering services, for the specialized follow-up during this period, for the planning of the discharge, for follow-up care, as well as for the active participation of the intersectoral articulation to promote the reintegration of the individual in their community (art. 9, § 3, Ministry of Health Ordinance No. 3,088/2011). The CAPS's are made up of multidisciplinary teams that work from an interdisciplinary perspective (art. 7, § 1) and play a fundamental role in recommending and referring patients to TCs.

The TCs were more specifically discussed in the Ministry of Health Ordinance No. 131, of January 26, 2012, which established a financial incentive to support the cost of Residential Care Services. In addition to establishing the funding amount, the Ordinance establishes a series of operating guidelines applicable to TCs. Entities providing residential care services must, for instance, respect the resident's right to establish frequent contact and receive regular family visits from day one, as well as encouraging social interaction and participation in activities outside the entity facilities (art. 8), without therefore isolating the sheltered individual. The Ordinance also requires the monitoring of the treatment of users and their families by the CAPS reference team (art. 17) and expressly prohibits the use of containment rooms and locks that do not allow the free movement of resident users to the accessible environments of the entity providing the service (article 9, sole paragraph).

As for the structure of Residential Care Services, the Ordinance establishes that such entities must be installed (art. 9) outside the limits of the hospital unit and in a place that allows easy access for the reintegration of the resident user to their community of origin.

Regarding the admission of new residents, the rule requires the express and informed consent of the users, encouraging the user to visit the TCs' premises in order to learn about the work proposal, in addition to a prior evaluation by the referring CAPS in conjunction with the Primary Care Team, made up of multidisciplinary professionals responsible for the individual care of users and, if possible, of their families (arts. 13 and 14).

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6 Psychiatric Reform and Mental Health Policy in Brazil – Regional Conference on the Mental Health Service Reform: 15 years after Caracas. Brasilia, November 2005. Ministry of Health. Available at: https://bvsms.saude.gov.br/bvs/publicacoes/Relatorio15_anos_Caracas.pdf, p. 8.
7 The deinstitutionalization strategies of the RAPS comprise a set of initiatives that aim to assure comprehensive care to people with mental disorders and with needs arising from the use of crack, alcohol and other drugs, in situations of long-term in-patient care, through substitute strategies, from the perspective of assuring rights with the promotion of autonomy and the exercise of citizenship, seeking their progressive social inclusion (art. 11, § 1, Ministry of Health Ordinance No. 3,088/2011).
8 Available at: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html.

IV. TAX IMMUNITY AND COMPLEMENTARY LAW No. 187/2021

Tax immunity refers to constitutional rules that prevent the executive and legislative branches of power from charging a certain tax from a certain person, because said person, in theory, serves and protects the greater interests of society.[9]

In this sense, art. 150, item VI, item "c", of the Federal Constitution grants tax immunity on income, assets, and services[10] of education, social assistance and health entities, established as legal entities governed by private law, not for profit, in what pertains to their essential activities, that is, to their core activities.

Also in terms of constitutional immunities, §7 of art. 195 establishes that education, social assistance and health institutions that act in a charitable manner, in accordance with the law, will be exempt from social contributions, including contributions levied on the payroll - CSLL (social contribution on net income), PIS/PASEP and COFINS (contribution to fund the social security system). To prove the charitable nature of its actions, the organization must be certified with CEBAS.

CEBAS also allows the entity to benefit from funding through capitalization bonds in the philanthropy modality[11]. In this modality, a person interested in participating in sweepstakes grants the right to redeem the funding balance to charitable social assistance entities certified with CEBAS.[12]

In March 2021, the Federal Supreme Court (STF) recognized the formal unconstitutionality of Ordinary Law No. 12,101/2009, which regulated the granting of tax immunity from social security contributions and the CEBAS. According to the STF, tax immunity must be regulated by a Complementary Law, particularly in order to "prevent false assistance and education institutions from being favored by the immunity".[13]

The decision mobilized the National Congress in order to process and vote on the Complementary Draft Bill No. 134/2019, giving rise to the current Complementary Law No. 187/2021, which "determines the certification of charitable entities and regulates procedures referring the immunity from social security contributions" (article 146, item II, and article 195, § 7, both of the Federal Constitution).

The process of being certified as a charitable social assistance entity described by Complementary Law No. 187/2021 defends the principle of universal service and, in this aspect, is very similar to that of Law No. 12,101/2009. However, it presents some innovations: entities that provide assistance in

9 According to Roque Antônio Carrazza, "constitutional statements (express or implied) that prevent the legislator from charging a certain tax from a given person, precisely because they serve and protect the greater interests of society" CARRAZZA, Roque Antônio. Imunidades tributárias dos templos e instituições religiosas. São Paulo: Noeses, 2015, pp. 5-9.
10 That is, federal, state and municipal taxes on income (IR - federal income tax), property (ITR - federal rural property tax; IPVA - state vehicle tax; IPTU - municipal urban property tax) and consumption (ICMS - state transaction tax, and ISS - municipal service tax).
11 Annex IX of SUSEP Circular No. 576/2018 - art. 3rd "Each philanthropic campaign must be associated with a charitable entity that will received the funds arising from the transfer of redemption rights of capitalization bonds. Sole Paragraph. The entity must have been established for at least five (5) years, in addition to having the Certification of Charitable Social Assistance Entities (CEBAS), granted by the Federal Government".
12 On this matter, it is worth mentioning Draft Bill No. 545/2022, originating in the Federal Senate, approved on 03/30/2022 in the Lower House, which is awaiting presidential approval and establishes a more specific regulation for this type of capitalization bond through philanthropy to entities certified with CEBAS, thus expanding funding possibilities.
13 Vote by Justice Gilmar Mendes. Available at: https://redir.stf.jus.br/paginadorpub/paginador.jsp?docTP=TP&docID=752454021, pp. 25-26.

more than one area (health, social assistance or education) are exempt from proving the specific requirements required for non-core areas; the requirements for gratuity percentages are segregated by specific services and activities; and, **in particular, TCs began to be treated as entities eligible for CEBAS.**

In spite of the fact that the rule introduced by Constitutional Amendment No. 95, through art. 113 of the Transitional Constitutional Provisions Act (ADCT) determines that every legislative proposal must be accompanied by an estimate of the budgetary and financial impact, LCP No. 187/2021 was approved without any such study being presented.

V. THERAPEUTIC COMMUNITIES AND LCP 187/2021

a. CEBAS AND THERAPEUTIC COMMUNITIES

According to Complementary Law No. 187/2021, TCs will be institutions designed to offer care through voluntary adherence to a transitory residential regime and in a protected environment, guided by ethical principles with a focus on personal and social development through abstinence.[14]

To be a beneficiary of tax immunity, the TC must be legally established as a non-profit private entity in the form of an "association, foundation or even a religious institution" and be registered with the "competent federal executive authority". In the case of TCs, therefore, the certification is under the purview of the SENAPRED[15], and no longer under the CNES[16], as if it were a health organization.

In order to become certified, the entity must present[17] a declaration issued by bodies that deal with the issue of drugs at the federal (e.g. ministry/councils), state (former secretariats/councils) and municipal (secretariats/councils) levels that have the jurisdiction to attest to the organization's performance in reducing or controlling drug use.

We should note that, despite the Law placing the CEBAS certification procedure of TCs under the Ministry of Citizenship – together with the certification of Social Assistance organizations –, the authority

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14 Art. 32, § 2 The therapeutic community is considered to be the therapeutic model of care in a residential and transitory regime, through voluntary adherence and permanence, for people with problems associated with the use, abuse or dependence of alcohol and other drugs sheltered in a protected and technically and ethically oriented environment, which aims to promote personal and social development, through the promotion of abstinence, as well as social reintegration, seeking a general improvement in the individual's quality of life.

15 Art. 32, § 4. The entities referred to in §§ 2 and 3 of this article, constituted as non-profit legal entities, in the form of items I, III or IV of the head provision of art. 44 of Law No. 10.406/2002 (Civil Code), must be registered with the competent federal executive authority and comply with the provisions of subparagraph A of item I of the head provision of art. 2 of Law No. 13.019/2014. § 5 The certification of the entities mentioned in the head provision of this article will be carried out by the unit responsible for the drug policy of the federal executive authority responsible for the social assistance area.

16 The Ministry of Health Ordinance No. 1.482/2016 established that "health promotion entities and TCs are considered eligible for registration in the CNES".

17 Art. 33. In order to be considered charitable and to qualify for certification, the entities referred to in art. 32 of this Complementary Law shall: I - Submit a statement issued by a federal, state, district or municipal authority with jurisdiction to attest that it acts in the area of drug use control or a similar activity; II - Keep an updated record in the unit referred to in § 5 of art. 32 of this Complementary Law; III - Prove, on an annual basis, pursuant to the regulation, the provision of the services referred to in art. 32 of this Complementary Law; IV - Register all those who are sheltered in a specific information system developed pursuant to the regulation, in the case of therapeutic communities; V - Prove the registration of at least twenty percent (20%) of its capacity in free services.

responsible for attesting to the performance in the area of "drug use control or similar activity" is not established and could be from other areas, such as health and justice and public safety.

The rule also establishes a different treatment in relation to other social assistance entities by not requiring registration with the Municipal Social Assistance Councils - COMAS, even though, at first, TCs have been equated with this type of entity, reducing the possibilities of control and inspection.

Following the general logic of the new law, the fact that they are considered charitable does not imply the need for total gratuitousness of the services provided, and such institutions may carry out activities that assure the necessary resources for the provision of services in the area of social assistance, even through branches, with or without the assignment of labor.

It is noteworthy that the legislation establishes multiple specific criteria for entities in the area of health, education, social assistance or TCs in relation to the requirement of free services. In health, there prevails a need to prove the investment of a percentage of the organization's revenue in specific services in the area. In the area of education, proof of free services is given through percentages of scholarship offers and other benefits. In terms of social assistance, the rule does not specifically mention a minimum or maximum percentage of free services, but rather establishes the possibility for organizations to develop activities that generate funds.

TCs, on the other hand, are treated in a special way by the legislation, and they must only prove that they allocate at least 20% of their capacity to free care services, and the jurisdiction for defining the service capacity of each entity is not clarified.

It is worth noting that the TCs are not the only organizations to receive special treatment. In this regard, one may draw a parallel between the TCs and the institutions dedicated to the social assistance care of the elderly.[18]

b. THERAPEUTIC COMMUNITIES AND SOCIAL ASSISTANCE ORGANIZATIONS

Considering that LCP No. 187/2021 dealt with the immunity of TCs in the same Section of the rule that specifies the granting of CEBAS to entities acting within the scope of social assistance, as organizations acting in a "therapeutic model of care in a residential regime", through "sheltering in a protected and technically and ethically oriented environment", we sought to analyze whether or not the TCs would be included in the Institutional Sheltering Services of the SUAS.

18 Long-stay Institutions for the Elderly (ILPIs) and Nursing Homes can enjoy the immunity provided for by art. 195, § 7 of the Constitution, provided that they have entered a service provision agreement with the sheltered elderly person. The new law maintains the possibility of charging up to 70% of the social security benefit (retirement) or social assistance benefit (continued benefit) received by the sheltered elderly person in order to pay for the contracted services.

CNAS Resolution No. 109, of November 11, 2009[19] it is the rule that approves, describes and classifies the Social Assistance Services and that provides, within the scope of the High Complexity Special Social Protection Services, a list of sheltering services.[20]

Social Assistance Services in Brazil are divided into: (i) Basic Social Protection Services of a preventive nature, aimed at avoiding vulnerability and social risk situations; and (ii) Special Social Protection Services of a remedial nature, aimed at fighting violations of rights that have already taken place and at rebuilding severed ties at the family and community levels.

Special Social Protection is intended for families and individuals in situations of personal and social risk, i.e. whose rights violations have already taken place due to abandonment, physical and psychological abuse, sexual abuse, use of psychoactive substances, fulfillment of socio-educational sentences, homelessness, child labor, among other reasons. The services that make up the Special Social Protection segment can be of medium or high complexity.

Medium-complexity services offer immediate, specialized, individualized, continuous and articulated care for families with one or more of their members in a situation in which their rights are threatened or violated, aiming at overcoming these conditions and strengthening and preserving family, social and community ties, in order to restore violated rights.

The highly complex ones are intended for the sheltering, in different modalities and facilities, of individuals and/or families far from their family and/or community nucleus of origin. The Institutional Sheltering Services that are part of the High Complexity Special Social Protection services under SUAS aim to shelter individuals under extreme vulnerability, with severed or fragile family ties, in units with residential characteristics inserted in the local community, with welcoming environments and adequate physical structures in terms of habitability, health, safety, accessibility and privacy, in order to assure that they are fully protected.

They are offered in four different types of facilities, units or structures: Institutional Shelter[21], Home[22], Halfway House[23], Inclusive Residence[24], depending on the individuals to be served. TCs are therefore not part of the Institutional Sheltering Services of the High Complexity Special Social Protection segment of the SUAS.

It is important to note that the SUAS, at least with regard to the Institutional Sheltering Service, does not have a specific institutional sheltering unit aimed at people who use drugs or are dependent on drugs. From the results of the last SUAS Census, for the year 2019[25], one may notice, for instance,

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19 Available at: https://www.mds.gov.br/webarquivos/public/resolucao_CNAS_N109_%202009.pdf.
20 The definitions, descriptions, intended recipients/users, conditions and forms of access to services, among other details, are presented in the Annex to CNAS Resolution No. 109.
21 Institutional Shelters are intended for the sheltering of children, adolescents, adults and the elderly, including those with disabilities; families; and women in situations of domestic and family violence, whether or not they are accompanied by their children. They resemble a residence and must be located in residential areas and cannot be identified with signs to avoid the stigmatization of those who are sheltered. These establishments should promote the use of facilities and services available in the local community to the individuals who are sheltered.
22 The Homes (Casas-Lares) serve children and adolescents and the elderly - including those with disabilities. These are smaller units where one or more people work as resident caregivers. The environment does not resemble the users' own home.
23 Halfway Houses offer immediate and emergency care for adults and families, for a maximum of 90 days. With the capacity to serve up to 50 people, assistance at Halfway Houses is provided by the Specialized Reference Centers for Social Assistance – CREAS, by the Social Approach Service or by the POP Centers (Specialized Reference Centers for Homeless People).
24 Inclusive Residences are an institutional sheltering service aimed at serving young people (over 18 and under 21) and adults with disabilities with a high degree of dependency, with the purpose of contributing to the progressive construction of autonomy, social and community-level inclusion, as well as the development of adaptive capacities for daily life.
25 Available at: http://aplicacoes.mds.gov.br/snas/vigilancia/index2.php.

that those who are “dependent on alcohol or other drugs” – using the terminology employed in the forms – are cared for in all units that make up the Institutional Sheltering Service.

In this sense, it appears that the TCs and the services provided by them - reduction of drug demand and/or sheltering of adults and adolescents who present problematic use of drugs – are not described in the Organic Social Assistance Law, nor do they find express provision in the rules that regulate the SUAS. The concept of TCs contained in article 32, § 2 of LCP No. 187/2021 is therefore not related to the policy or legal definition of a social assistance organization.

c. THE CREATION OF A SPECIFIC TYPE OF CERTIFICATION FOR ENTITIES WORKING ON DRUG DEMAND REDUCTION

The inclusion of institutions that work on reducing drug demand – including sheltering TCs – by art. 32 of LCP nº 187/2021 as eligible entities for CEBAS represents, in practice, the creation of a new category of organizations immune to social contributions.

A guidance booklet recently published by the Ministry of Citizenship (available on the Ministry’s website since March 14, 2022)[26] on the certification of these entities recognizes this intention, when defining CEBAS as a “Certification granted by the Federal Government to non-profit organizations recognized as charitable social assistance entities that provide services in the areas of education, social assistance, health or Entities Working on the Reduction of Drug Demand”.

The procedure for certifying entities working on the reduction of drug demand is poorly detailed in LCP No. 187/2021, being guided by the general guidelines defined for the certification of social assistance entities; however, this procedure must be subject to subsequent regulation by the “unit responsible for by the drug policy of the federal executive authority responsible for the social assistance area” (art. 32, § 5).[27]

In other words, it is a specific procedure created by the new standard and which is not to be confused with the certification process of health entities or the certification process of social assistance organizations, which, among other requirements, requires registration with the Municipal Social Assistance Councils or at the CNES/MS.

In its introduction, the material also reinforces the trend of increasing public funding for TCs when it states that the certification process is important in order to strengthen the national public policy on drugs, the public-private partnership between the State and private organizations, and for the improvement of services.

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26 Steps for cebas social assistance certification (www.gov.br)
27 The aforementioned booklet even warns that the procedure depends on the regulation of LCP 187/2021 by the Executive Branch, highlighting on the cover of the material that its use is “Pending the publication of a Decree that regulates Complementary Law 187/2021”.

The material informs that SENAPRED will be responsible for fulfilling the procedures and presents the steps of the certification process. If SENAPRED is granted this jurisdiction, it will accumulate several activities and functions with strategic relevance for the registration process, access to public funding, inspection, and obtaining of CEBAS by the TCs.

In this sense, the implementation of its own certification process "CEBAS/ Entities Working on the Reduction of Drug Demand" in the Ministry of Citizenship constitutes a peculiar instance with regard to the certification procedure of charitable entities, whose performance is disconnected from the established legal and social assistance policy.

It is evident that this inclusion of "Entities Working on the Reduction of the Drug Demand" as an additional area of activity for the certification of charitable entities eligible for CEBAS subverts the purpose of the Complementary Law itself, contrary to what is established in § 7 of art. 195 of the Constitution. This is because this legal content directly contradicts art. 2nd. of LCP No. 187/2021, which lists the only three possible areas of action for organizations seeking CEBAS, namely: health, education, and assistance.

Although disguised as "social assistance organizations", the institutions that work to reduce drug demand – which includes the "Sheltering TCs" – there is evidence that they do not work in the area of social assistance[28], and it is not legally possible to frame them as such. Thus, it is undeniable that the inclusion of TCs in the aforementioned rule represents a true privilege granted to these entities, in affront to the constitutional principle of isonomy between legal entities, insofar as it favors a specific type of entity operating in a segment that is not related to education, health or social assistance.[29]

VI. TCs: TREATMENT OR SHELTERING?

From the analysis of the TCs in the light of the legislation that regulates the provision of services in the area of mental health, which regulates the National Drug Policy and that defines the offer of sheltering services in the field of social assistance, it is evident that the expression "TCs" may designate non-profit organizations whose activities are covered by the Health Policy (RAPS, under the purview of the Ministry of Health) as well as organizations whose activities are covered by the National Drug Policy (under the purview of the Ministry of Citizenship and the Ministry of Justice and Public Safety).

28 Social assistance aims to protect the family, motherhood, childhood, adolescence and the elderly; to support children and adolescents in need; to promote and rehabilitate people with disabilities and promote their integration into community life, as well as assuring a monthly benefit amounting to the minimum wage to people with disabilities and elderly individuals who prove that they do not have the means to provide for their own sustenance to or have it provided by their family, as provided by law (art. 203, CF/88). Although Therapeutic Communities are meant to provide some type of support for people in vulnerability, their work does not fit into these concepts.

29 This is the case, for instance, of organizations that work with non-formal education, including sports education, environmental education, human rights education, and education for citizenship, among many others. Therefore, it is up to the legislator to adhere to the constitutional requirement of isonomy, which is also a principle that governs the performance of the Public Administration, according to the wording of article 37 of the Federal Constitution and reiterated understandings of the Federal Supreme Court. (ADI 4.650/DF, MI 58)

The Federal Council of Medicine (CFM), through Resolution No. 2056/2013, defined and standardized medical services and environments, determining minimum criteria for the operation and performance of medical professionals in these places. The aforementioned rule expressly provided for the role of TCs of a medical nature, imposing rules regarding their operation that are the same as those followed by in-patient care establishments (article 28, §2 and §3), assuring, for instance, on-call medical care throughout its working hours, and the presence of medical assistants and a complete staff.

The same Resolution expressly acknowledged the existence of non-medical TCs. As they are not considered medical care services, in these institutions "medical prescriptions should not be provided, and involuntary and compulsory hospitalizations due to psychiatric disorders, including chemical dependency, or pathologies that require on-site and constant medical attention, are strictly prohibited." (art. 29 and §1).

In the same sense, the CFM, when establishing minimum safety criteria for hospitals or psychiatric care establishments of any nature, also defining the anamnesis model and the path for forensic investigations in psychiatry, pursuant to Resolution No. 2,057/2013, reaffirmed the difference between Medical and non-medical CTs by highlighting that:

> Art. 11. An establishment that provides psychiatric care under an inpatient regime (during shifts, daily stays or full-time) must offer the following specific conditions for the practice of Medicine:
>
> § 3 Therapeutic communities of a medical nature must be endowed with the same conditions as other hospitalization establishments, assuring in-house doctors on duty throughout their working hours, the presence of assistant physicians and a complete staff in accordance with Law No. 10.216/ 2001 and the current rules and the Manual of Inspection and Control of Medicine in Brazil.
>
> Art. 12. In the case of conviviality centers, sheltered homes, community sharing establishments and non-medical or similar therapeutic communities, their organization must comply only as provided for in art. 10, without being characterized as a psychiatric service.

ANVISA, through the Resolution of the Collegiate Board of Directors - RDC No. 29, of June 30, 2011, also established health safety requirements for the operation of institutions that provide care services to people with disorders resulting from the use, abuse or dependence of psychoactive substances (SPA) in a residency regime that use the conviviality among peers as their main therapeutic instrument.

At the time this rule was issued, however, there was no mention of TCs. In 2013, ANVISA issued Technical Notice 055/2013[30], in order to clarify the content of RDC No. 29, expressly referring to TCs as "institutions that provide care services to people with disorders resulting from the use, abuse or dependence of psychoactive substances (SPA)".

In the same sense, ANVISA answered questions about the technician in charge (with a college degree, legally qualified, and graduated in a course from any area of knowledge), personnel management (full-time human resources) and the admission process of the sheltered individuals (requiring evaluation by institutions of the health network), based on the regulation of health safety requirements for the operation of these institutions under a residency regime" (Resolution RDC No. 29/2011, of the ANVISA Collegiate Board). It is worth noting that in a recent decision on the subject, the Regional Federal Court (TRF) of the 3rd Region[31] understood that the legal framework of the TCs clearly differentiates the "sheltering" organizations from those meant for "treatment", the first being the TCs' specific activity, as determined in CONAD Resolution 01/2015, and the second as a treatment that "should be ordered in a health care network, with priority for outpatient treatment modalities, exceptionally including forms of in-patient care in health units and general hospitals under the terms of the rules established by the Federal Government and articulated with social assistance services", with in-patient care being prohibited in sheltering TCs."

With the analysis that we have carried out and based on these elements, therefore, we can conclude that the expression "TCs" encompasses two categories of organizations with different natures, namely:

A. **Therapeutic Communities for treatment** – Therefore, medical establishments, part of the RAPS and subject to the technical standards of ANVISA for environments where conviviality between peers predominates as a therapeutic instrument, but where there is the practice of medical acts and treatments, observing regulations and supervision by the CFM. These communities, as they are linked to the RAPS, also shelter adults who are part of the mental health target audience; and

B. **Therapeutic Communities for sheltering** – Bound to the National Policy on Drugs, they act in accordance with instructions from CONAD and use conviviality among peers as a therapeutic instrument and, as a rule, do not perform medical acts and treatment.

So much so that, in 2020, through Technical Note No. 02, ANVISA established new clarifications and guidelines on the functioning of institutions that provide care services to people with disorders resulting from the use, abuse or dependence of psychoactive substances. ANVISA described Sheltering TCs as "those that use coexistence among peers as a therapeutic instrument, without

30 ANVISA. Technical Note No. 055/2013 – GRECS/GGTES/ANVISA - Clarifications about articles of Anvisa RDC No. 29/2011 and its applicability in institutions known as Therapeutic Communities and similar entities. Available at: http://antigo.anvisa.gov.br/documents/33852/5906701/Nota_T%C3%A9cnica_55_2013/75219a81-22f3-4405-8e3c-346928c91815. Last accessed on: 03/23/2022

31 Interlocutory appeal in Public Civil Lawsuit 0014992-18.2016.403.61.00 - Available at: http://web.trf3.jus.br/acordaos/Acordao/BuscarDocumentoGedpro/7286477. Last accessed on: 03/23/2022

performing any therapy that depends on health professionals, are considered services of interest to health, and not health services."[32]

This 2020 Technical Note differentiates the Sheltering TCs from the TCs that offer health care, that is, that promote therapies or perform procedures exclusively meant for health professional

categories, clarifying that the latter must observe, in addition to RDC Anvisa No. 29/2011, the health rules related to health establishments (such as RDC 50/2002, RDC 63/2011, RDC 36/2013 and RDC 222/2018, or the health standards that may replace them.

The ANVISA Note also concludes that "if the establishment is classified as a Therapeutic Community, it is because conviviality between peers is predominant as a therapeutic instrument. As for structural issues, RDC 50/2002 (or whichever replaces it) would only be applied to environments that perform health activities (such as medical offices and infirmaries)."[33]

Finally, in 2021, ANVISA once again addressed the issue in instructive material with questions and answers about TCs, where it highlighted, from the perspective of monitoring and inspection, that health TCs, as well as those of interest to health, are subject to inspection by local (municipal or state) Sanitary Surveillance agencies, based on federal and local sanitary regulations on the subject. It is the role of the sanitary inspection body to evaluate the infrastructure, documentation, human resources and work processes and apply sanctions in case of irregularities according to the seriousness of the sanitary infraction, ranging from warnings and fines to the interdiction of the establishment. It is also possible that the State Attorney's Office and Professional Councils may supervise these entities, within the scope of their attributions.[34]

As a result, TCs that fit the classification of "treatment TCs" can obtain the CEBAS certification following the procedure established for the certification of Health entities, therefore subjecting them to the provisions of Section II of LCP No. 187/2021 "On Health", regulated by art. 7 and subsequent of the Law (described in item III.I of this opinion).

32 ANVISA. Technical Note CSIPS/GGTES/ANVISA No. 02/2020, p. 4. Available at http://antigo.anvisa.gov.br/documents/33852/5906701/NOTA+T%C3%89CNICA+CSIPS+SOBRE+COMUNIIDADES+TERAP%C3%8AUTICAS+ACOLHEDORAS_vers%C3%A3o+final/f9c8ccad- fbf5-4baa-b098-52c0c56e14a6 . Last accessed on: 03/23/2022

33 Idem. ANVISA. Technical Note CSIPS/GGTES/ANVISA No. 02/2020, p.4.

34 ANVISA. Questions and answers – Therapeutic communities. Coordination of Services of Interest to Health - CSIPS General Management of Technology in Health Services - GGTES National Health Surveillance Agency – Anvisa, p. 10. Available at: https://www.gov.br/anvisa/pt-br/centrais-deconteudo/publicacoes/servicosdesaude/publicacoes/perguntas-e-respostas-comunidades-terapeuticas-2021.pdf. Last accessed on: 03/23/2022

The lack of definition of the length of stay of the sheltered individual, the idea of a protected environment and the non-limitation to the adult public are elements that differentiate the TCs described in the RAPS from those described in the new legislation. The concept of TCs brought by article 32, § 2 , of LCP No. 187/2021, when referring to TCs as entities that work to reduce drug demand, differs greatly from the contents established by Ordinance No. 3.088/2011 and Ordinance No. 131/2012, both of the Ministry of Health, which deal with TCs.

The specific procedure introduced in the legal system by the LCP No. 187/2021, which created a Subsection II dedicated to “Entities Working with the Reduction of Drug Demands”, within Section IV aimed at “Social Assistance” organizations, concerns only sheltering TCs.

10. BASE QUESTIONNAIRE SENT TO STATE AND DISTRICT GOVERNMENTS AND STATE CAPITAL CITY HALLS

1. Between the years 2017 and 2020, did the government of XXXXXXXXXXX contract or fund private services of permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts?

2. Between 2017 and 2020, did the government of XXXXXXXXXXX support or fund, directly or indirectly – through the provision of material, transport, human resources, training or any other type of support – private for-profit or non-profit entities that provide permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts?

3. In the case of a positive answer to one of the cases of questions 1 or 2, what are the amounts of expenses committed, settled and paid, and what are the bidding modalities for profit or non-profit private entities that provide permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts offered between the years 2017 and 2020?

4. In the case of a positive answer to one of the cases of questions 1 or 2, which entities and functions, sub-functions and budgetary programs originated the funds used to pay or support for profit or non-profit private entities that provide permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts offered between the years 2017 and 2020?

5. Between the years 2017 and 2020, did the government of XXXXXXXXXXX contract openings at private entities, for profit or non-profit, that provided services of permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts? How many openings were contracted each year and how was the accreditation of the contracted entities carried out?

6. In case of an affirmative answer to Question 5, which is the entity responsible for monitoring and controlling the openings hired with private for profit or non-profit entities that provide permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts?

7. Between the years 2017 and 2020, did the judiciary branch determine that the government of XXXXXXXXXXX should contract any openings at private entities, for profit or non-profit, that provided services of permanent or temporary residential therapeutic care for the recovery of people with problem drug use or psychoactive drug addicts? How many openings were hired per year and for what amount were the vacancies hired?

8. I request the database with records of payments made between 2017 and 2020 for for-profit or non-profit private entities that provide permanent or temporary residential therapeutic care service for the recovery of people with problem drug use or psychoactive drug addicts, in a machine-ready format (csv; xls; txt or similar), containing “name of beneficiary”, “CNPJ of beneficiary” and the amount paid in reais.

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