SSRC | Drugs, Security and Democracy Program

Working Paper Series

THERAPEUTIC COMMUNITIES IN BRAZIL

Editors
Mauricio Fiore
Taniele Rui

JUNE 2021

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The Social Science Research Council (SSRC) is an independent, international, nonprofit organization founded in 1923. The SSRC fosters innovative research, nurtures new generations of social scientists, deepens how inquiry is practiced within and across disciplines, and mobilizes necessary knowledge on important public issues.

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The Drugs, Security and Democracy (DSD) Program supports research on drugs in Latin America and the Caribbean with a goal of producing evidence-based knowledge to inform drug policy in the region and beyond. The program seeks to foster a global interdisciplinary network of researchers engaged with drug policy, committed to policy-relevant outcomes, and able to communicate their findings to relevant audiences.

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Table of Contents

THE PHENOMENON OF THERAPEUTIC COMMUNITIES IN BRAZIL: EXPERIENCES IN ZONES OF INDETERMINATION

MAURICIO FIORE[1] AND TANIELE RUI[2]

While this working paper series on therapeutic communities (TCs) in Brazil was being prepared, the Netflix documentary series *SanPa: Sins of the Savior* was launched about an Italian TC that had been the largest in Europe in the 1980s. When asked why a documentary had been produced on the topic, its director replied that the series is "about the power of drugs, about the power of people, about the power of ideas, about the power of politics."[3] Though distant in time and space, this working paper series could also be presented in these terms.

It is impossible to investigate the phenomenon of TCs in contemporary Brazil without discussing the role assumed by the state in response to drugs—its drug policy, in effect—especially its position concerning the network of care and attention for people with problems related to the consumption of psychoactive substances. Reflecting on the TCs also entails asking about the everyday experience of the thousands of people who turn to them to alleviate their suffering and stay for months, sometimes years, engaged in a project of giving new meaning to their life. And, of course, discussing TCs means debating what is represented by the fact that this type of institution is one of the main political and financial investments of the federal government and various state governments in Brazil, given that their activities are frequently questioned in terms of more radical aspects of discipline and religiosity—with strong evidence of rights violations.

Spread across the country and attaining an unparalleled political force, the TCs are as inescapable in the debate on drugs as they are complex to define. As shown in the articles making up this series, indeterminations concerning their structural characteristics and their role appear to be an integral part of their political potency. The TCs practice isolation but cannot be defined as either clinics or psychiatric hospitals. They shelter those in a vulnerable situation but are not to be confused with therapeutic residences or social assistance facilities like shelters. The practice of religiosity is quotidian, usually unconditional, yet these institutions do not present themselves as churches, nor are they seen as such. In this ambiguous zone, TCs are no longer limited to self-funding—they acquire strength through their

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[2] Professor of the Department of Anthropology at UNICAMP and Master and Doctor in Social Anthropology from the same university. She is the author and coauthor of various works on urban poverty, vulnerability, and marginality, whose empirical specialties include the political interfaces of the association between street, drugs, peripheries, and social assistance, public health, and punishment facilities, like prisons and therapeutic communities, among which we can highlight the books *Novas Faces da Vida nas Ruas* (2016) and *Nas tramas do Crack: etnografias da abjeção* (2014).

[3] Interview with Carlos Gabardini, one of the directors of the documentary series *SanPa: Sins of the Savior*, produced and broadcast by Netflix in 2020. Available at https://www.netflix.com/br-en/title/81010965.

own associations, and have regularly received increasingly substantial funds from different spheres of the public sector.

It is important to mention that TCs are not a Brazilian creation, nor is their expansion exclusively a national phenomenon. On the contrary, emergent as an alternative mental health care facility/model in the 1950s, from early on these entities have specialized in receiving people with problems related to the use of drugs in the United States and Europe. Operating in Brazil since the 1960s, they began to expand more significantly from the 1990s. In 2015, the most comprehensive study of the subject estimated that at least two thousand TCs were operating in the country[4]—a methodologically conservative estimate since the difficulty of defining these entities makes counting them a somewhat challenging task. To provide a scale of comparison, a survey published in 2014, which established 2011 as a cut-off point, identified that there were 1,160 TCs operating across the entire European Union.[5]

If, as stated, defining them is not simple, this does not imply an absence of general principles guiding their objectives and the paths for attaining them. For example, the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) defines the therapeutic community as follows:

> TCs offer a drug-free environment in which people with addictive (and other) problems live together in an organized and structured way in order to promote change and make it possible for them to lead a drug-free life in the outside society.[6]

Or, again, in the definition of the United States' National Institute on Drug Abuse (NIDA):

> TCs encourage participants to examine their personal behavior to help them become more pro-social and to engage in 'right living'—considered to be based on honesty, taking responsibility, hard work, and willingness to learn.[7]

It can be perceived that neither definition presents substantial differences from the following definition, proposed in the context of the IPEA study,[8] other than its broader scope:

> Non-governmental initiatives, these institutions function as temporary collective residences where people with a problematic use of drugs enter, remaining there for a length of time, isolated from their previous social relations, with the purpose of renouncing the use of drugs for good and adopting new lifestyles, based on abstinence from [psychoactive substances]. During their stay at the TCs, these people are subject to a disciplined routine, which encompasses work activities and spiritual and/or religious practices, as well as psychological therapies, mutual help

[4] IPEA— Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasilia: IPEA, 2017).
[5] Wouter Vanderplasschen, Stijn Vandevelde, and Eric Broekaert, *Therapeutic Communities for Treating Addictions in Europe: Evidence, Current Practices and Future Challenges* (Lisbon: European Monitoring Center for Drugs and Drug Addiction, 2014).
[6] Ibid., 9.
[7] NIDA—*National Institute on Drug Abuse*, "What Are Therapeutic Communities?" (July 2015), accessed March 18, 2021, https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-are-therapeutic-communities.
[8] IPEA, *Nota Técnica nº 21*, 8.

group meetings, and so on, depending on the financial and human resources available to each TC.

In Brazil, advocates of outpatient, community-based care and treatment denounce the TCs as contemporary derivations of the mental asylum, based on institutional isolation and on punitive-authoritarian codes of conduct. Advocates of TCs, for their part, point to the voluntary nature of the care offered and its community premise, which potentially leads to a real transformation of the people cared for. The discussion on the definition of TCs is very far from being the only controversy in the debate.

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When we accepted the invitation from the Drugs, Security and Democracy Program of the Social Science Research Council (SSRC) to participate as editors of a collection of works dedicated exclusively to TCs, we saw a great opportunity since, as well as the production of original articles that could contribute to knowledge in the field, the idea was to add a capacity-building component for researchers coming from various academic areas. This process began with the selection of research projects through a call for researchers at different stages of their careers. To broaden the thematic spectrum, the candidates were asked to choose one of eleven themes preselected by the organizers. The specialists invited to the selection panel were asked to make their choice based on both the academic excellence of the projects and the thematic, regional, and demographic diversity of the finalists.

During the selection process, the biggest global health crisis of this century erupted, the Covid-19 pandemic. The work dynamic was affected by all the compulsory limitations that arose, like the impossibility of face-to-face meetings between editors, mentors, reviewers, and researchers, the delay in the approval of the projects by institutional review boards, and, without doubt the most complex of all, the impact on the projects based on fieldwork and interviews with residents, staff, and other people involved with the TC universe. A few projects had to be adapted, in some cases radically, adopting methodological approaches quite different from those originally planned.

Over the course of the research and the write-up of the articles, all stages of the work were continually supervised, including the submission of preliminary materials discussed monthly with the editors as well as bringing all authors together in a workshop in which the articles were discussed among them and together with invited specialists, a process that brought the series closer to a collective work.

The engagement of the authors, combined with the financial and academic support of the SSRC, meant that, at the end of the process, we had eight original articles that explored and informed the debate on TCs in Brazil in a multidisciplinary form. Thematically, these articles can be grouped into two sets. The first consists of works exploring the interface between the state and the TCs, related more to the field of research commonly known as drug policy. Their data comes from legal regulations, budget items, administrative reports, and the perceptions of the technicians involved in the process of regulating and inspecting the TCs. The second set of texts includes qualitative investigations focused directly on the trajectories and opinions of people involved in the everyday life of the TCs, especially those who spent many periods living in these institutions.

Although they can be read individually, the strength of the eight articles making up this series becomes clearer when read as a whole. Offering distinct perspectives, the works are also complementary in their delineation of the phenomenon of TCs in Brazil.

The article by **Noelle Coelho Resende**, which opens this series, maps and analyzes the legal instruments regulating TCs in Brazil, taking as a starting point the Psychiatric Reform Law of 2001. Identifying a legal reality constituted by numerous overlapping norms, the author organizes a regulatory map that spans the fields of health, justice, security, and, more recently, social assistance. Her endeavor illuminates the contradictions that emerge in this legal framework involving distinct areas, as well as points of tension and indefinition—*legal knots*—that underlie the inclusion of TCs in the public network of care. This reading prompts us to observe that the configuration of a "regulatory patchwork," by making explicit structural problems of incompatibility between care models, also paradoxically supports the institutional strengthening of the TCs.

The normative dispute is concomitant with the dispute surrounding the federal budget allocated to TCs and, consequently, the ministries responsible for channeling these funds. Examining this issue, the article by **Renata Weber** provides an estimate of the public funds spent on TCs between 2010 and 2019. To avoid adopting this as an isolated data point, the author undertakes two complementary analyses: one concerning the budget of the National Anti-Drugs Fund, the origin of the funds for financing TCs at the federal level, and the other concerning the National Health Fund, the source for hospital and outpatient expenses for the programs and actions in the area of mental health, alcohol, and other drugs. This combined analysis offers elements for comprehending the characteristics and scale of this funding, as well as their different mechanisms of public oversight. The study reveals the important insight that public funding of TCs should be contemplated alongside the decrease in public investments in mental health and, more widely, in the Brazilian Unified Health System (Sistema Único de Saúde, or SUS).

With the possibility of accessing public funds through specific tenders, the relationhip between these entities with the regulatory frameworks entails two processes: on the one hand, an effort to adapt to existing norms; on the other, organization to exert the political pressure needed to influence the production of these norms. Among various questions that can be inferred from this are, for example, the issuance of health permits, which become an important element in the process of regularizing and institutionalizing TCs. Seldom examined in the works already published on the theme, the role of health surveillance, especially at the municipal level, was studied by **Jardel Fischer Loeck**. In his article, the author observes that, in the space of a decade, there has been a loosening in the resolutions of the Brazilian Health Regulatory Agency (Agência Nacional de Vigilância Sanitária or ANVISA). In the form that they are organized locally, the bureaucratic processes of licensing, regularization, and inspection necessary for the issue of the health permit not only present gaps but also end up allowing the operation of entities with serious structural problems.

If there are limitations to health inspections, it is the moment when the TCs are reported and inspected that some of these structural problems are more clearly revealed. Along these lines, the analysis by **Carolina Gomes Duarte** and **Mathias Variano Glens** describes the experience of inspections by the Public Defender's Office of the state of São Paulo in eighteen TCs between 2013 and 2019. Their account contains a profile of the denounced and inspected TCs, highlighting very compelling evidence of human rights violations arising, among other reasons, from the large-scale presence of admissions made against the user's wishes, compulsory unpaid labor imposed under the pretext of "labortherapy," and long periods of stay with no time limit or therapeutic project. The relative ineffectiveness of the inspections, the lacuna in the work of the Public Prosecutor's Office—the entity with legal responsibility in this instance—and the carelessness of the justice system, which continues to send people with a problematic use of drugs to these establishments on a compulsory basis, show how, in practice, a

regulatory vacuum exists in which rights violations not only go unpunished but are also sanctioned by the judiciary.

A new range of questions appears when we turn to the debates that unfold in the scope of the organizations representing the TCs—their respective federations and confederations. Although they can be grouped together when considered generically, it is necessary to bear in mind that the approximation of the TCs to the state bureaucracy should not be read as a homogenous bundle of interests and political relations. Some of the disagreements that were previously known to a more limited set of actors related to the TCs were, with the Covid-19 pandemic, publicized through virtual events, the live streams broadcast on internet platforms. **Priscila Farfan Barroso** undertook an ethnography of these broadcasts, producing a detailed analysis of thirty-six of them, held by four federations with a national profile between April and August 2020. Based on her analysis, it is possible to glimpse internal tensions that surface as these TCs request recognition and legitimization from the state. Here, it can be noted that while some focus their efforts on technical and bureaucratic professionalization, flirting with a secularization of their practices, other TCs with a more traditional-religious profile resist the reformulation of their core tenets, revealing a process of faith abdication in exchange for public funding. Beyond the dispute surrounding models of work, it is interesting to observe how these divergences are hierarchically materialized according to their level of influence on the state.

Among the other set of works, those that set out to investigate the trajectories and perceptions of people who lived in or are currently staying in TCs, the article by **Janine Targino** is the only one where the researcher managed to enter the TCs during the pandemic. Observing all health protocols, eighteen interviews were conducted in three TCs dedicated exclusively to women, each with distinct structures and affiliated with different Catholic and Evangelical denominations. Her investigation sought to respond to the question of how gendered moralities are attributed to the resident women and how the latter, in turn, understand the meanings of the treatment to which they are linked. Seen as deviant women with an errant life, the female drug users in these localities become subject to a project of transformation for them to become a supposed ideal model of Christian woman (good mother, good wife, good Christian). In her investigation, Targino observes that the strength of the morality on the role of mother and wife is even greater than religious dogmas, possibly due to their association with the potent social marking in gender roles. While it is important to understand how this project is presented during the period in which the women are staying in the institutions, albeit experienced from specific subjective viewpoints, the great test of their “success” can only be achieved in the world outside the TCs.

On the outside, at a Psychosocial Care Center specializing in alcohol and other drugs (Centro de Atenção Psicossocial de Álcool e outras Drogas, or CAPSad) in Salvador, Bahia, **Leandro Dominguez Barretto** and **Emerson Elias Merhy** heard from people who had spent time at TCs and who, at some point, desisted from completing the period initially estimated for their treatment. Using a methodological tool widely adopted in the field of collective health, they followed five users-as-guides who, though outside the TCs, maintained contact with the municipal care network. Proffered in very specific contexts of interaction, the statements by these individuals contain references to mistreatment, disrespect for their autonomy, and the imposition of subjective changes that went against their will. Gathering experiences from the CAPSad’s professionals and investigating the trajectories related to the users-as-guides from the perspective of promoting access or imposing barriers to healthcare, the article offers a severe critique of the work of the TCs. The text also points, though, to a kind of role these entities take on at critical moments of the personal life of users, a role without equivalent replacement in the care network due to the latter’s insufficient coverage or even precarity. The article also contributes to the discussion on the

subjective experiences of those who pass through the TCs by exploring the capacity of users to construct their own therapeutic projects, fighting for them, not without suffering, vis-à-vis the collective models established by the entities.

The article by **Carly Machado,** which closes this series, offers an original perspective in the discussion of the phenomenon insofar as it does not examine the efficacy of the treatment but, rather, the way in which the TCs become zones of urban exile that, located between the secular and the religious, operate as one more mechanism in the management of violence in peripheral territories. Based on interviews with people who passed through TCs, the majority of whom subsequently became linked to the routine of Pentecostal churches, the author identifies life trajectories in which moments of expulsion precede their arrival at the so-called recovery centers. Understanding this dynamic is important to comprehending the TCs as spaces of refuge when exile becomes vital. Exile, in this case, describes a series of forced and violent dislocations from peripheral territories, such as flight or temporary leave from prison, a lucky escape from death, and the threats of militia groups, police officers, and drug gangs. These narratives show how life in the TCs and the churches, despite the many difficulties, creates possibilities for future projects. It can also be observed that the recovery of life is a much longer and arduous project than recovery from dependence on drugs. Understanding the complexity of this observation requires us to acknowledge that, given brutal conditions of existence, calculating what is "best for one's life" is not always easy.

From the range of information and analyses contained in the articles from this series, we can unpack some of the central questions of the debate about TCs in Brazil. The first point is that the intense political conflict on the nature of the work performed by TCs has consequences for the academic production itself relating to the theme. As in the more general context of the debate on drug policy, entrenched positions affect the production and reception of the knowledge produced. As editors, we strove to ensure that the data, sources, and methodologies employed to collect information and testimony were highlighted in the written text. Empirical and theoretical grounding were demanded for all the information used, a process in which we received substantial support from the specialist reviewers. Autonomous and intellectually responsible for their own articles, the authors sought to divorce themselves from any political positioning to attain the main objective of the series, namely, to contribute, in rigorous form, to the field of knowledge on TCs.

The second question develops from the relationship between the TCs and the state and the type of care and treatment offered to people with problems related to drug use. Part of the Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS)—in which, according to their critics, the entry of these institutions was contrary to the basic principles of the Unified Health System—the TCs are increasingly connected to the state bureaucracy. Far from being concentrated on regulatory issues—ultimately, the seal of approval for these entities to operate—in recent years, this relationship has intensified and become more complex with the growth in public funding and the occupation of political space. In different forms, the TCs have become vocal actors in the debate on drug policy and, therefore, dispute not only the care and treatment models for people whose use of drugs is problematic, but the entire role of the state in response to drugs. On the other hand, this protagonism also opened them up to increased public scrutiny and, therefore, their activities have been increasingly questioned in terms of infringements of basic democratic principles, such as respect for human rights, secularity, and the efficient use of public funds, among other issues. As we know, and as the reading of the articles reinforces, the state is not an entity to which one can resort without consequences.

Finally, the third question pervades all the articles from this series, but is directly related to the articles by Carly Machado, Janine Targino, and Leandro Barretto and Emerson Merhy, who listened directly to people who passed through or are still residing in TCs: what is the nature of the work of the TCs in the context of the problematic use of drugs? Without entering into the finer details of this debate, it is perceptible that TCs and their historical model of work merge the concept of dependence with a program of moral reform of individuals and, in this way, successfully mobilize two powerful aspects related to drug use: protection and change. By removing the user from wider social coexistence, the TCs offer an interruption, a time, a shelter. Thus they both emulate medical care and provide a form of protection within broader contexts of vulnerability, such as violence and everyday poverty, making them a social refuge facility (or, in the concept proposed by Carly Machado, they enable an *exile*). However, this protection is always offered along with a program of radical change in behavior that goes beyond abstaining from drugs. It is not by chance that a significant proportion of TC staff are people who had problems with drugs and attribute their recovery to the period spent in TCs, embodying the experience of the project, which they consider proof of its success.

Here we can return to the argument at the start of this introduction. The zone of indefinition, ambiguity even, in which TCs operate allows them to transit both through different and sometimes contradictory regulatory frameworks, where they figure simultaneously as health, social assistance, and justice/security facilities, and also through care and treatment models for people with a problematic use of drugs, either pursuing a program of moral and spiritual reform, or drawing from the medical-therapeutic lexicon (from which, indeed, one part of their name derives). Between the controversies and debates on how to define their work, the TCs offer a concrete, though highly controversial, response to a central problem of the contemporary world: what should be done with people who suffer from drug dependence?

The TCs base their work on a radical project of individual transformation the ultimate goal of which is a person whose reformed moral values will protect them from drug use. What type of regulatory framework can simultaneously guarantee adequate operation and basic rights in an institution founded on these premises? How can these frameworks be deployed in the context of the different levels of inspection of the Brazilian bureaucracy? In what context has the growth in their public funding taken place? How is their work with the state debated internally by their different organizations? How are their strict moral conceptions perceived by those who resort to them for help? What contradictions emerge in their insertion in the mental healthcare network constructed on the principle of outpatient, community-based care? From distinct perspectives, the articles in this series seek to contribute to an informed debate on these and many other issues pertaining to the activities of therapeutic communities in Brazil.

REGULATORY FRAMEWORK OF THERAPEUTIC COMMUNITIES IN BRAZIL: DISPUTED MEANINGS AND LEGAL KNOTS

NOELLE COELHO RESENDE[1]

The aim of this article is to map and analyze the legal instruments that regulate therapeutic communities (TCs) in Brazil,[2] clarifying the regulatory framework relating to these institutions as facilities associated with providing care for people considered to have a problematic use of alcohol and other drugs.[3]

As will be observed, in recent decades the TCs have strengthened their close ties with the regulatory fields of healthcare, justice, and security, and more recently, with the field of social assistance. In this process, numerous legal instruments have been approved to regulate diverse aspects of their operational activities. These instruments contain contradictions and gaps that reflect the debates surrounding the inclusion of TCs in Brazil's psychosocial care network. Comprehending the legal framework of the TCs is fundamental for a coherent reflection on this model of care and its relationship to public policies for mental healthcare.

The norms applicable to TCs are divided between those published by the Ministry of Health (Ministério da Saúde, or MS) concerning mental health and health surveillance; by the Ministry of Justice (Ministério da Justiça, or MJ – later the Ministry of Justice and Public Security), specifically those issued by the National Drug Policy Council (Conselho Nacional de Políticas sobre Drogas, or CONAD); by the Ministry of Citizenship through the National Secretariat for Drug Prevention and Care (Secretaria Nacional de Cuidados e Prevenção às Drogas, or SENAPRED); and by the National Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, or ANVISA); as well as laws in the strict sense, passed by Brazil's National Congress.

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[2] Among the documents analyzed are those with a broad thematic range, applicable not just to TCs, and others pertaining exclusively to them.

[3] The discussion about the definition of what qualifies as problematic use is complex and has frequently tended to be informed by moralistic arguments. On this question, we can highlight the following: "The term 'problematic use' comprises the consumption of psychoactive substances associated with a social or health risk to the user or to third parties. Such a definition exceeds, but includes, more biomedical definitions, such as dependence, and also encompasses use patterns that, though perhaps episodic, generate social and health problems (for example, driving a vehicle under the influence of substances, intravenous use of drugs, and so on)… By a social 'question' or 'problem' we mean '*the angle from which societies can be described, read, and problematized in terms of their history, their dilemmas, and their future prospects*' (p. 85), involving diverse actors, institutions, and regulations that seek to find a solution to this issue. Drug use constitutes a topic of public debate and a social question that mobilizes multiple interests and diverse policies, although it has only recently been recognized as a social problem." Débora Gomes-Medeiros, Pedro Henrique de Faria, Gastão Wagner de Sousa Campos, and Luís Fernando Tófoli, "Política de drogas e Saúde Coletiva: diálogos necessários," *Cadernos de Saúde Pública*, 35, n. 7, July 2019, 2.

Among the possible reasons for the complexity of this regulatory framework are divergent conceptions of the drugs "problem," disputes over care and treatment models, and the strategy employed by TCs of finding ways to circumvent the general health regulations, especially in terms of the limits established for public funding. Another important aspect of this jigsaw puzzle is that TCs were operating in Brazil for at least three decades prior to efforts to regulate this care model, further exacerbating the scattered nature of the regulations.

The survey carried out for the present study also indicated a way forward for the work: mapping points of tension and indefinition—*legal knots*—as material for a future detailed examination of different themes. Questions like the public funding of TCs, the concept of *acolhimento*,[4] the treatment model, inspections, and respect for human rights are identified as fundamental given that they refer to the core tenets that structure care. Better knowledge of the current regulatory framework pertaining to TCs is understood to be the basis for deepening these reflections—and this is the direction in which the present article aims to contribute, sketching a general panorama of the regulations and identifying legal elements that are important to debate more widely.

After approval of the Psychiatric Reform Law (Lei da Reforma Psiquiátrica, or LRP)—Law 10,216/2001, the starting point on this research timeline—seventeen documents were found to exist in the health area and thirteen in the justice, security, or social assistance areas, six of these published in 2019 alone, all directly or indirectly related to the activities of the TCs. The increase in the number of norms published by the Ministry of Justice and by the Ministry of Citizenship in recent years demonstrates the greater influence of the TCs in these political fields, as can be observed in Table 1 below. The end point for the collection of the data on which this article is based is the year 2020.

In addition to the analysis of norms, conversations were also held with people whose work is dedicated to studying and debating drugs and mental health, such as universities researchers and public policy managers.[5] These conversations focused on the historical, political, and legal context of the TCs, as well as key themes related to the regulatory framework. The talks were free-flowing, and each encounter resulted in the recommendation of other actors who could contribute to the work, which enabled the formation of a network of exchanges linked to the reflection on the disputes surrounding the regulations under analysis.

The research clearly revealed that the TCs do not constitute an institute with their own specific legal treatment. One could say that the persistence of legal ambivalences paradoxically allows their institutional strengthening in a play of forces that encompasses the political, legal, and social fields.

The notion of construction becomes appropriate since the regulation is manifested not as a coherent universe but as a set of rules under development and in dispute. A panoramic view highlights some of the norms composing this regulatory framework: the LRP, which redirects mental healthcare with the end of the asylum model; Ordinance 3,088/2011 of the MS, which establishes the Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS) in which the TCs are included; Ordinance 131/2012 of

[4] *Acolhimento* (Translator's Note: reception, welcome, care, sheltered care) is an emic term found in regulations referring to the functioning of TCs.

[5] Fifteen conversations were held which neither followed a structured interview model nor were used as specific sources of data. Instead, the objective was to guide the collection of information, identifying important aspects that influenced the legal process of constructing the norms applicable to TCs.

the MS, which institutes the criteria for public funding for health; ANVISA Board of Directors' Resolution (Resolução da Diretoria Colegiada, or RDC) 29/2011, which sets out criteria for the health licensing of care institutions; CONAD Resolution 1/2015, considered the specific regulatory landmark of the TCs; and the Drugs Law (Law 11,343/2006), the amendment of which in 2019 included a section on TCs.

The next section in this article presents the main points of these and other mapped instruments, delineating a panorama of the legal framework and identifying questions central to the development of the analysis. Next are presented the *legal knots*, relating them to the national and international protective instruments in the field of mental health, specifically the International Convention on the Rights of Persons with Disabilities (2007)[6] and the Brazilian Law for the Inclusion of Persons with Disabilities (Lei Brasileira de Inclusão da Pessoa com Deficiência, or LBI—Law 13,146/2015). The conclusion goes over the analyzed points and some paths are indicated for future development of the debate on the issues explored here.

2001 A 2020: GUIDING DOCUMENTS FOR A NORMATIVE CONSTRUCTION OF TCS IN BRAZIL

The idea of *construction* stems from the perception that this is an open field, and no ***single*** regulatory framework can be deemed to exist. Most of the actors[7] involved with TCs identify CONAD Resolution 1/2015 as the existing framework—however, while some political significance can be recognized in this identification, it does not correspond to the legal reality, revealed more as a diversity of forms than as a clearly delineated set of regulatory directives.

Over the course of this article, the regulatory instruments will be presented chronologically to facilitate understanding and analysis. The type of norm and its position in the legal hierarchy are important variables. In broad terms, this hierarchy takes the following order:

- At the **first level** are the Federal Constitution and the International Human Rights Treaties incorporated into domestic law through Constitutional Amendments.
- At the **second level** are the complementary, ordinary, or delegate laws, provisional measures, legislative decrees, regulatory decrees issued by the Executive Power, and legislative resolutions, among other items, with a legal value inferior to the first level but superior to the non-statutory regulations (*normas infralegais*). It must be stressed that, despite comprising the same general level, there exist differences in scope and legal value among these regulations. Provisional measures, for example, utilized in the form of urgent actions by the Executive and legally binding, must be confirmed later by the Legislature or

[6] In 2008, this was the first International Human Rights Treaty incorporated into national legislation as a Constitutional Amendment, as provided for in Art. 5, §3, of the Federal Constitution (Constitutional Amendment 45/2004).

[7] Examples of references to CONAD Resolution 1/2015 as the regulatory framework can be seen in news items reported by the National Confederation of Therapeutic Communities, the Ministry of Justice and Public Security, as well as in a document issued by the Brazilian Federation of Therapeutic Communities. Accessed February 14, 2021: http://www.confenact.org.br/?p=225;http://www.cruzazul.org.br/artigo/126/resgate-historico-da-construcao-do-marco-regulatorio-das-comunidades-terapeuticas-do-brasil
https://www.justica.gov.br/news/comunidades-terapeuticas-sao-regulamentadas
https://febract.org.br/portal/wp-content/uploads/2020/04/MENU-LEGISLA%C3%87%C3%83O-DAS-CTs-NO-BRASIL.pdf.

else lose their legal force. Decrees cannot create rights and have the purpose of regulating a given legal content. The resolutions can regulate internal questions specific to the entities from which they originate or regulate the contents of laws and decrees in more detail.

- At the **third level** are the regulations considered non-statutory, such as ordinances, normative instructions, and resolutions, among others.

The table below shows the norms analyzed[8] with labels to make the reading clearer: the blue rows correspond to the health area, while the gray rows to the justice, security, and social assistance areas.[9]

Table 1. Legal norms regulating TCs

Publication	Policy Area/Body	Norm	Summary	Status
April 2001	Health/Presidency of the Republic	Law 10,216 (LRP)	Provides for the protection and rights of people with mental disorders and redirects the mental healthcare model.	In force
May 2001	Health/MS-ANVISA	RDC 101	Establishes the requirements for the operation of services for people with disorders arising from the use or abuse of psychoactive substances, known as Therapeutic Communities.	Revoked
February 2002	Health/MS-ANVISA	RDC 50	Provides the Technical Regulations for the physical projects of healthcare establishments.	In force
April 2002	Health/MS	Ordinance 816	Establishes the National Program for Integrated Community Care for Users of Alcohol and other Drugs.	In force
September 2004	Health/MS-ANVISA	RDC 216	Provides the Technical Regulation on Good Practices for Food Services.	In force
August 2006	AD/Presidency of the Republic	Law 11,343	Establishes SISNAD; prescribes measures for preventing the misuse of drugs, and for the care and social reinsertion of drug users; establishes rules for suppressing	In force, amended by Law 13,840/2019

[8] This research focused solely on federal norms, and state and municipal instruments were not included in the analysis.

[9] The proposal in this study is that legal regulation through these three areas (justice, security, and social assistance) composes a political field of disputes and strategic investment in evading the regulatory rigor of the health area. For a clearer organization and comprehension of the norms, this field is designated AD—alcohol and drugs—in Table 1.

Publication	Policy Area/Body	Norm	Summary	Status
			illicit drug trafficking; defines crimes and makes other provisions.	
September 2006	AD/Presidency of the Republic	Decree 5,912	Regulates Law 1,343 of 2006.	In force
May 2010	AD/Presidency of the Republic	Decree 7,179	Creates the integrated plan to combat the use of crack and other drugs.	Revoked
June 2011	Health/MS- ANVISA	RDC 29	Provides for the health safety requirements for the operation of institutions admitting people with disorders arising from the use, abuse, or dependence on psychoactive substances.	In force
December 2011	Health/MS	Ordinance 3,088	Establishes RAPS in the scope of the SUS.	In force
January 2012	Health/MS	Ordinance 131	Introduces the financial incentive to fund Residential Care Services, including TCs.	In force
August 2015	AD /MJ—CONAD	Resolution 1	Regulates entities that provide sheltered care for people, on a voluntary basis, characterized as Therapeutic Communities.	In force
October 2015	Health/MS	Ordinance 1,646	Creates the National Registry of Health Establishments (CNES).	In force
April 2016	Health/MS	Ordinance 834	Redefines the procedures for the certification of charitable social assistance entities working in the healthcare area (CEBAS).	In force
October 2016	Health/MS	Ordinance 1,482	Includes Type 83 in the CNES Table: Centre for Preventing Disease and Promoting Health.	In force
September 2017	Health/MS	Consolidation Ordinance 3	Consolidation of norms relating to SUS networks.	In force, amended by Ordinance 3,588/2017
September 2017	Health/MS	Consolidation Ordinance 6	Consolidation of the norms on the financing and transfer of federal resources for SUS health actions and services.	In force, amended by Ordinance 3,588/2017

Publication	Policy Area/Body	Norm	Summary	Status
December 2017	Health/MS	Ordinance 3,588	Amends Consolidation Ordinances 3 and 6.	In force
December 2017	AD/Ministry of Justice and Public Security, Ministries of Health, Social Development and Labor	Joint Ministerial Ordinance 2	Establishes the Interministerial Steering Committee for the articulation and integration of programs and actions relating to the use, abuse, or dependence on psychoactive substances.	In force
March 2018	AD /MJ—CONAD	Resolution 1	Approves guidelines for the realignment and strengthening of PNAD.	In force
October 2018	Health/MS	Ordinance 3,449	Creates a committee with the purpose of consolidating norms, guidelines, and strategies relating to TCs.	In force
February 2019	Health/MS	Technical Note 11	Clarifies the changes to the National Mental Health Policy and to the National Drug Policy Guidelines.	In force
March 2019	AD/Ministry of Citizenship	Ordinance 562	Creates the TC Inspection and Monitoring Plan.	In force
March 2019	AD/Ministry of Citizenship	Ordinance 563	Creates the register of accreditation of TCs in the Ministry of Citizenship.	In force
March 2019	AD/Ministry of Citizenship	Ordinance 564	Establishes the Certification of Quality for TC Training Courses.	In force
April 2019	AD/Presidency of the Republic	Decree 9,761	Approves the new PNAD.	In force
June 2019	AD/Presidency of the Republic	Law 13,840	Amends Law 11,343/2006 and other norms to provide for SISNAD and for the conditions for care and financing of drug policies.	In force
November 2019	AD/Ministry of Citizenship	Ordinance 1	Provides for the operationalization of the Electronic Therapeutic Communities Management System.	In force
March 2020	AD/Ministry of Citizenship	Ordinance 340	Establishes measures for combating Covid-19 within the scope of the TCs.	In force

Publication	Policy Area/Body	Norm	Summary	Status
May 2020	Health/MS-ANVISA	Technical Note 2	Provides clarifications for TCs on application of ANVISA RDC 29/2011.	In force

Comprehending the political and legal strengthening of the TCS requires an extensive historical study. In this work, however, a time frame was delimited to allow for a detailed exposition of the mapped normative references. As mentioned earlier, the LRP was adopted as the starting point as it represents a turning point in the debate on the construction of public policies in the mental health field. The LRP guidelines are taken as essential guides to the analysis since they determine the end of the asylum model and the priority given to community-based care.

Based on the analysis developed here, it can be inferred that legally the TCs are characterized as healthcare facilities and that, in this sense, they should be subject to the corresponding regulatory directives. However, although this interpretation results from the normative study developed here and is limited to examination of the current legal framework of the TCs, it is important to emphasize that the dimensions of this discussion extend beyond the technical-normative aspect and reverberate in other areas of public policies, especially in relation to the debate on the inclusion of TCs in the care network for users of alcohol and drugs.[10] As TCs become increasingly present, it is essential to deepen and expand the study and debate on them, but without losing sight of the fact that mental healthcare in Brazil must always be based on the LRP.

The LRP establishes as rights the insertion in the family and the community, protection from abuses and forms of oppression, and treatment using the least invasive means possible, preferentially via community mental health services.[11] It also determines that care is under the responsibility of the health field, which must be guaranteed by the state, while enabling the participation of society and the family.[12] Inpatient care must only be utilized as a last resort, with provision of such care in asylum-like institutions prohibited.[13] Three types of admission are distinguished—voluntary, involuntary, and compulsory—with voluntary admission preceded by the individual's consent, involuntary admission requested by a third party, and compulsory admission ordered by a court.[14] The LRP requires all involuntary admissions to be reported to the Public Prosecutor's Office within 72 hours, thus attributing the latter institution an important supervisory role.[15]

In May 2001, less than two months after approval of the LRP, ANVISA RDC 101 was published, which regulates health licenses for public and private care services (specifically the TCs) for users of alcohol and other drugs. Among the minimum requirements were inspection by a health authority (with unrestricted access to all facilities and documentation, respecting any necessary confidentiality) and a

[10] Other articles in this series deal with important questions relating to this debate, especially those by Renata Weber and Leandro Dominguez Barretto.
[11] LRP, Art. 2, Sole Paragraph.
[12] Ibid., Art. 3.
[13] Ibid., Art. 4.
[14] Ibid., Art. 6, Sole Paragraph.
[15] Ibid., Art. 8, § 1.

minimum frequency of annual inspections.[16] This norm, revoked in 2011 by ANVISA RDC 29, established criteria related to consent to treatment; biological, psychological, social, family, and legal commitments; procedures; human resources; infrastructure; and monitoring.

ANVISA RDC 29/2011, for its part, does not establish any obligatory minimum frequency for inspection. Meanwhile ANVISA RDC 50, a 144-page document published in 2002, defines the regulation for the physical projects of healthcare establishments. Since the health regulations attribute TCs with the legal status of health facilities, following the legal interpretation maintained in this article, ANVISA RDC 50/2002 can be considered part of their regulatory framework.

In April 2002, the MS published Ordinance 816 through which, based on the psychiatric reform and harm reduction guidelines, it instituted the National Program for Integrated Community Care in the area of Alcohol and other Drugs. Launched in 2003, the Care Policy for Users of Alcohol and other Drugs was also founded on the integration of care with the territory, following the principle of harm reduction and the LRP guidelines.

Published in 2006, Law 11,343, which created the National System of Public Policies on Drugs (Sistema Nacional de Políticas Públicas sobre Drogas, or SISNAD), is a landmark in the political-legal process of asserting an AD field distinct from the field of health. In terms of the directives guiding prevention activities, Law 11,343/2006 advocates individual autonomy, risk and harm reduction, and individualization of treatment,[17] in line with the LRP.

Law 13,840/2019, which amended the aforementioned Law 11,343/2006, included a specific section referring to admission to TCs, stipulating that therapeutic projects should be guided by voluntary admission, day-to-day interaction between peers, the prohibition of physical isolation, and abstinence.[18] Here the stipulation of abstinence *as the sole treatment guideline* in TCs is taken to be contrary to the more plural and diversified approach of harm reductions as a general guideline,[19] stipulated in the same legal text. The new text also determined that treatment for harmful use of alcohol and drugs should be carried out in the healthcare network, preferentially through outpatient care. Exceptional cases of hospitalization should be carried out in health facilities, with admission to TCs prohibited in any modality.[20]

In September 2006, Decree 5,912 was published, implementing Law 11,343/2006, and regulating the development of drugs policies and SISNAD's operation. In terms of jurisdiction, the Ministry of Health was allocated responsibility for regulating care policies and services.[21] The Ministry of Justice[22] was made responsible for articulating activities for suppressing the production and illicit trafficking of drugs

[16] ANVISA RDC 101/2001, Arts. 1, 2 and 6.
[17] Law 11,343/2006, Arts. 19, 20, and 22.
[18] Law 11,343/2006, Art. 26-A.
[19] For a brief history of harm reduction policies in Brazil, as well as the different meanings attributed to this care guideline, see Iara Flor Richwin Ferreira, "O Paradigma da Redução de Danos na Clínica com Usuários de Drogas: inflexões, deslocamentos e possibilidades de escuta e posicionamento clínico," *Boletim de Análise Político-Institucional,* no. 18 (Brasília: IPEA, 2018), 71-79, accessed February 25, 2021, https://www.ipea.gov.br/portal/images/stories/PDFs/boletim_analise_politico/181206_bapi_18_cap_8.pdf.
[20] Law 11,343/2006, Art. 23-A.
[21] Decree 5,912/2006, Art. 14, I.
[22] Ibid., Art. 14, III.

and preventing use, as well as proposing the updating of national policy within its sphere of jurisdiction. It can be noted that this decree, currently in force, established the health area as responsible for regulating treatment policies and services. This fact is highly relevant given that, from the 2010s onward, there was a steadily growing influence of TCs in relation to their regulation through the AD field.[23]

The beginning of the 2010s was marked by the construction of the moral and security discourse on the crack epidemic,[24] which became one of the pillars of public investment in private facilities—notably the TCs—as a supposedly effective response to the problematic use of drugs. In May 2010, Decree 7,179 was published,[25] which instituted the Integrated Plan for Confronting Crack and other Drugs. In the same vein, the "Crack, You Can Beat It" program was created.[26] The decree established the need for

[23] This fact is verified in the expansion of the regulatory norms approved by this field in the last decade, the topic of the present article. An analysis supporting this perception can be found in the collection *Comunidades terapêuticas: temas para reflexão*, published by the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, or IPEA): "In addition, a significant penetration of TCs is observable in different public policy management councils at municipal, state, and federal levels (IPEA, 2017), in parallel with obtaining certificates and accreditations that authorize them to access benefits and engage in partnerships with governments for their implementation. Finally, we can also highlight the relationships established with members of the Legislature at the three levels of the federation, involving the creation, in the National Congress, of a parliamentary group supporting the work of TCs in 2011, subsequently renewed in 2015. This group has engaged in active defense of TCs in congressional debates and presented law bills aimed at expanding the forms of public financing of these institutions." Roberto Rocha Coelho Pires, "Um campo organizacional de comunidades terapêuticas no Brasil? Dos processos de convergência e suas implicações às clivagens emergentes," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 134.

[24] The process of constructing this discourse can be observed in its constant propagation in the press. Some examples can be found in the following news reports: Aluizio Freire, "Epidemia de crack está fora de controle, adverte especialista," *G1*, June 8, 2010, accessed February 15, 2021, http://g1.globo.com/rio-de-janeiro/noticia/2010/06/
epidemia-de-crack-esta-fora-de-controle-adverte-especialista.html; "Campanha da Sobrati contra as Drogas," *Medicina Intensiva*, accessed February 15, 2021, http://www.medicinaintensiva.com.br/crack-epidemia.htm; José Renato Salatiel, "Epidemia de crack—A polêmica da internação à força de usuários," *UOL*, accessed February 15, 2021, https://vestibular.uol.com.br/resumo-das-disciplinas/atualidades/epidemia-de-crack-a-polemica-da-internacao
-a-forca-de-usuarios.htm; Biaggio Talento and Tássia Correia, "Crack vira Epidemia na Bahia e autoridades reagem," *A Tarde*, January 30, 2010, accessed February 15, 2021, https://atarde.uol.com.br/bahia/salvador/noticias/1254324-crack-vira-epidemia-na-bahia-e-autoridades-reagem; "Jornal Washington Post diz que Brasil vive epidemia do Crack," *UOL*, December 27, 2012, accessed February 15, 2021, https://noticias.uol.com.br/internacional/ultimas-noticias/2012/12/27/washington-post-diz-que-brasil-vive-epidemia-de-crack.htm.

[25] Revoked Decree 10,473/2020.

[26] In a news report on its launch, the Ministry of Justice defined the program as follows: "Launched in December 2011, the program '*Crack, You Can Beat It*' is a set of Federal Government actions for combating crack and other drugs. With an investment of R$ 4 billion and coordination with states, Federal District, and municipalities, as well as the participation of civil society, the initiative has the objective of increasing the provision of healthcare treatment to drug users, combating trafficking and crime organizations, and expanding prevention activities until 2014. The program includes actions of the Ministries of Justice, Health, and Social Development and Combating Hunger, as well as the Presidency's Civil Office (*Casa Civil*) and the Department of Human Rights," Ministério da Justiça e Segurança Pública, "Conheça o Programa Crack, é possível vencer," *Agência MJ de Notícias,* accessed February 15, 2021, https://www.justica.gov.br/news/conheca-o-programa-crack-e-possivel-

actions to prevent and treat the supposed epidemic of crack use,[27] and served as the foundation for public funding of the TCs by the National Secretariat for Drug Policy (Secretaria Nacional de Políticas sobre Drogas, or SENAD), part of the then Ministry of Justice.

Among the Plan's objectives[28] were the structuring and expansion of actions for prevention, treatment, and social reinsertion, and for the strengthening of healthcare and social assistance networks. Responsibility for execution of these actions was assigned to the Ministry of Health,[29] stipulating that these actions could be developed through agreements with the private sector.[30] The plan was a landmark in the regulation of the TCs within the AD field, for their inclusion in the RAPS and for access to public funding through SENAD.

In December 2011, MS Ordinance 3,088 created the RAPS within the scope of the Unified Health System (Sistema Único de Saúde, or SUS), based on the precepts of the LRP.[31] The RAPS units are considered health facilities and must ensure respect for human rights, autonomy, freedom, comprehensive care, multidisciplinary assistance, harm reduction, and territory- and community-based care, with participation and social oversight by users and families.[32] The ordinance defines as one of the components of the network the modality of transitory care, constituted by two different care points: the *acolhimento* units and the residential care services.[33] TCs are included in the latter category as services for adults with stable needs related to the use of alcohol and other drugs, and for a maximum stay of nine months.[34]

One month later, in January 2012, the MS published Ordinance 131, which set forth the criteria for public funding of residential care services, including TCs, confirming their legal status as a healthcare service.[35] This regulation lists amounts and requirements for funding requests, and determines the prerequisite that those interested must be in a region with at least one CAPS, one *acolhimento* unit, a hospital referral service, and emergency care. It also stipulates that funding requests should be accompanied by an official letter from the local health manager, a valid health license, proof of existence and operation for at least three years, a technical project, and a Certificate of Charitable Social

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vencer#:~:text=Lan%C3%A7ado%20em%20dezembro%20de%202011,o%20crack%20e%20outras%20drogas.&text=O%20programa%20conta%20com%20a%C3%A7%C3%B5es,da%20Secretaria%20de%20Direitos%20Humanos.

[27] In a report entitled "Crack, desinformação e sensacionalismo" published by the Escola Politécnica de Saúde Joaquim Venâncio (Fiocruz), the psychiatrist Sergio Alarcon emphasizes that the problem with the studies on drug use is that they are dated and biased, based on questionable methodologies and thus that their characterization of the crack issue as an epidemic was rash. In the same report, Marco Aurélio Soares Jorge, professor and researcher at Fiocruz, claims that the use of the notion of epidemic, in addition to being statistically imprecise, implies the idea that the use of crack is contagious, producing a prejudice in relation to users and a perception of them as dangerous. André Antunes, "Crack, desinformação e sensacionalismo," *Fiocruz*, March 14, 2003, accessed February 15, 2021, http://www.epsjv.fiocruz.br/noticias/reportagem/crack-desinformacao-e-sensacionalismo.

[28] Decree 7,179/2010, Art. 2.

[29] Ibid., Art. 7.

[30] Ibid., Art. 7-A.

[31] Ordinance 3,088/2011 of the MS, Art. 1.

[32] Ibid., Art. 2.

[33] Ibid., Art. 5.

[34] Ibid., Art. 9.

[35] Ordinance 131/2012 of the MS, Art. 1.

Assistance Entity (Certificação de Entidade Beneficente de Assistência Social, or CEBAS).[36] Responsibility for inspection is assigned to the state, municipal, or district health departments with monitoring by the SUS' National Audit Department.[37]

Analysis of this ordinance reveals the strict conditions established for the concession of funding for healthcare. Because of these requirements, there do not presently exist any TCs subsidized with federal health resources.[38]

It is in this context that the intervention of actors related to TCs in the AD policy area has deepened. As mentioned above, the dissemination of the idea that there was a crack epidemic was one of the landmarks in this play of forces and cleared the way for the first subsidies for TCs, distributed by the Ministry of Justice via SENAD. The following years reveal the legal consequences of this movement with the approval of norms by the justice, security, and social assistance areas and the attempt to de-characterize the TCs as health facilities.

The publication in August 2015 of CONAD Resolution 1 is a landmark (if not legal, certainly political) in this movement. This norm stipulates that TCs are facilities providing a service of *voluntary sheltered care (acolhimento voluntário)*, of interest to and supported by public care policies, and are not health establishments.[39] The permitted maximum stay is different from the period determined by the health sector, extending it from nine to twelve months.[40] This is an important example of the contradictions that emerge in the process of developing legal regulations in distinctive areas. In terms of the monitoring of the application of public funds, despite the stipulation for TCs to submit information annually, CONAD's responsibility to ensure the transparency of this information, as well as the possibility of administrative and legal sanctions in cases of non-compliance, there is no provision for specific inspection activities.[41]

After the publication of Resolution 1/2015, there was an important legal debate on its validity under the argument that CONAD had failed to observe the Ministry of Health's jurisdiction to regulate the area. Although this norm has been determined valid by court decision,[42] it should be underlined that the

[36] Ibid., Arts. 4 and 5.
[37] Ibid., Art. 23.
[38] For a detailed discussion on the funding mechanisms for TCs, see the article by Renata Weber in this series.
[39] CONAD Resolution 1/2015, Art. 2, § 1.
[40] Ibid., Art. 6, § 1.
[41] Ibid., Arts. 25, 26 and 27.
[42] On the legal dispute surrounding the validity of this resolution, Maria Paula dos Santos reports that: "The legal effects of the 2015 CONAD Resolution, however, were suspended by a preliminary injunction granted by the 2nd Federal Court of São Paulo on August 4, 2016, at the request of the Federal Public Prosecutor's Office—more precisely, the São Paulo Regional Attorney for Citizen Protection (PRDC). The plaintiff argued that TCs cannot be regulated by CONAD, which is a body of the Ministry of Justice, since they are health facilities and should therefore be regulated solely by the MS. The legal questioning of Resolution 1/2015 (Brazil, 2015) was supported by various civil society organizations and by the professional councils of psychology and social services professionals…. One of the major concerns of these stakeholders in relation to TC care derives from reports of rights violations in these institutions, identified in inspections carried out by the Federal Psychology Council, the Public Prosecutor's Office, and the National Mechanism for the Prevention of Torture of the Ministry of Justice (CFP, 2011). This preliminary injunction was overturned more than a year later by the Federal Court of the 3rd Region (São Paulo), and final judgment on the action was reached on June 19, 2018, maintaining the validity of CONAD Resolution 1/2015."

decree that regulated the Drugs Law assigned jurisdiction for regulating treatment and care services for users of alcohol and drugs to the health area—a point discussed in more detail in the next section.

In October 2015, the MS published Ordinance 1,646, which created the National Registry of Health Establishments (Cadastro Nacional de Estabelecimentos de Saúde, or CNES),[43] making registration obligatory for such establishments to operate. Subsequently, MS Ordinance 1,482/2016 established the inclusion of TCs in the CNES table,[44] as "type 83—Center for Preventing Diseases and Promoting Health." In April 2016, MS Ordinance 834 redefined the procedures for certifying charitable social assistance entities in the health area (CEBAS),[45] establishing the requirements for residential and transitory care services, including TCs.[46]

At the end of 2017, the MS published Ordinance 3,588, which amended Consolidation Ordinances 3/2017 and 6/2017, concerning the RAPS, a change that did not impact the TC's regulatory framework. On one hand, the wording of Consolidation Ordinance 6 was maintained with regard to funding for TCs, which had absorbed the provisions of MS Ordinance 131/2012, analyzed earlier in this text. On the other hand, Consolidation Ordinance 3 does not regulate specific questions related to the TCs.

Joint Ministerial Ordinance 2,[47] also published in December 2017, instituted the Steering Committee as a space for the coordination of programs focused on prevention, training, research, care, and social reinsertion, relating to the harmful use of alcohol and other drugs. This norm determines the prioritization of services of transitory sheltered care (*acolhimento residencial transitório*), referring specifically to the TCs.[48] In March 2018, CONAD Resolution 1/2018 was published,[49] with guidelines for the realignment and strengthening of the National Drug Policy (Política Nacional sobre Drogas, or

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Maria Paula Gomes dos Santos, "Comunidades terapêuticas e a disputa sobre modelos de atenção a usuários de drogas no Brasil." in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 29.

[43] Official information system for registration of health establishments, Art. 2.

[44] MS Ordinance 1,482/2016, Art. 1.

[45] Private non-profit legal entities.

[46] In 2016, Osmar Terra, an important figure connected to the strengthening of TCs, already possessed a strong political influence on the government. In May 2016, under the Michel Temer administration, he became Minister of Social and Agrarian Development. His political place influenced the approval of regulations related to TCs, and his appointment to the Ministry of Citizenship, controlling the agenda of SENAPRED, at the start of the Bolsonaro administration in 2019, is a key occurrence in this field.

[47] Joint Ordinance of the State Ministries of Justice and Public Security, Health, Social Development, and Labor.

[48] Joint Ministerial Ordinance 2/2017, Art. 6.

[49] In Maria Paula dos Santos's evaluation, the primacy given to the strategy of abstinence by the resolution, along with the possibility of resuming long-stay admissions, implies a worrying agenda of counter-reforms. As she emphasizes: "CONAD, for its part, now with some new members nominated by the incoming government, would publish a new resolution in March 2018 (Resolution 1/2018), determining the primacy of the promotion of abstinence as a care strategy for drug users (Art. 1, III)—in clear contradiction with the premises of the Ministry of Health's policy of Comprehensive Care for Users of Alcohol and other Drugs from 2003 (Brazil, 2003). The advance of this agenda of (counter) reforms of mental health policies—including care strategies for drug users—raises major concerns. Firstly, because the measures adopted favor the resumption of long-stay admissions, a care approach already amply criticized and considered obsolete by the international community, including the WHO. Specifically in terms of care for drug users, it should be noted that there is no scientific basis for claiming that the strategies for promoting abstinence are superior, in terms of efficacy, to any others." Gomes dos Santos, "Comunidades terapêuticas," 30-31.

PNAD), in which abstinence is mentioned as a treatment approach and TCs are promoted as components of the social support network for users of alcohol and other drugs.[50,51]

In November 2018, the MS published Ordinance 3,449/2018, which created the Therapeutic Communities Committee with the objective of proposing related regulatory norms in the scope of public policies in AD.[52] The establishment of committees related to TCs, with a composition favorable to acquiring space in the construction of public policies, reflects the growth of their influence over the last decade and, especially, in recent years. Another reflection is the existence, since 2011, of parliamentary affinity groups related to the TCs, an important instrument for their political organization in the House and the Senate.[53] The collective organization of the TCs in federations and confederations over recent decades is a central element driving their increasing influence on public policies.[54]

In January 2019, the beginning of President Jair Bolsonaro's administration marked a shift towards far-right government and the impacts of this fact cannot be ignored in the analysis developed here. In February 2019, the Ministry of Health published Technical Note 11, a document explaining the new National Mental Health Policy. The proposed guidelines reveal the strengthening of hospital care as central, reinserting psychiatric hospitals among the RAPS units. Although the Technical Note claims to be guided by the psychiatric reform consolidated previously, the new policy reintroduces practices already outdated in this field. In relation to the TCs, the document merely mentions the Therapeutic Communities Committee (created by MS Ordinance 3,449/2018) and refers to CONAD Resolution 1/2015 as regulating their operation.

In terms of the analysis of the regulations issued in 2019, it is important to recall that Provisional Measure 870, approved on the first day of the current administration, determined changes in the jurisdictions of the ministries, with Decree 9,674/2019 defining the Regulatory Structure of the Ministry of Citizenship, stipulating that the actions of care, prevention, and social reinsertion pertaining to the theme of the drugs would now be transferred from the Ministry of Justice and Public Security's SENAD to the Ministry of Citizenship 's SENAPRED.

This change is politically and legally significant: since the ministries have jurisdiction to regulate the matters under their administration, the political forces that occupy these entities, in each historical context, possess a direct influence on the regulation of these topics, making them capable of changing the direction assumed by the development of national public policies. Along these lines, it is important to stress that the first Minister of Citizenship of the current government was Osmar Terra,[55] one of the

[50] Resolution 1/2018 of the Ministry of Citizenship, Art. 1, III.
[51] Ibid., Art. 1, VII, § 2.
[52] MS Ordinance 3,449/2018, Art. 1.
[53] The parliamentary affinity groups are reformulated when the legislatures change. The group now functioning was created in 2019.
[54] In the 1990s, CONFEN (later CONAD) played an important role in stimulating the movement of standardization of the TCs through federations and confederations, and in the process of their legal regulation. See the debate in Ana Regina Machado, "Uso prejudicial e dependência de álcool e outras drogas na agenda da saúde pública: um estudo sobre o processo de constituição da política pública de saúde do Brasil para usuários de álcool e outras drogas" (MSc thesis, Universidade Federal de Minas Gerais, 2006). On this topic, also see the article by Priscila Farfan Barroso in this series.
[55] Affiliated to the Brazilian Democratic Movement (Movimento Democrático Brasileiro, or MDB), Osmar Terra is a federal representative for the state of Rio Grande do Sul. He held the post of Minister of Social Development in the

politically influential names related to TCs and the author of the bill to amend the Drugs Law, which, as we have seen, included a specific section on these institutions.

In March 2019, the Ministry of Citizenship published three ordinances relating to the regulation of TCs. Ordinance 562 created a monitoring plan in the scope of SENAPRED, making the latter responsible for inspecting the TCs covered by government bidding processes; Ordinance 563 created the accreditation registry for TCs and established the rules and procedures for this process within the scope of the Ministry of Citizenship; and Ordinance 564 created the certification of quality for training courses. Despite the issuance of these norms, no rules for effective monitoring of the TCs exist and, therefore, these ordinances remain without any practical effects.

In April 2019, the PNAD was approved through Decree 9,761 with specific key elements relating to the TCs and the provision of abstinence as a general guideline for treatment.[56] In its premises and objectives, as well as in the actions of prevention and treatment, the guideline of user abstinence appears recurringly. Two months later, in June 2019, the New Drugs Law was approved, the content of which was examined earlier. In November 2019, the Ministry of Citizenship published Ordinance 1, regulating the Electronic Therapeutic Communities Management System (Sistema Eletrônico de Gestão de Comunidades Terapêuticas, or SISCT) with the objective of making SENAPRED's funding procedures public, notably setting the maximum time for staying in TCs at twelve months.[57]

In March and May 2020 were published, respectively, Ordinance 340 of the Ministry of Citizenship, with measures relating to the Covids-19 pandemic, and ANVISA Technical Note 2, with guidelines for applying ANVISA RDC 29/2011. As they do not cover points specifically related to the regulatory framework discussed in this article, these documents are not explored here in detail, though they also apply to the TCs.

In July 2020, CONAD Resolution 3 was published, which covers the admission of adolescents to TCs. Although the aim of this article is not to go deeper into the sensitive and complex debate on childhood and adolescence, it should be emphasized that this possibility of admitting adolescents to TCs opens up a new discussion front on the rights and guarantees of this population vis-à-vis the protective regulations specific to them under Brazilian law.

These, then, were the last regulations mapped in this research, the timeline for which established 2020 as the final year for review.

This brief exposition of the norms relating to TCs published between 2001 and 2020 has the objective of producing a map that can contribute to the debates on the operation, treatment model, access to public funds, inspection, and regulatory jurisdiction itself pertaining to these establishments. In this period, a

Michel Temer government and Minister of Citizenship in the Bolsonaro government. Osmar Terra is known for his political influence in strengthening the TCs.

[56] Examples are: "Stimulate and support, including financially, the work of therapeutic communities based on the voluntary and transitory admission and residence of the *acolhido*, including those entities that bring them together or represent them" (Decree 9,761/2019, Appendix, item 5.2.5); and "Stimulate and support, including financially, the improvement, development, and physical and functional structuring of therapeutic communities and other entities focusing on treatment, *acolhimento*, recovery, support and mutual help, social reinsertion, prevention and ongoing training" (Ibid., item 5.2.6).

[57] Ordinance 1/2019 of the Ministry of Citizenship, Art. 12, § 8.

regulatory framework was developed drawing from the areas of health, justice, security, and social assistance that enabled the insertion of TCs in the public care network and their financing by the state, without, however, a consolidated policy of oversight and inspection of the services offered by them.

Analysis of this legal base is indispensable to identifying the legal contradictions and gaps that produce practical—and very often harmful—effects on the development of public policies. Furthermore, the legal discussion cannot remain separate from the empirical field to which it applies: it is essential to examine the reality of the ways in which TCs operate to ascertain whether they meet the guarantees relating to mental health and human rights. The premise of the research behind this article was that comprehending the legal basis supporting the existence, functioning, and public funding of TCs is a component essential to the diverse debates on these themes.

The next section highlights the main elements of interest identified over the course of the analysis—*legal knots*—and proposes a reflection in light of human rights.

LEGAL KNOTS AND PROTECTIVE REGULATIONS IN MENTAL HEALTH

Examination of the regulations described above allowed the identification of controversial questions in the regulation of TCs. Although the scope of this article is not to unravel these *knots*, it is essential to make explicit these points of tension, important to the reflection on the legal framework in which TCs are inserted and their practical repercussions. Among the problems identified, one appears central with the others deriving from it: the indefinition of the legal status of TCs, which affects the entire regulatory framework of the treatment model. To advance it is also crucial to reflect on another knot: which policy area is responsible for regulating the treatment and services relating to the harmful use of alcohol and other drugs?

Concerning the legal status of TCs, two documents are key: MS Ordinance 3,088/2011 (RAPS Ordinance) and CONAD Resolution 1/2015. While the RAPS Ordinance defines the services included in the network as *health facilities* (the same line followed by other health norms, such as Ordinances 1,646/2015 and 1,482/2016, which regulate the register of TCs in the CNES), CONAD Resolution 01/2015 stipulates that TCs have the status of *facilities of interest to and in support of care policies.*[58] Both possess a similar legal value. However, Decree 5,912/2006, superior to these two norms in terms of legal hierarchy, established the health area as responsible for regulating matters associated with treatment and care services.[59]

Since this decree was not subsequently replaced by another norm that might have attributed this jurisdiction to different area, the understanding here is that the legal status of health facility indicated in Ordinance 3,088/2011 prevails and that, in terms of regulating the treatment and care services related to alcohol and other drugs, CONAD exceeded its jurisdiction in regulating these questions.

[58] "Health facilities" are locations that structure the different SUS' public policies across a wide range of areas and must legally adhere to health regulations. The "facilities of interest to and in support of care policies" are an indeterminate concept relating to locations that possess some connection to healthcare policies but that, since they do not belong to this area of public policy, are not covered by the latter's regulations.

[59] Decree 5,912/2006, Art. 14, I.

Moreover, Law 13,840/2019, even though it created a specific section on TCs, did not explicitly regulate their legal status, indicating merely that they are prohibited from realizing **any modality of inpatient care**. Thus, following the interpretation of the regulatory framework proposed here, the TCs should be considered health facilities subject to the same norms relating to such facilities.

In terms of the express prohibition on inpatient care in TCs provided for in the aforementioned law, the practical repercussions are important. Despite the prior understanding that the TCs provide *voluntary sheltered care* (*acolhimento voluntário)* and not inpatient care (the indefinition of the notion of voluntary sheltered care is discussed below), this prohibition makes explicitly illegal not only to carry out involuntary admissions but also the practice of compulsory admissions in these institutions, determined by the court system itself.

Considering the applicable norms and without exploring the other dimensions of public policies relating to this debate, the TCs, as health facilities, should comply with the LRP guidelines. Given these guidelines, can the provision of mental health treatment services by these institutions be considered adequate? Put otherwise, can the precepts that structure the TC treatment model, especially mandatory abstinence, the consequent lack of individual autonomy in the choice of treatment, and social isolation, be made compatible with these guidelines? It could be said that more than a problem of adapting practices through monitoring and inspection—essential actions, since currently the TCs are widely inserted in care policies—we are faced with a structural problem of incompatibility in care models.

Another legal knot can be identified on this same issue: even understanding the legal status of TCs as health facilities, it is unclear what defines their treatment modality. Despite their regulatory classification as sheltered care services, a gap exists in the legal classification of this practice. Is it possible, for example, to legally differentiate the TC model of sheltered care from voluntary admission practices? In terms of the maximum period for admission, it can be inferred that this differentiation remains nebulous. Since inpatient care (*internação*) is prohibited in TCs, the nomenclature *acolhimento* (sheltered care) seems to function simultaneously as a discursive solution that is meaningless in terms of its capacity to define the service provided, but also quite purposeful in terms of sustaining imprecision as a means of deflecting critical debate and maintaining loopholes that allow for flexibility in the rules for their operation.

The maximum period for admission concerns both the debate on sheltered care and the discussion of regulatory jurisdiction. Two time periods overlap in the current regulations: while in the health area Ordinance 3,088/2011 stipulates a maximum admission period of nine months, in the AD area CONAD Resolution 1/2015 and Ordinance 1 of the Ministry of Citizenship stipulate a period of twelve months. Adopting time as a variable relating to treatment, it follows that the health area has jurisdiction for regulating this matter and that the maximum period of nine months should be respected. It is important to also consider that this prolonged time of social isolation revives an asylum-type of treatment model.[60]

[60] On the social isolation implemented by TCs, Maria Paula dos Santos says that: "In the case of medical clinics and TCs, the postulate of abstinence has been accompanied by antiquated practices of psychiatric treatment, especially confinement of patients in closed institutions where they are subject to social isolation and strict rules of conduct and daily interaction, under the monitoring and custody of a management team. Adoption of these measures for drug users is frequently justified by arguments concerning the inability of these individuals to control their own impulses and their distorted perceptions of reality, supposedly making them incapable of enjoying liberty and autonomy." Gomes dos Santos, "Comunidades terapêuticas," 23.

As well as the maximum admission period, the discussion concerning abstinence as the *sole guideline* adopted by the TCs, in contrast to the wide range of harm reduction strategies, also relates to treatment. On this point, attention is drawn to MS Technical Note 11, which establishes the New Policy for Mental Health and sets out a model founded primarily on abstinence. However, the analysis developed here reveals that, even in the AD policy field, harm reduction strategies are highly relevant in the regulatory sphere. An important example, considering its hierarchical strength, is the stipulation in Law 11,343/2006 of slowing down use and of risk and harm reduction as guidelines for treatment and for the formulation of therapeutic projects. Despite referring to abstinence in the section dedicated to TCs, the new legal text did not alter the general orientation for the development of prevention and treatment activities.

Analysis of the regulatory contradictions provides an interesting clue to the evolution of the debate, which will be used as a key for reading the norms protecting human rights vis-à-vis their application in discussions related to drug policies. While TCs can be considered from a *conjunctural* perspective, which emphasizes the immediate need to structure effective inspections to ensure compliance with the regulatory provisions and to eliminate violence and abuses, there is also an urgent need to problematize these establishments from a *structural* perspective, ascertaining whether their core tenets may in fact be incompatible with the precepts of the LRP and with protecting the human rights of users of alcohol and other drugs.

While the growth of TCs and their access to public funds demand systematic forms of inspection—the action of ANVISA,[61] the role of the Public Prosecutor's Office, and the adequate structuring of independent bodies to perform these inspections, such as the Mechanisms for Preventing and Combating Torture—these themes exceed the inspection dynamic and involve structural contradictions. Based on these two dimensions, some brief observations follow, specifically on the International Convention on the Rights of Persons with Disabilities (Convention) and the Brazilian Law of Inclusion (Lei Brasileira de Inclusão, or LBI) and their pertinence in this context.[62]

The 2007 Convention was approved by Legislative Decree 186/2008, under the terms of Article 5, § 3 of the Federal Constitution. In 2009, Decree 6,949 promulgated the Convention, making it the first human rights treaty incorporated into the domestic legal system with the value of a Constitutional Amendment. In 2015, the LBI was approved based on the Convention's precepts. These norms address the physical, mental, intellectual, and sensorial dimensions of disabilities.[63] Some researchers see the inclusion of the mental dimension as another space for the debate on protection in situations involving the harmful use of alcohol and other drugs.[64] Nonetheless, it should be stressed that although inclusion of this theme

[61] For more details concerning the topic of inspection, see the article by Jardel Fischer Loeck in this series.

[62] The discussion of the human rights of drug users has gained impetus in recent years. For more details on how the fields of drug policies and human rights are interconnected, see "Diretrizes internacionais sobre direitos humanos e política de drogas," published in 2019 by the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Development Program (UNDP), and the World Health Organization (WHO), among others, accessed February 24, 2021, https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/international-guidelines-on-human-rights-and-drug-policy.html.

[63] Art. 1 of the Convention and Art. 2 of the LBI.

[64] On this debate, the 2017 Therapeutic Communities National Inspection Report produced by the National Mechanism for Preventing and Combating Torture, the Federal Psychology Council and the Federal Attorney for Citizen Rights of the Federal Public Prosecutor's Office, states: "It should be emphasized that the difference posited in the legislation between intellectual disability and mental disability is not accidental. This distinction

expands the protections for the human rights of substance users, there also exists the risk of a stigmatizing appropriation of the notion of disability in the sphere of problematic drug use and the increase in abusive interventions made on male and female users.

This work presents just a brief reflection on some repercussions of the application of these norms for the protection of users of alcohol and other drugs, offering an insight into the possible future paths of this debate. In any event, the inclusion of the AD theme in the scope of these norms should go hand in hand with a more libertarian understanding of mental health, in which individual autonomy prevails. It should also be accompanied by investment in collective health and the strengthening of the care network dispersed across local regions. In general terms, this interpretative disposition is related to an express ethical commitment to life, liberty, and autonomy.

The Convention prohibits any discriminatory act made on the basis of disability and which prevents the free exercise of all fundamental rights. The LBI stipulates that the disabled person must be protected from any form of discrimination, violence, oppression, neglect, or inhuman or degrading treatment.[65] One question raised by this point is whether treatment models intended to readjust behaviors considered to be deviant are not inherently discriminatory since they presume a failure to conform to a supposedly adequate form of existence. Here the Convention stipulates that stereotypes, prejudices, and harmful practices aimed at people with disabilities must be combated.[66]

Individual autonomy is affirmed as a guiding principle in mental health,[67] which makes it essential to assess whether the treatment structure in TCs, based fundamentally on the compulsoriness of precepts like abstinence and social isolation,[68] does not infringe upon free choice and, therefore, the autonomy of the user. This aspect goes beyond the debate on whether the user effectively knows what he or she is agreeing to when signing a term of consent,[69] itself a highly relevant question, and also concerns

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incorporates into the agenda of protection people with mental disorders—including those arising from the use of alcohol and other drugs. Based on this Convention, Brazil approved in 2015 the Statute of the Person with Disability, which reinforces the veto on forced treatment or institutionalization.... It is confirmed, therefore, that the deprivation of liberty cannot be justified by the existence of disability—including mental disability arising from the use of alcohol and other drugs. The logic guiding this Convention is similar to the one found in the 1988 Federal Constitution and the Psychiatric Reform Law, indicating a convergence between professionals from the fields of healthcare, law, and human rights in Brazil and abroad. The emphasis on healthcare in the community—and not in isolated spaces—seeks precisely to avoid the rupture of social ties." Conselho Federal de Psicologia, Mecanismo Nacional de Prevenção e Combate à Tortura, and Procuradoria Federal dos Direitos do Cidadão do Ministério Público Federal, *Relatório da Inspeção Nacional em Comunidades Terapêuticas* (Brasília: 2018), 28.

[65] LBI, Art. 5.

[66] Convention, Art. 8, 1, B.

[67] Ibid., Art. 3.

[68] On social isolation and abstinence as core tenets of the treatment provided in TCs, Maria Paula dos Santos argues: "The specific objective of TCs is to get those in their care to suspend the use of drugs through a subjective transformation induced by a set of practices and activities carried out in a context of social isolation and complete abstinence from drugs. [The TCs] comprise temporary collective residences in which individuals should be admitted on a voluntary basis and remain there for extended periods (in general from nine to twelve months) among a group of peers (people who also have drug problems) and under the supervision of monitors—usually people who have already undergone the same treatment." Gomes dos Santos, "Comunidades terapêuticas," 11.

[69] For a discussion of voluntary admission to TCs in the context of the inspections conducted by the Public Defender's Office of the São Paulo, see the article by Carolina Gomes Duarte and Mathias Glens published in this series.

inspection activities. In its structural dimension, the issue of autonomy in the TCs seems incapable of meeting these requirements.

Another point that collides structurally with the TCs is the Convention's guarantee of the right to live in community and to be able to access services close to home,[70] as well as community inclusion and social non-isolation.[71] Along the same lines, the LBI lists among the guidelines for treating people with disabilities the right to family and community life,[72] full social participation, and the provision of services close to home.[73]

Among the points of the Convention that are more directly related to the inspection dynamics are: the right to privacy; the training of workers and their awareness of human rights; and the prohibition on forced labor, slave labor, or systems of servitude. In relation to the inspection aspect, the LBI establishes the need for prior and informed consent; the adequacy of the architectural project to universal design principles; the guarantee of accessibility; ongoing training, and so on.

The Convention stipulates that people must not be arbitrarily deprived of their liberty, with any existing disability not being permissible as a justification.[74] On this point, a specific circumstance concerning inspections of TCs emerges since, despite involuntary or compulsory admissions not being permitted, their practice is a reality in Brazil.[75] The need for effective inspection is expressly stipulated in the Convention itself, which advises that, to curb abusive practices, states should ensure monitoring of institutions by independent authorities.[76] Finally, the Convention stipulates that states take into consideration the promotion and protection of human rights in the development of all public policies.[77]

In sum, this article has described and analyzed the main points presently referring to the construction of the regulatory framework applicable to TCs, as well as the controversial questions embedded in this framework and their relation to mechanisms for protecting human rights.

CONCLUSION

This study aimed to map the legal instruments relating to the regulation of TCs in Brazil in order to understand what could be considered as the regulatory framework of these institutions under the national legislation. The research encompassed norms published between 2001 and 2020 by the areas of health, justice, and social assistance directly or indirectly pertaining to the services provided by TCs.

[70] Convention, Art. 25, C.
[71] Ibid., Art. 19, B.
[72] LBI, Art. 6, V.
[73] Ibid., Art. 15, III, IV, V.
[74] Convention, Art. 14, 1.
[75] For more information on this theme, see the Therapeutic Communities National Inspection Report (2017), published in 2018 by the Federal Psychology Council, the National Mechanism for Preventing and Combating Torture, and the Federal Prosecutor for Citizen Rights of the Federal Public Prosecutor's Office. Also see Luciana Barbosa Musse, "Internações forçadas de usuários e dependentes de drogas: controvérsias jurídicas e institucionais," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018).
[76] Convention, Art. 16, 3.
[77] Ibid., Art. 4, C.

The survey identified a scenario composed by regulations that, far from revealing a coherent framework, present significant overlaps, and lacunas. Based on this study, an interpretative line suggests that the regulation of the treatment and organization of public and private services is the responsibility of the health area. Without pretending to resolve all the *knots* that emerge from this legal analysis, this work seeks to raise questions that develop and deepen the debate initiated here, reinforcing the importance of more researchers from the area of law focusing attention on these themes.

Comparison between the treatment model of the TCs and the directives that guide the development of public policies in mental health—which has the psychiatric reform as its pillar—revealed a path for future reflection: to examine, on one hand, *conjunctural* problems and, on the other, *structural* questions. The work thus analyzed the International Convention on Persons with Disabilities and the LBI and concluded that the TC model can be understood to be structurally incompatible with the precepts for safeguarding rights, not just limiting the debate to issues related to oversight of the provided services and adjustments to institutional practices.

The growth and strengthening of TCs over time make it essential to reflect on whether the services provided in these institutions meet the regulations presently in force. Nevertheless, in this deep structural reflection, it is also essential to consider the inclusion of TCs as public healthcare facilities, based on an evaluation of the core tenets of their treatment model. It is also important to stress the need to examine the construction of public care policies for users of alcohol and other drugs as a question of collective health, considering psychiatric reform and human rights, with respect to singularized treatment, individual freedom, autonomy, and the connection to the local territory. These reflections are necessary when we observe that the TC model in Brazil is structurally dissonant with these relevant guidelines.

PUBLIC FUNDING OF THERAPEUTIC COMMUNITIES: FEDERAL EXPENDITURE BETWEEN 2010 AND 2019

RENATA WEBER[1]

The study of funding for programs and actions relating to mental health, alcohol, and other drugs is fundamental to the consolidation of public mental health policies at the global level. Governmental allocation of resources for these policies is directly related to the treatment gap, with implications including a failure to treat those with mental suffering and disorders.[2] Allocating specific funds is insufficient, however, to reduce this gap: among various factors, it is crucial to know how and where these funds are being spent.[3] The World Health Organization expressly recommends the development of community-based care policies for mental health, alcohol, and other drugs, and warns member countries of the dangers of losing resources during the transition from hospital-centered care to community care.[4]

Following publication of Law 10,216/2001—known as the Psychiatric Reform Law, which treats hospitalization as the last recourse in treatment and assures people the right to be treated preferentially in community-based services with guaranteed respect for their human rights—Brazil assumed an unequivocal stance in terms of building a network of community-based services.

From the 2000s, the federal government began the transition from hospital-centered care to outpatient care (*cuidado em liberdade*), achieved through a network of community-based services. A study of the funding of this process in the country showed a real growth in federal funds for the health sector allocated to programs and actions in mental health, alcohol, and drugs between 2001 and 2009.[5] Over this period, there was a sizeable investment in extra-hospital/community initiatives, accompanied by

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[2] Martin Knapp, David McDaid, Silvia M.A. A. Evers, Luis Salvador-Carulla, and Vidar Halsteinli, *Cost-Effectiveness and Mental Health* (London: London School of Economics and Political Science, 2008).

[3] Anna Dixon, David McDaid, Martin Knapp, Clare Curran, "Financing Mental Health Services in Low and Middle Income Countries," *Health Policy Plan* 21, no. 3 (2006): 171–82, DOI:10.1093/heapol/czl004; K. S. Jacob et al., "Mental Health Systems in Countries: Where Are We Now?" *Lancet* 370, no. 9592 (2007): 1061–77; David McDaid, Martin Knapp, and Clare Curran, *Policy Brief Mental Health III–Funding Mental Health in European Observatory on Health Systems and Policies* (Copenhagen: World Health Organization, 2005).

[4] World Health Organization, *Relatório Sobre a Saúde no Mundo 2001. Saúde Mental: Nova Concepção, Nova Esperança* (OMS, 2001).

[5] Renata Weber Gonçalves, Fabíola Sulpino Vieira, and Pedro G. Delgado, "Política de Saúde Mental no Brasil: evolução do gasto federal entre 2001 e 2009," *Revista Saúde Pública* 46, no. 1 (2012): 51–8, https://doi.org/10.1590/S0034-89102011005000085.

the growth and internalization of the Psychosocial Care Network[6] (Rede de Atenção Psicossocial, or RAPS).

Around 2010, however, a facility outside of the public health sector began to receive federal resources—primarily in the form of contracts for vacancies—to provide care services for people with disorders arising from the use, abuse, or dependence on psychoactive substances:[7] the therapeutic community (TC). The funding of TCs through state and municipal public resources was already a common practice in Brazil.[8] Federal funding of these places became increasingly available, though, following the "Crack Plan,"[9] coordinated by the Institutional Security Office of the President of the Republic and by the Ministry of Justice.

The transfer of policy on alcohol and other drugs away from the healthcare portfolio has been a trend evident in Brazilian government since the 1990s.[10] It was in the 2010s, however, that this shift deepened. Following the 2017 establishment of an Interministerial Steering Committee—coordinated by the Ministry of Justice and Public Security and focused on the coordination of actions for social reinsertion and care for people with disorders arising from the harmful use of alcohol and other drugs—the transfer of drug policy away from the healthcare portfolio was officially realized, even though the Ministry of Health forms part of the Supervisory Committee.[11]

In a publication from 2005,[12] the Ministry of Health already considered that Brazilian public healthcare had not paid enough attention to the serious question of treating and preventing the problematic use of alcohol and other drugs until 2001, having left this complex issue to benevolent, pedagogical, justice, and public security institutions. It is this historical gap that provided space for TCs—generally asylum-type institutions founded on religious practices and focused on abstinence[13]—to present themselves as

[6] The study found a growth in real terms of 51.3 percent in expenditure on mental health over the period. A breakdown of this expenditure revealed a large increase in extra-hospital care funding (404.2 percent) and a decrease in funding for hospital-based care (-39.5 percent).

[7] As defined in Public Call Notice 1/2012 of the National Department for Drugs Policies, published in the Federal Official Gazette of November 8, 2012.

[8] Research carried out by the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, or IPEA) on TCs found an overlap in their public funding: 8 percent of TCs that answered questions about their funding reported receiving funding from federal, state, and municipal governments. Around 56 percent reported that they received funding from at least two spheres of government. The most common is the overlap of municipal and state funding (35 percent). IPEA – Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017), https://www.ipea.gov.br/portal/images/stories/PDFs/nota_tecnica/20170418_nt21.pdf.

[9] Decree 7,179/2010, which "establishes the Integrated Plan for Confronting Crack and other Drugs, creates a Management Committee, and sets out other measures."

[10] Nelson Cruz, Renata Gonçalves, and Pedro G. Delgado, "Retrocesso da reforma psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019," *Trabalho, Educação e Saúde* 19, no. 1 (2021): e00285117, DOI:10.1590/1981-7746-sol00285.

[11] Joint Ministerial Ordinance 2/2017.

[12] Ministério da Saúde, Secretaria de Atenção à Saúde, DAPE, and Coordenação Geral de Saúde Mental, *Reforma Psiquiátrica e política de saúde mental no Brasil: 15 anos depois de Caracas* (Brasília: OPAS, 2005).

[13] Conselho Federal de Psicologia, Mecanismo Nacional de Prevenção e Combate à Tortura and Procuradoria Federal dos Direitos do Cidadão/Ministério Público Federal,, *Relatório da Inspeção Nacional em Comunidades Terapêuticas—2017* (Brasília: CFP, 2018). *The Report of the National Inspection of Therapeutic Communities*, published in 2017, shows that these characteristics still largely define these institutions.

an option amid a relative absence of the state and the public health sector in responding to the issue. It was only from 2002 on that public health bodies began to construct a specific public policy to provide care to people using alcohol and other drugs.[14]

There were intense debates in the field during the 2010s,[15] with the public financing of TCs one of the themes under dispute. At the same time as federal funding became channeled through public notices published by the Ministry of Justice, deploying resources from outside the health sector, large steps were taken in the regulatory field,[16] amid significant government tensions and protests from the public health field,[17,18] to enable TCs to function as Unified Health System (Sistema Único de Saúde, or SUS) facilities. These movements took place in a historical moment of defunding the SUS[19] and in the context of increasing rupture with the care model adopted in the field of mental health since Law 10,216/2001.[20] In this sense, the so-called "New Policy for Mental Health,"[21] made public through Technical Notice 11/2019, is a landmark.[22]

This study seeks to contribute to this discussion by estimating the amount of federal public funding spent on TCs between 2010 and 2019. To frame this question more clearly, it also estimates federal expenditure through the SUS on programs and actions relating to mental health, alcohol, and other drugs, based on the categories *hospital-based expenditure* and *extra-hospital expenditure*. How is spending on TCs related to spending on the SUS? How does this spending vary over time? What impact does financing of TCs have on the increase in government expenditure on hospital-based care for actions and programs relating to mental health, alcohol, and other drugs? Has mental health in the SUS lost federal resources over recent years? These are some of the questions informing the analysis pursued in this article.

[14] National Program for Integrated Community Care for Users of Alcohol and other Drugs, implemented through Ordinance 2,197/2004 of the Ministry of Health.

[15] For more information, see Mirian Cátia Vieira Basílio Denadai, "O Legislativo federal e os projetos de lei sobre drogas no Brasil: uma guerra entre velhos discursos ou novas alternativas?" (PhD diss., Universidade Federal do Rio de Janeiro, 2015).

[16] In 2011, TCs appear in the Ministry of Health's Ordinance 3,088 as one of the components of the RAPS; in 2012, Ordinance 131, also issued by the Ministry of Health, established financial incentives for support to residence-based services (including TCs); in 2016, Ordinance 1,482, issued by the same ministry, included TCs in the National Register of Healthcare Establishments.

[17] Between 2010 and 2012, considerable pressure was placed on the federal government–principally by parliamentarians linked to the Parliamentary Alliance in Defense of Therapeutic Communities–to assimilate these facilities into the SUS. See Denadai, "O legislativo federal."

[18] For further details, see Cruz, Gonçalves, and Delgado, "Retrocesso da reforma psiquiátrica."

[19] Constitutional Amendment 95/2016 "froze" SUS resources within the scope of the federal government's fiscal and social security budgets. Expenditure was limited for twenty years to the maximum amount set for the immediately preceding financial year, adjusted by the variation in the Extended Consumer Price Index (Índice de Preços ao Consumidor Amplo, or IPCA).

[20] Since 2016, the annual increase of CAPS has been dropping off significantly. For more information, see Cruz, Gonçalves, and Delgado, "Retrocesso da reforma psiquiátrica."

[21] Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas e Coordenação-Geral de Saúde Mental, Álcool e Outras Drogas, "Nota Técnica nº 11/2019, de 4 de fevereiro de 2019," accessed February 10, 2021, https://cetadobserva.ufba.br/pt-br/legislacoes/nota-tecnica-no-112019-cgmaddapessasms.

[22] This rupture is also made explicit in other documents such as the 2019 Annual Report of the Multi-Annual Plan.

FUNDING OF THE SUS

Understanding the methodology of the present investigation—or even the interpretation of its findings—requires some understanding of the federal budget. The Brazilian government today possesses a number of planning instruments to meet its targets. The Annual Budget Law (Lei Orçamentária Anual, or LOA), expressed as a work plan for a determined year, indicates the set of actions to be implemented and reserves the funds needed for their execution: for each set of actions there must be a source of funds. The Multi-Annual Plan (Plano Plurianual, or PPA), for its part, is a four-year planning instrument intended to establish long-term governmental programs and targets. The Budget Guidelines Law (Lei de Diretrizes Orçamentárias, or LDO) is an intermediary instrument between the PPA and the LOA, anticipating the guidelines, spending priorities, regulations, and parameters that guide the elaboration of the Budget Law Bill for the following fiscal year. The LOA, LDO, and PPA share the same language, that of programmatic functional actions, budget actions that pertain to programs, specific areas of government, and the budget units that execute them. Parliamentarians can make amendments to the federal budget, and any approved amendment focuses on a programmatic functional action. It should be noted that one of the guidelines of these documents is the observance of the principles of the supremacy of the public interest over the private and of the impossibility of disposing of the public interest (*indisponibilidade do interesse público*).

The aim of this study is to examine the federal government's spending on TCs, as well as on programs for mental health, alcohol, and other drugs. All these expenses must be described in the LOA. The information sought, however, may appear in detail in a programmatic functional action, focused on just one set of actions, or may be dispersed within a broader programmatic functional action. This is precisely what the methodology adopted herein must take into account.

Federal government expenditure on TCs is disbursed from the National Anti-Drug Fund (Fundo Nacional Antidroga, or FUNAD), a budget unit officially managed by the National Secretariat for Drug Policies (Secretaria Nacional de Políticas sobre Drogas, or SENAD).[23] Federal expenditure on actions relating to programs for mental health, alcohol, and other drugs in the health field, for their part, are covered by the National Health Fund (Fundo Nacional de Saúde, or FNS), a substantial budget unit managed by its executive board under the orientation and supervision of the Executive Office of the Ministry of Health. All of the SUS' federal resources originate from FNS.

Both FUNAD and FNS are subject, therefore, to the norms defining the Annual Budgets, the Budget Guidelines, and the Multi-Year Plans, over and above the specific laws that regulate them. These funds are not similar to each other, however.[24] Beyond their differences in purpose and scale (FUNAD's

[23] With the publication of Provisional Measure 870/2019, SENAD's powers and responsibilities were reformulated with some retained by the Ministry of Justice and Public Security and others (related to prevention, reinsertion, care, and research linked to these topics) transferred to the Ministry of Citizenship, under the responsibility of the National Office for Drug Care and Prevention (Secretaria Nacional de Cuidados e Prevenção às Drogas, or SENAPRED).

[24] FUNAD was created by Law 7,560/86, and it was then called the Fund for the Prevention, Recovery and Combat of Drug Abuse (Fundo de Prevenção, Recuperação e de Combate às Drogas de Abuso, or FUNCAB). Its remit is to fund actions, projects, and programs related to drug policy, especially actions intended to reduce the supply of drugs, reduce demand, or support campaigns, studies, and training courses related to drug issues. The funds are

revenue is less than one percent of the FNS' revenue), the SUS has a tradition of participation by social oversight bodies that is of huge democratic importance:[25] the national, state, and municipal Health Councils. These are composed of entities and movements of SUS users, representatives of healthcare professionals and the scientific community, as well as representatives of service providers and the government itself.

Law 8,142/90 establishes that the Health Councils at the various levels are responsible for overseeing execution of health policy, including its economic and financial aspects. This law also requires that in order to receive funds from the FNS, the municipalities, states, and Federal District must have their own health funds, which enables federal resources to be transferred to the other entities of the federation in capillary form (known as fund-to-fund transfers).

In the field of mental health, alcohol, and other drugs, four national conferences—another SUS collegiate body that enables community participation in the management of public health policies—maintain guidelines for the actions and, therefore, for SUS expenditure on the sector across all levels of government. The conception of robust social oversight means that, in theory, funding of the health field is more in line with social demands and is kept under permanent oversight.

For a clearer understanding of FNS spending on actions and programs relating to mental health, alcohol, and other drugs, it is necessary to explain at least some of the complex elements of SUS funding. Transfer of financial resources from the FNS today involves funding blocks. The most traditional and usual form of sending funds to municipalities is known as "fund-to-fund transfer." In these cases, the municipalities and states receive funds directly from the FNS, which are deposited in municipal and state health funds.

The criterion used to determine the amount of funds to be transferred is generally the magnitude of the capacity in place in each territory and/or the estimated population. Some transfers are also defined by the production of services, registered by the federated entity that executes them and to be remunerated subsequently by the SUS via the Hospital Information System (Sistema de Informações Hospitalares, or SIH) and the Outpatient Information System (Sistema de Informações Ambulatoriais, or SIA). The mode in which these transfers are made depends directly on the "management conditions" of each municipality or state, which are related, in turn, to the responsibilities for health service provision attributed to these subnational entities, depending on the size of their population, among other criteria.[26] There are five funding blocks through which federal transfers to the subnational units are made for the purpose of executing health actions and programs, namely:[27]

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also applied to the management of FUNAD itself as well as the expenses incurred by executing the duties of the SENAD, the body responsible for managing the Fund.

[25] "Social oversight" in the sense used in the area of public health and sanitary reform.

[26] There are two management conditions at municipal level in the SUS: (a) Full Management of Amplified Primary Care (the municipality receives an amount defined according to an estimate of its population to finance primary care actions); and (b) Full Management of the Municipal System (the municipality receives the total amount of federal resources programmed for the cost of healthcare in its territory). States are also empowered to use two types of management conditions. The condition of Full Management of the State Health System (a) gives the state manager greater autonomy to conduct the state health system (here the resources relating to medium and high complexity care, under the management of the state health office, are automatically transferred from the National Fund to the State Health Fund). When the state is empowered in a Full Management of the State System, (b) the funds relating to primary care and those relating to medium and high complexity care under the management of

- Primary Care Block – funds transferred for the joint maintenance of teams from the family health program, oral health teams, community health workers, and others.
- Medium and High Complexity Care Block – has two components: (a) the Financial Limit for Medium and High Complexity Outpatient and Hospital Care (Média e Alta Complexidade Ambulatorial e Hospitalar, or MAC), which combines the resources from the financial ceiling for medium- and high-complexity care (outpatient and hospital services), as well as resources for promoting the formation of care networks, Emergency Ambulance Service (Serviço de Atendimento Móvel de Urgência, or SAMU), and other areas; and (b) the Strategic Actions and Compensations Fund (Fundo de Ações Estratégicas e Compensações, or FAEC), which generally covers procedural costs, as well as emergency strategic actions.
- Health Surveillance Block – also has two components: (a) Health Surveillance, which encompasses the actions of surveillance, prevention, and control of diseases, aggravating and risk factors, and actions for promoting health; and (b) Health Regulation, which covers actions relating to health regulatory agencies (*vigilância sanitária*).
- Pharmaceutical Assistance Block – has three components: (a) Basic Pharmaceutical Assistance Component; (b) Strategic Pharmaceutical Assistance Component; and (c) Specialized Pharmaceutical Assistance Component.
- Management of the SUS Block – roughly speaking, finances two components: (a) Qualification of SUS management; and (b) Implantation of healthcare actions and services.

Most of the resources for actions and programs relating to mental health, alcohol, and other drugs come from the funding for the Medium and High Complexity Care Block, with another significant portion coming from the Pharmaceutical Assistance Block. Until 2008, the funding for Psychosocial Care Centers (Centros de Atenção Psicossocial, or CAPS) and Therapeutic Residential Services (Serviços Residenciais Terapêuticos, or SRT)[28] was provided by FAEC, which was intended for the payment of actions and services of high complexity identified as priorities by the Ministry of Health. These were funds added to those initially programmed for specific units of the federation (Unidades da Federação, or UFs) and this supplementation induced a strong expansion in the number of CAPS and SRTs in the country. Since 2008, however, the services provided by the CAPS and other mental health facilities ceased to receive

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the municipality in Full Management of the System are transferred from the National Fund to the Municipal Health Funds. For more information on the SUS, the Pact for Health and its legislation, see Healthcare Operational Regulation/SUS 1/2001, implemented by the Ministry of Health's Ordinance 95/2001, as well as Ordinances 399/2006 and 699/2006, also the Ministry of Health, and Decree 7,508/2011, among others.

[27] Presented here schematically.

[28] The Ministry of Health's Ordinance 3,088/2011—which institutes the RAPS for people with mental suffering or disorders within the scope of the SUS, including those with needs arising from the use of crack, alcohol, and other drugs–defines the Psychosocial Care Centers (CAPS), in their diverse modalities, as open and community-based healthcare services, formed by a multi-professional team that works from an interdisciplinary perspective and provides care primarily for people with serious and persistent mental disorders and for people with mental suffering or disorders in general, including those with needs arising from the use of crack, alcohol, and other drugs in their area, whether in crisis situations or in processes of psychosocial rehabilitation. The same ordinance defines the Therapeutic Residential Services (Serviços Residenciais Terapêuticos, or SRT) as residences embedded in the community, intended to shelter people coming from long-term admission (two years or more, uninterrupted) in psychiatric hospitals and forensic psychiatric hospitals, among others.

additional funding and began to "compete" for resources with other medium and high complexity procedures in the same UF.[29]

METHODOLOGICAL CHOICES

Many methodologies can be used to estimate federal expenditures. All of them depend on choices that allow use of the best information available for each analytic objective. Here, the aim has been to adopt strategies that enable the construction of a time series of data between 2010 and 2019,[30] which depends essentially on the availability of the same types of data for the entire period to be analyzed. As administrative records were used—that is, data produced for the purposes of SUS management rather than for research—there is a large chance that data present in the SUS databases for some years is no longer available for others. This requires the adoption of a variety of specific methodological procedures. In the following analyses, the aim has been to explain all the methodological procedures employed during the research.

Estimating FUNAD's expenditure on TCs

Federal funding of TCs began with the launch of the "Crack, you can beat it" program in 2010/2011. Through public calls for notices, the federal government selected TCs that would be authorized to offer available spots at their facilities, paid by public funds.[31] Initially, three of these public notices were elaborated jointly by the Ministry of Health and SENAD. However, only eleven of the projects applying for funding in these competitions were subsequently approved, since the majority of proposals failed to comply with the requirements determined for the health area—none of these projects received funds from the FNS.[32] The *Em Discussão!* blog of the Federal Senate even reported that TCs refused to participate in the selection process due to the conditions imposed by the Ministry of Health, which these institutions considered excessive.[33]

Despite the Ministry of Health's evident opening of funding paths for TCs over recent years, no records exist of financial transfers made to TCs with resources from the FNS between 2010 and 2019. The federal funds transferred to TCs all come from FUNAD, previously managed by SENAD and since 2019 by SENAPRED. These amounts are provided for in the functional programmatic actions established in the Multi-Annual Plans.[34] Thus, to estimate FUNAD's federal expenditure[35] on TCs, the author opted to

[29] Flávia Helena Miranda de Araújo Freire, "Cartografia do financiamento em saúde mental: modelagens na rede de atenção psicossocial na relação do cuidado à loucura" (PhD diss., Escola Nacional de Saúde Pública Sérgio Arouca – ENSP, 2012).
[30] Data from the SUS' financial implementation for 2020 will only be sufficiently reliable for study after the second semester of 2021. Hence data from 2019 is the last to be included in this time series.
[31] The TCs can also be subject to parliamentary amendments.
[32] Edinéia Figueira dos Anjos Oliveira, "Gastos da política de saúde mental e os rumos da reforma psiquiátrica" (PhD diss., Universidade Federal do Espírito Santo, 2017).
[33] Federal Senate, accessed February 10, 2021, https://www.senado.gov.br/noticias/Jornal/em-discussao/dependencia-quimica/sociedade-e-as-drogas/recursos-publicos-comunidades-terapeuticas-religiao-medicos.aspx.
[34] FUNAD's resources are employed in contracting places for people seeking treatment in TCs. The funded TCs are selected through public calls for tender or covered by parliamentary amendments.
[35] Fiscal and Social Security Budgets of the Budget Unit: 30912–National Anti-Drugs Fund (FUNAD).

calculate the total amount committed[36] through functional programmatic actions[37] verifiable on the Federal Budget Portal—and present in Programs 0655, 2060, and 2085 of the Multi-Annual Plans in effect between 2010 and 2019[38]—which were explicitly covered by public call notices for TCs,[39] and whose Budget Plans are expressly related to TCs (Patient Care, Care Services, Care Networks, Social Reinsertion, and Training of Therapeutic Communities). Also calculated were the amounts relating to parliamentary amendments pertaining to actions explicitly related to TCs in official statements on budget amendments published by the Ministry of Justice, as well as amounts directly allocated to TCs (noted when the name of a TC was mentioned textually in the action tracker).

Data was recorded in an electronic spreadsheet, recording the specific amounts for each year, adjusted to the equivalent in Brazilian reais for 2019 by applying the Extended Consumer Price Index (Índice de Preços ao Consumidor Amplo, or IPCA) published by the Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística, or IBGE), thus allowing them to be compared. The amounts were also adjusted according to the US dollar exchange rate (commercial - sale) for the end of each year studied, also enabling comparison between the years in question.

Estimating FNS' expenditure on actions and programs relating to mental health, alcohol, and other drugs

Currently, six functional programmatic actions of the FNS are related to the Ministry of Health's actions and programs for mental health, alcohol, and other drugs, forming part of the MAC, the first component of the Medium and High Complexity Care Block. These are: (a) Action 8585–Healthcare for the Population for Medium and High Complexity Procedures,[40] which, divided into two Budget Plans, finances the monthly cost of the CAPS, the SRTs, and the recently created Multi-Professional Teams for Specialized Mental Healthcare (PO 000F), as well as funding the specific cost-sharing incentive for 24-

[36] For this research, whenever consulting the amounts spent on programmatic actions on the Federal Budget Portal, the decision was taken to work with the allocated sum—in other words, those amounts formally earmarked for payment in the federal budget allocation, whether or not dependent on some condition. This methodological decision primarily derives from the difficulties of working with annual time series on the basis of executed amounts. Very often an expenditure authorized and allocated today will be paid in a later financial year, making reconstruction of the financial trajectories involved a complex task. On the other hand, the allocated sums were closest to a certain expectation of expenditure created by the budget allocation to the actions in the years under study—very often the sums executed in the action were so far below the expected amount that they generated the sensation of an error that might be elucidated by another research methodology.

[37] Functional/Programmatic Action 8236 (Support for Projects of Interest to the National System of Drugs Policies), 20EV (National Combat of Crack and other Drugs, Budget Plan 0001), 20IE (Public Drugs Policy, Budget Plan 0006) and 20R9–Prevention of the Use and/or Abuse of Drugs, Budget Plan 0008).

[38] The programs of the Multi-Annual Plans related to the so-called transversal management of the National Drug Policy and to FUNAD received different names, and sometimes different numbers, over the period under study. These are: In PPA 2015-2019, Program 2085–Reduction of the Social Impact of Alcohol and other Drugs: Prevention, Care, and Social Reinsertion; in PPA 2012-2015, Program 2060–Coordination of Policies for Prevention, Care and Social Reinsertion of Users of Crack, Alcohol, and other Drugs; and in PPA 2008-2011, Program 0665–Management of the National Drug Policy.

[39] Public Call Notice 1/2012 (published in DOU 216, November 8, 2012, Section 3), Public Call Notice 1/2013 (published in DOU 153, October 9, 2013, Section 3), Public Call Notice 7/2014 (published in DOU 124, July 2, 2014, Section 3), and Public Call Notice 1/2018 (published in DOU 79, April 25, 2018, Section 3). SENAPRED's Public Call Notice 17/2019 was not studied because it has financial effect from 2020.

[40] Budget Plans 0002 (Crack, You Can Beat It) and 000F (Psychosocial Care Network–RAPS/CAPS).

hour Psychosocial Care Centers for Alcohol and other Drugs (Centro de Atenção Psicossocial de Álcool e outras Drogas 24h, or CAPSad III), Care Facilities (*Unidades de Acolhimento*), and the cost-sharing incentive for implantation of Referral Hospital Services–SHRs (PO 0002); (b) Action 8535–Structuring of Specialized Healthcare Units,[41] which finances incentives for building CAPS and Care Facilities, and incentives for implanting SHRs; (c) Action 6233–Implantation and Implementation of Mental Healthcare Policies, for agreements and events; (d) Action 20B0–Specialized Mental Healthcare, which finances incentives for implanting SRTs, CAPSad III and Care Facilities, and incentives for Psychosocial Rehabilitation programs; (e) Action 20AI–Aid for the Psychosocial Rehabilitation of Former Long-Term Psychiatric Inpatients, which finances the Back Home Program (*Programa de Volta para Casa*); and (f) Action 20AD, which since 2013 has financed the Street Clinic (*Consultório na Rua*) program.[42] The amounts allocated to all these actions were obtained for the years between 2014 and 2019 on the Federal Budget Portal, with some exceptions.[43]

For the years between 2014 and 2019, data was also collected on resources from the FAEC (the second component of the Medium and High Complexity Care Block), which are transferred to the funds of the states, municipalities, and the Federal District upon proof of execution of the selected procedures. The outpatient and hospital procedures of FAEC, obtained from the TABNET/DATASUS Health Information System,[44] were chosen since they are associated with the mental health sector in various forms.[45] Some of them, though now discontinued, still present residual expenditures.

[41] Budget Plans 0009–Crack, You Can Beat It, from 2014 to 2016, and 000B–Structuring of the Psychosocial Care Network (RAPS/CRACK) for 2019.

[42] Tatiana Simões, "Missão e efetividade dos Consultórios na Rua: uma experiência de produção de consenso, Saúde em Debate," *Revista do Centro Brasileiro de Estudos em Saúde* 41, no. 114 (2017): ISNN 0103-1104. The actions in the field of mental health, alcohol, and other drugs were reduced in terms of the Street Clinic project with the integration of the clinics with the Primary Care (PC) teams in 2011. Although the articulation of the clinics with the RAPS mechanisms was challenging, the use of harm reduction in the clinics is commonplace, which makes them fundamental for the user's access to primary care. For this study, these mechanisms were still considered as part of the mental health sector. The Ministry of Health's Ordinance 3,088/2011, which institutes the RAPS for people with mental suffering or disorders within the scope of the SUS, including those with needs arising from the use of crack, alcohol, and other drugs, defines the Street Clinic as a team constituted by professionals working in mobile form, offering healthcare for the homeless population, considering their diverse health needs, which include demands relating to mental health.

[43] Because these exceptions were neither included on the Federal Budget Portal nor in the financial appendices to the annual reports of the 2016-2019 Multi-Annual Plan: (i) the Action 8585 expenditures for the years 2018 and 2019 were estimated from information available in the Medium and High Complexity Financial Limit Control System (Sistema de Controle de Limite Financeiro da Alta e Média Complexidade, or SISMAC); (ii) the Action 20AD expenditures for the years 2018 and 2019 were estimated from the increase in the number of Street Clinics implanted between 2017 and 2019 (according to data from the annual reports of the 2016-2019 Multi-Annual Plan); (iii) the Action 20B0 expenditures for 2019 were estimated as being the same as 2018 (representing less than one percent of the FNS' total expenditure, the time series showed decrease in the amount since 2017); and (iv) the Action 6233 expenditures for the years 2018 and 2019 were estimated as being the same as 2017 (representing 0.1 percent of the FNS' total expenditure, the time series showed decrease in the amount since 2015).

[44] TABNET/DATASUS Health Information System: http://www2.datasus.gov.br/DATASUS/index.php?area=02.

[45] Outpatient: 0211100013 Application of Psychodiagnostic Test, 0301070040 Neuropsychological Follow-up of Patient in Rehabilitation, 0301070059 Psychopedagogical Follow-up of Patient in Rehabilitation, 0301070075 Care/Follow-up of Patient in Rehabilitation of Neuropsychomotor Development, 0301010072 Medical Appointment in Specialized Care (Professional–CBO: 06162 Psychiatrist, 225133 Psychiatrist, 223153 Psychiatrist

Box 1. Components of the FNS' expenditure on actions and programs relating to mental health, alcohol, and other drugs—2010-2019.

Medium and High Complexity Block	**MAC**	Action 8585 Action 8535 Action 6233 Action 20B0 Action 20AI Action 20AD
	FAEC **SIH**	Hospital Procedures: Mental Health, Alcohol and other Drugs
	SIA	Outpatient Procedures: Mental Health, Alcohol and other Drugs
Pharmaceutical Assistance Block	**Specialized Component** **Basic Component**	Mental Health Medications

For the years 2017 to 2019, it was necessary to estimate the federal expenditure on specific medications for mental health (federal expenses on the Specialized Pharmaceutical Assistance Component, as well as the Basic Pharmaceutical Assistance Component). The information from the Hórus System (National System of Pharmaceutical Assistance Management, implemented by the SUS) is available only to municipal, state, and federal managers. For this reason, data collected in another study for the years

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Psychoanalyst Psychotherapist), 0301070083 Care in Therapeutic Workshop I for Person with Special Needs (per Workshop), 0301070091 Care in Therapeutic Workshop II for Person with Special Needs (per Workshop), 0301080046 Follow-up of Mental Health Patient (Therapeutic Residence), 0301040036 Group Therapy, 0301080160 Group Psychotherapeutic Care, 0301040044 Individual Therapy, 0301080178 Individual Psychotherapeutic Care. Hospital (Autorização de Internação Hospitalar, or AIH): 0303170018 Diagnosis and/or Urgent Psychiatric Care, 0303170026 Treatment of Acute Intoxication in Users of Alcohol and other Drugs, 0303170034 Treatment of Alcohol Abstinence Syndrome in Referral Hospital Service for Care I, 0303170042 Treatment of Alcohol Dependence in a Referral Hospital Service for Integral Care to Users of Alcohol and other Drugs, 0303170050 Treatment of Abstinence Syndrome for Prejudicial Use of Alcohol and Drugs, 0303170069 Treatment of Mental and Behavioral Disorders Due to the Use of Psychoactive Substances, 0303170077 Psychiatric Treatment (Classification PT GM 251/02), 0303170085 Psychiatric Treatment–in General Hospital (per day), 0303170093 Psychiatric Treatment (per day), 0303170107 Psychiatric Treatment in Day Hospital, 0303170115 Treatment of Patients who Use Cocaine and Derivatives in Referral Care Hospital, 0303170123 Treatment of Patients who Use Cocaine and Derivatives with Comorbidity in Referral Hospital, 0303170131 Clinical Treatment in Mental Health in Situation of High Risk of Suicide, 0303170140 Clinical Treatment for Containment of Disorganized and/or Disruptive Behavior, 0303170158 Clinical Treatment for Diagnostic Evaluation and Therapeutic Adaptation, Including Needs, 0303170166 Clinical Treatment of Mental and Behavioral Disorders Due to the Use of Alcohol, 0303170174 Clinical Treatment of Mental and Behavioral Disorders due to the Use of Crack, 0303170182 Clinical Treatment of Mental and Behavioral Disorders Due to the Use of other Drugs, 0303170190 Short-stay Psychiatric Treatment per Day (Stay up to 90 Days), 0303170204 Psychiatric Treatment per Day (Stay over 90 Days, Admission or Readmission).

between 2014 and 2016 was used.[46] For the years between 2017 and 2019, federal expenditure on medications was estimated.[47]

For the years 2010 to 2013, data published by the publication *Saúde Mental em Dados* was utilized,[48] since it employs a data collection methodology compatible with this study. This methodology does not consider federal expenses linked to court decisions pertaining to the field of mental health, alcohol, and other drugs. Here too the data from each year was recorded on an electronic spreadsheet and adjusted to the equivalent in Brazilian reais for 2019 through application of the IPCA, adjusted to the US dollar exchange rate (commercial - sale) for the end of each year studied.

Hospital expenses versus extra-hospital expenses

Among the FNS expenses relating to the FAEC, those designated "hospital" (AIH–Authorization for Hospital Admission) were considered as such, while those designated "outpatient" were considered "extra-hospital." One exception is Procedure 0303170107 (Psychiatric Treatment in a Day Hospital), which, having been historically treated as a facility for transition to community care, was classified among extra-hospital expenses (representing around 0.3 percent of the total expenditure of both funds in 2019). Spending on medication is also considered extra-hospital.

The six FNS' functional programmatic actions currently related to Ministry of Health's actions and programs for mental health, alcohol, and other drugs were, for their part, considered as extra-hospital (Actions 8585, 8535, 6233, 20B0, 20AI, and 20AD). Although Action 8585 (PO 002) includes the cost for Referral Hospital Services and Care Facilities, the separation of these amounts from the total for the action, which also finances the cost of CAPSad III, is not immediate. Hence, the estimate for the total extra-hospital expenditures should be considered slightly overestimated. FUNAD's spending on TCs was considered hospital expenditure.[49]

RESULTS

FUNAD's federal expenditure on TCs varies according to the presence or absence of a public call notice for funding published in the year studied and the amounts allocated through agreements and direct

[46] Oliveira, "Gastos da política de saúde mental."

[47] Representing around 15 percent of the FNS' total expenditure, the time series has presented a decline since 2014 (various medications began to be bought at lower prices). The figure established for 2016 was considered the benchmark for the years between 2017 and 2019. The information was requested from the Federal Government/Ministry of Health via the Access to Information Law on September 9, 2020; the response obtained on October 2, 2020, however, was incomplete.

[48] *Saúde Mental em Dados* was published in electronic format only by the Ministry of Health/Department of Programmatic and Strategic Actions/National Coordination of Mental Health between 2006 and 2015, comprising 12 issues in total. The last issue is available at http://portalarquivos.saude.gov.br/images/pdf/2015/outubro/20/12-edicao-do-Saude-Mental-em-Dados.pdf.

[49] In general terms, it is the isolation from the outside world combined with long-term stay—practices typical of the TCs—that approximate these institutions to the "hospital" category here. Other practices (limiting the means of communication with the outside world, among others), such as those listed by the Conselho Federal de Psicologia's Report of the National Inspection of Therapeutic Communities, are, for their part, considered by Law 10,216/2001 as asylums—distant from the requirements established for community-based mental health services.

transfers to these institutions on the recommendation of parliamentary amendments. There are two expenditure peaks, one in 2014 and the other in 2018. Even so, it would be incorrect to state that expenses either increased or decreased over the time series, presented in Brazilian reais adjusted to 2019 values, since these expenses oscillated significantly (see Table 1).50 More important, perhaps, is the observation that in each year studied, federal funds were transferred to these entities, with funding available from the FUNAD for this purpose. Likewise, it should be noted that the transfer of funds depends more directly on the action of the federal fund manager and the respective criteria established by this manager.

Table 1. Federal expenditure[a] (FUNAD) on TCs. Brazil, 2010-2019.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
in reais	7.61	14.27	15.61	82.76	104.79	95.09	71.55	68.47	119.58	70.41
in 2019 reais	12.86	22.78	23.40	117.19	140.10	119.48	81.24	73.13	124.06	70.41
in US dollars	4.57	7.61	7.64	35.33	39.45	24.35	21.96	20.70	30.86	17.47

[a] in millions

Sources: Federal Budget Portal; IBGE (annual variation of the Extended National Consumer Price Index); Brazilian Central Bank – Olinda, Agile Data Services Platform (US dollar rate, commercial sale, on the final business day of the year).

Meanwhile, FNS' total federal expenses on actions for the National Policy on Mental Health, Alcohol, and other Drugs, shown in Table 2, presented a total real reduction of 14.7 percent between 2010 and 2019,[51] with a constant decrease in expenses on hospital actions (and stabilization at the end of the period) and oscillation in extra-hospital expenses. The decrease in hospital expenses (64.7 percent between 2010 and 2019)[52] is expected, since the programmed and agreed reduction of beds in hospital psychiatric wards forms part of the policy of the Annual Program for the Restructuring of Hospital Care in the SUS, especially through beds providing poor quality care (as evaluated by the National Program of Hospital/Psychiatry Assessment) in large hospitals.[53]

In the extra-hospital funding series, however, we can identify a 22.6 percent increase in funds between 2010 and 2015 and a decrease in 2016, followed by a stabilization of expenditure until 2019 (when the years 2010 and 2019 are considered, extra-hospital expenses increased by 6.3 percent). It should be noted that the increase in extra-hospital expenses between 2010 and 2015 took place during a period of readjustment in the amounts of the Back Home Program,[54] an increase in the costs for the CAPS[55] and

[50] All the tables and charts were elaborated by the author based on the indicated sources.
[51] Although the time series in Brazilian reais shows a rise in extra-hospital funds between 2010 and 2011 (an increase of around 1 percent), the 2019 series corrects the data, showing an actual decline over the same period. Inflation of around 6 percent between these years accounts for this difference.
[52] For the purposes of analytic comparison, all the observations of variation are based on 2019 values in Brazilian reais, obtained by updating the individual amounts for each year by applying the IPCA, supplied by the IBGE, as explained in the methodology.
[53] For more information, see Ordinance 52/2004; Ordinance 2,644/2009 and Ordinance 404/2019, all issued by the Ministry of Health.
[54] Ordinance 1,511/2013 of the Ministry of Health.

Therapeutic Residences,[56] as well as the institution of other incentives for the RAPS. In the years between 2016 and 2019, extra-hospital expenses, which had tended to rise before, became virtually constant, after a significant decrease. During this same period, hospital expenses, previously on a downward trend, became relatively stable.[57]

Table 2. Federal expenditureª (FNS) on the National Policy for Mental Health, Alcohol and other Drugs. Brazil, 2010-2019.

Type of expenditure		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Extra-hospital	in reais	1,277.49	1,291.09	1,691.32	1,822.44	1,927.85	2,107.82	2,018.02	2,126.13	2,211.13	2,294.79
	in 2019 reais	2,159.49	2,060.68	2,534.73	2,580.53	2,577.47	2,648.32	2,291.04	2,270.93	2,294.05	2,294.79
	in US dollars	766.71	688.29	827.66	777.96	725.79	539.80	619.20	642.72	570.64	569.33
Hospital	in reais	537.96	525.17	496.14	472.99	406.69	362.40	320.17	289.94	306.17	321.00
	in 2019 reais	909.38	838.21	743.55	669.74	543.72	455.33	363.48	309.69	317.65	321.00
	in US dollars	322.87	279.97	242.79	201.91	153.11	92.81	98.24	87.65	79.02	79.64
Total	**in 2019 reais**	**3,068.87**	**2,898.90**	**3,278.28**	**3,250.27**	**3,121.19**	**3,103.65**	**2,654.52**	**2,580.62**	**2,611.70**	**2,615.80**

ª in millions

Sources: From 2010 to 2013, *Saúde Mental em Dados*; from 2014 to 2019; DATASUS/TABNET, Medium and High Complexity Financial Limit Control System (SISMAC); Federal Budget Portal.

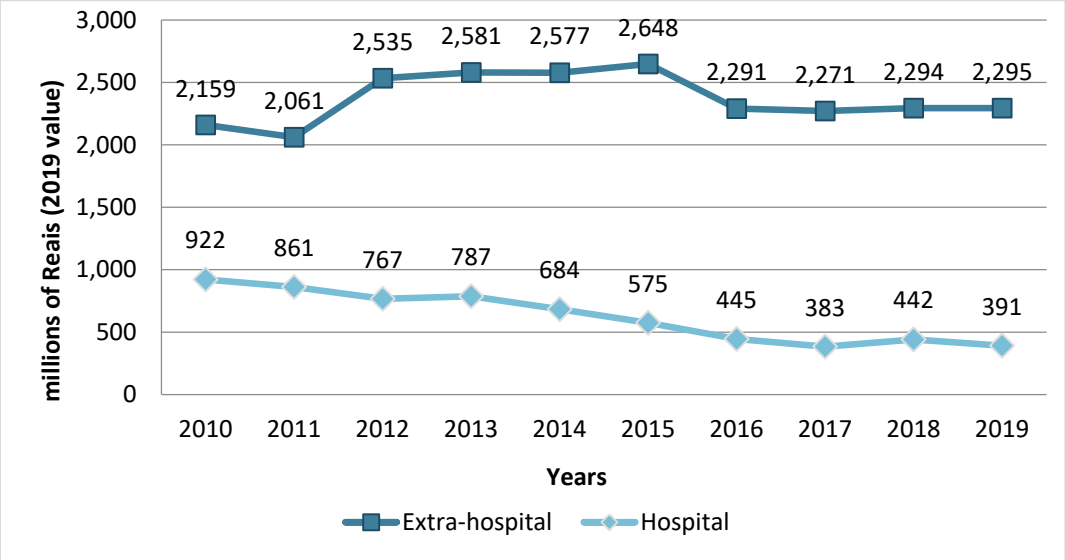
When FUNAD's expenditure on TCs is added to the FNS expenditure on actions and programs for mental health, alcohol, and other drugs (also dividing the expenses between hospital and extra-hospital actions and classifying expenditure on TCs as hospital expenses), it can be seen that the year 2016 inaugurates a period of relative stabilization in the expenses on hospital and extra-hospital actions (Chart 1).

[55] Ordinance 3,089/2011 of the Ministry of Health.

[56] Ordinance 3,090/2011 of the Ministry of Health.

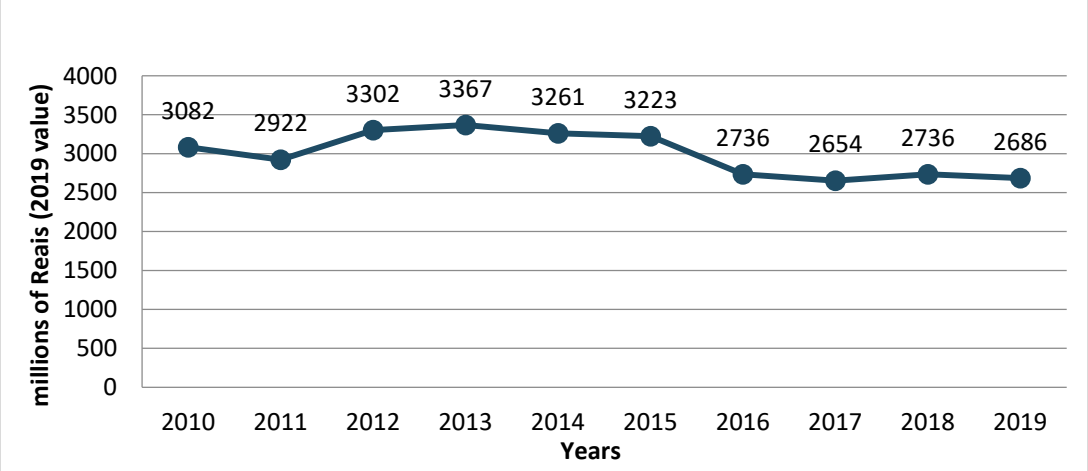
[57] Any analysis of the variation in the adjusted US dollar values requires being aware of the periods of significant devaluation in the Brazilian currency (the years 2019 and 2015, in that order, are those with the largest devaluation in the Brazilian real).

Chart 1. FNS' total expenditure* on actions and programs for mental health, alcohol and other drugs combined with FUNAD's expenditure on TCs: hospital and extra-hospital expenditures. Brazil, 2010–2019.**



*in millions of Reais, 2019 value| **FUNAD's expenditure on TCs are considered as hospital expenses.

Chart 2. FNS' total expenditure* on actions and programs for mental health, alcohol and other drugs combined with FUNAD's expenditure on TCs. Brazil, 2010–2019.**



* in millions of Reais, 2019 value | **FUNAD's expenditure on TCs are considered as hospital expenses.

When comparing the amounts spent by FUNAD on TCs with the estimated expenditure of the FNS only on the costs of CAPSad and CAPSad III in 2019 (around R$292,500.00),[58] we find that FUNAD's

[58] Approximate value. The analysis of Programmatic Action 8585 and its Budget Plans 0002 (Crack, You Can Beat It) and 000F (Psychosocial Care Network–RAPS/CAPS) does not allow an immediate separation of expenditure on specific facilities.

expenditure on TCs corresponds today to approximately 24 percent of the FNS' expenditure on the cost of the CAPS network focused on alcohol and other drugs (CAPSad and CAPSad III).

The decrease in the FNS' extra-hospital expenditure from 2016 cannot be explained solely by the drop in value of the Brazilian currency due to inflation. In the period between 2016 and 2019 there is actually a slight increase in the number of CAPS financed by the Ministry of Health,[59] as well as a temporary interruption in the funding for community-based services,[60] and a sizeable increase in the value of hospital daily rates.[61]

DISCUSSION

So far federal expenditures on TCs have been estimated and elements gathered to ascertain their size and characteristics. This aim in mind, the study also estimated the federal expenditure on actions and programs for mental health, alcohol, and other drugs within the scope of the SUS. Based on the data analyzed here, FUNAD's expenditure on TCs does not come from the health sector and is related either to the issuance of public call notices (more frequent since 2014) or to parliamentary amendments.

Combining FUNAD's expenditure on TCs with FNS' expenditure on actions and programs for mental health, alcohol, and other drugs–in a time series, considering amounts adjusted to 2019 values–as part of the virtual category *total federal expenditure*, it can be surmised that the amounts obtained overall have helped stabilize the category of hospital expenditure over the final years of the series, albeit not decisively. The tendency for stabilization of hospital expenditure seems to be due rather to the recent health sector policy (since 2017) of recomposing the daily hospital rates for psychiatric care, as shown by the data cited earlier.

Estimating FNS' expenditure in 2019 with the funding of CAPSad and CAPSad III alone and comparing this amount with FUNAD's expenditure on TCs during the same year, it is clear that the latter represents approximately 24 percent of the Ministry of Health's expenditure on the cost of the CAPS network dedicated to the issue of alcohol and other drugs.

The time series of FNS' expenditure on actions and programs for mental health, alcohol, and other drugs, for its part, shows some worrying trends: on one hand, a decrease and stabilization of extra-hospital expenditure from 2016 onward; on the other, stabilization of hospital expenditure. The health funding for community-based services in the field of mental health, alcohol, and other drugs has not increased over recent years, with a substantial loss of funds between 2015 and 2016. This is the context in which the federal government has financed TCs.

Earlier studies[62] showed that there was no decline in federal resources for the National Policy for Mental Health, Alcohol, and other Drugs between 2001 and 2009, a period in which mental healthcare in Brazil

[59] Cruz, Gonçalves, and Delgado, "Retrocesso da reforma psiquiátrica."
[60] The Ministry of Health's Ordinance 3,659/2018 suspended the financial transfer to 72 CAPS, 194 SRTs, 31 Care Facilities, and 22 Mental Health Beds in General Hospital due to an absence of records of procedures in the SUS information systems. This ordinance was later revoked by Ordinance 2,387/2019 of the same ministry.
[61] The Ministry of Health's Ordinance 3,588/2017 increased the value of the daily rates of psychiatric admissions by around 60 percent.
[62] Gonçalves, Vieira, and Delgado. "Política de Saúde Mental no Brasil."

was redirected following Law 10,216/2001 (the Psychiatric Reform Law). On the contrary, there was a real growth (of 51.3 percent) in the resources invested in mental health, albeit in a broader scenario of underfunding of the SUS.[63] The present study reveals that over the subsequent period from 2010 to 2019 there was a decrease of 14.7 percent and a stabilization of FNS' expenditure on mental health, alcohol, and other drugs, especially from 2016 onward, the moment when the budget restrictions for the SUS deepened further due to promulgation of Constitutional Amendment 95/2016, which curbed social investments in the country for twenty years.

This is the context in which the federal public funding of TCs must be understood. The federal government allocates public resources, coming from FUNAD, to a treatment model based on isolation and possible institutionalization, while expenditure on community-based care for people with problems arising from the use of alcohol and other drugs in the ambit of the SUS has stabilized at a lower level, in a framework of large budget constraints for health sector funding. Simultaneously, there has been intense pressure on the SUS to finance TCs by itself with funds from the FNS.

Up to now, the field of mental health, alcohol, and other drugs has managed to prevent the funding of TCs through the FNS/SUS–in compliance with the deliberations of the National Conferences on Mental Health held in 1988, 1992, 2002, and 2010. In contrast, there has been clear consolidation of the financing of TCs with funds from FUNAD (with municipal and state public funding of TCs an already established fact). The data presented here verifies a decline in funding and a recent stabilization of federal expenditure from FNS/SUS on public mental health policies while at the same time showing the consolidation of TC funding through FUNAD.

[63] Treasury, https://sisweb.tesouro.gov.br/apex/f?p=2501:9::::9:P9_ID_PUBLICACAO:28265. Public expenditure on public health in Brazil is historically inferior to the volume of resources employed in countries with universal healthcare systems (like the United Kingdom and Sweden, for instance). This difference between what is ideally necessary for the SUS and what is effectively spent in the system has been called a "defunding" or "underfunding" of the SUS by the public health field since its implantation. The Pan-American Health Organization (PAHO) recommends that investments in public health correspond to 6 percent of the country's Gross Domestic Product (GDP). In 2009, Brazil spent just 3.4 percent of its GDP on public health. In 2015, this expense was around 3.8 percent of GDP. Brazil, Tesouro Nacional. *Aspectos Fiscais da Saúde no Brasil* (Brasília: Tesouro Nacional, 2015).

INSPECTION OF THERAPEUTIC COMMUNITIES BY A MUNICIPAL HEALTH REGULATORY AGENCY AND ITS PRACTICAL IMPLICATIONS: THE CASE OF A LARGE BRAZILIAN MUNICIPALITY

JARDEL FISCHER LOECK[1]

In the first two decades of the twenty-first century, Brazil witnessed two distinct movements in the area of public policies related to therapies for people with disorders associated with the use of psychoactive substances.[2] Since the introduction of the Psychiatric Reform Law in 2001[3] and the enactment of the Ministry of Health's Policy for Comprehensive Care for Users of Alcohol and Other Drugs in 2003,[4] public policies in the sector were aimed toward community-level care, avoiding long-term hospitalization as a preferential measure. However, from 2010 a gradual shift back in the opposite direction was discernible.[5]

Over this period, Brazilian therapeutic communities (TCs) began to receive federal public funding[6] while also being integrated into the public healthcare system for drug users, as established in official public policies via the Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS).[7] This movement became stronger and more substantial from 2016—since then, regulatory changes have been accompanied by alterations to the design of public policies on drugs and mental healthcare. Some of the consequences include the fact that psychiatric inpatient treatments have, in general, reverted to being a

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[2] No single standardized definition exists of these disorders. The main diagnostic manuals in clinical medicine (CID-11) and psychiatry (DSM-V) contain their own specific definitions of what constitutes problematic or harmful use of psychoactive substances. Seeking to avoid strict diagnostic categories, here they are taken as people whose use of psychoactive substances becomes associated with harm—whether physical, psychological, or social—and whose life trajectories converge with therapeutic processes designed to respond to these issues.

[3] Law 10,216/2001, which "Regulates the protection and rights of people with mental disorders and redirects the care model for mental health."

[4] Ministry of Health, "A política do Ministério da Saúde para Atenção Integral aos usuários de álcool e outras drogas" (Brasília: Ministério da Saúde, 2004).

[5] These time frames are used for the purposes of contextualization. Analyzed in more depth, these movements present a mixture of diverse elements and a series of ebbs and flows. The year 2010 is commonly used as a reference for the launch of the federal program "Crack, you can beat it," which demarcates the start of some of these changes. For more details on the evolution of the regulatory framework over the years, see the article by Noelle Coelho Resende in this series.

[6] Partnerships between TCs and municipal and state administrations have been recorded in different parts of Brazil prior to this period. These earlier partnerships should be considered not as a type of systematic integration but simply as one-off arrangements.

[7] Ministry of Health's Ordinance 3,088/2011, which: "Institutes the Psychosocial Care Network […] with the aim of creating, expanding and interconnecting healthcare points for people with mental health issues or mental disorders and with needs arising from the use of crack, alcohol and other drugs, as part of the Unified Health System [*Sistema Único de Saúde*: SUS]."

common procedure for treating mental suffering,[8] while TCs have been considered, from a public policy perspective, a leading therapeutic option for users of psychoactive substances who develop disorders associated with their use.[9]

Another important landmark occurred in 2011 when the National Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, or ANVISA) published Board of Director's Resolution (Resolução da Diretoria Colegiada, or RDC) 29/2011,[10] which currently "regulates the health safety requirements for the operation of institutions that provide care services to people with disorders arising from the use, abuse, or dependence on psychoactive substances." With federal public funding now available, the issue of health permits for TCs became an important instrument for legitimizing and institutionalizing these entities vis-à-vis the state. The permit was needed for their accreditation, together with compliance with a series of specific requirements stipulated in federal, state, or municipal public biddings.

This article analyzes the formal and regulatory processes involving health surveillance by health regulatory agencies (*vigilância sanitária*) and TCs, while also examining how health surveillance initiatives are put into practice at the municipal level. The aim is to understand the role of health regulatory agencies in the process of supervising and institutionalizing TCs as a mode of treatment for the disorders associated with the use of psychoactive substances. This aim in mind, the article is based on qualitative empirical research, using diverse sources of data (documents, legislation, specialized literature, and interviews with employees of the municipal health regulatory agency). Ultimately, the study concludes that due to the organization of supervision of TCs, important regulatory and supervisory loopholes exist which allow precarious institutions to continue to emerge and operate outside the regulatory control of the state.

The article begins by discussing the theoretical and methodological dimensions of the research, problematizing the role of health surveillance as an instrument of state bureaucracy, and indicating how anthropology can assist in understanding this type of phenomenon. Next, the article contextualizes the powers and responsibilities attributed to health regulatory agencies in Brazil, briefly exploring the different statutory instruments that have regulated TCs in recent years. Finally, the article goes into a more detailed examination of the health inspection process at the municipal level, and its implications, deepening the analysis of the data obtained from interviews. This discussion highlights some important observations, the most significant of which is the large number of entities on the fringes of regulation.

THEORETICAL AND METHODOLOGICAL ASPECTS OF THE RESEARCH

The present research is based on qualitative methodologies of data production and analysis,[11,12] and makes use of diverse data sources, namely: documentary research, teaching material for a TC Inspection

[8] Fernando Sérgio Pereira de Sousa and Maria Salete Bessa Jorge, "O retorno da centralidade do hospital psiquiátrico: retrocessos recentes na política de saúde mental," *Trabalho, Educação e Saúde* 17, no. 1 (2019): 1–19, https://doi.org/10.1590/1981-7746-sol00172.

[9] Nelson Falcão de Oliveira Cruz, Renata Weber Gonçalves, and Pedro Gabriel Godinho Delgado, "Retrocesso da reforma psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019," *Trabalho, Educação e Saúde* 18, no. 3 (2020): 1–20, https://doi.org/10.1590/1981-7746-sol00285.

[10] ANVISA RDC 29/2011.

[11] Uwe Flick, *Desenho da pesquisa qualitativa* (Porto Alegre: Artmed, 2009).

Best Practices Course designed for health surveillance professionals,[13] and interviews conducted with health surveillance officers with TC inspection experience in a large Brazilian municipality.[14]

The bibliographic and documentary research considered the existing legislation on TCs, as well as earlier regulatory frameworks, which guide the health regulatory agency's inspection processes and its issuing of permits to TCs. The material from the Best Practices Course helped interpret existing regulations and also provided a benchmark for what a health inspection in a TC ideally sets out to achieve. Additionally, the in-depth interviews aimed to collect accounts of the actual practices of health surveillance professionals in a large municipality, focusing on their work routines and the situations experienced while performing their role as health inspectors. This focus on the experience of individuals carrying out their duties not only complemented but also added empirical depth to the analysis, revealing situations that mere documentary analysis would not allow to be glimpsed.

The theoretical background for this study comes from anthropology, specifically its debates on phenomena like public policies and state bureaucracy, including how the latter makes its presence felt in everyday life. Here, the health regulatory agencies are taken as representatives of state power, responsible for ensuring compliance with regulations designed to mitigate risks to the population's health that derive from the circulation or availability of goods and services in particular kinds of establishments. The analytic interest in these processes goes beyond simply noting the existence of particular norms or verifying compliance with them.

Some authors have called attention to the proliferation of "policy" in the discourse of everyday life. In the corporate business world and the world of government alike, "policies" are depicted as guiding principles for action with a particular kind of rationality. Social sciences, especially anthropology, according to these authors, allow these assertions to be relativized and observed along with the political effects of these declarations about reality: "An anthropological approach attempts to uncover the

[12] Jean Poupart, Jean-Pierre Deslauriers, Lionel-H. Groulx, Anne Laperriére, Robert Mayer, and Álvaro P. Pires, *A Pesquisa Qualitativa: enfoques epistemológicos e metodológicos* (Petrópolis: Vozes, 2012).

[13] Hospital Moinhos de Vento – Educação e Pesquisa, "Inspeção em Comunidades Terapêuticas," accessed February 16, 2021, https://edx.hospitalmoinhos.org.br/course/inspecao-em-comunidades-terapeuticas. The course forms part of the EAD ANVISA Good Practices Project, which offers diverse free courses, stemming from the partnership between ANVISA and the Moinhos de Vento Hospital, and financed by the Ministry of Health. The first course focused on TCs was offered in May 2020 with the following proposal: "The main objective of this course is to train health surveillance (VISA) professionals to implement health initiatives in therapeutic communities, aiming to ensure the resident's safety. During the course, you will be oriented to identify the main situations that may appear in the inspections and the aspects that cannot be forgotten. This course is expected to assist the team in making decisions during the inspections. Target public: VISA professionals, professionals of mental health services, and partners."

[14] The research was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa, or CEP) of UNISINOS, the university with which the author is affiliated, as well as by the CEP of the municipality where the research was conducted. The in-depth interviews, guided by a semi-structured script, were conducted in November 2020 through audio or video calls. All the participants declared their agreement with the research project's Free and Informed Consent Form before the interviews were held. The material was recorded and later transcribed for analytic purposes. As usual, the anonymity of the participants has been assured.

constellation of actors, activities, and influences that shape policy decisions and their implementation, effects, and how they play out."[15]

Mendes de Miranda,[16] discussing contemporary state bureaucracy as a field of study for anthropology, emphasizes how, in conjunction with the implementation of a state apparatus, a legal culture also forms, and how this culture, beyond the regulatory framework, contributes to the expression and resolution of conflicts. The author goes further, highlighting the wealth of detail obtainable through studying the actions of civil servants and other representatives of the state apparatus—an approach already proposed by Lipsky in 1980.[17] Their actions may well express conflicts and inconsistencies, which suggest the need to avoid premising analyses on the homogeneity of the modern state, or its primacy over other social actors. Inspired by Marc Abelés, Mendes de Miranda also suggests that "it is a question, therefore, of employing another strategy: understanding the plurality of roles that the state, and its different forms of government, has performed as social practices."[18]

Bierschenk and de Sardan, reflecting on the ethnographic approach to bureaucracies, argue that it "should take into account the double face of bureaucracy, as a form of domination and oppression as well as of protection and liberation, and all the ambivalences this entails."[19] The viewpoint of the actors is valorized here, whether they be bureaucrats themselves (state representatives), or the "clients" of the state apparatus. In their words: "An ethnographic study of bureaucracies which focusses on actors and practices… will necessarily highlight bureaucracies as heterogeneous social fields of contention and thereby deconstruct overly coherent forms of the bureaucracy-idea."[20] Another important question raised by Bierschenk and de Sardan, one that touches on the present research, is that "the rich literature on health professionals is almost always embedded in a public health perspective… not linked to an anthropology (or sociology) of public institutions or the state."[21]

Didier Fassin also appeals to an empirically constructed theory of the state that takes into consideration the diversity of rationalities that may exist within it: "The state, we believe, is what its agents do under the multiple influences of the policies they implement, the habits they develop, the initiatives they take, and the responses they get from their publics."[22] The author points to a moral dimension of institutions to be explored empirically: "how institutions assess and feel, so to speak."[23] This aim in mind, he

[15] Janine R. Wedel, Chris Shore, Gregory Feldman, and Stacy Lathrop, "Toward an Anthropology of Public Policy," *ANNALS of the American Academy of Political and Social Science* 600, no. 1 (2005): 39, https://doi.org/10.1177/0002716205276734.

[16] Ana Paula Mendes de Miranda, "Antropologia, Estado Moderno e Poder: perspectivas e desafios de um campo em construção," *Avá. Revista de Antropología*, no. 7 (2005): 1–27, Redalyc, https://www.redalyc.org/articulo.oa?id=169021460008.

[17] Michael Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (New York: Russell Sage Foundation, 1980).

[18] Mendes de Miranda, "Antropologia, Estado Moderno e Poder," 11.

[19] Thomas Bierschenk and Jean-Pierre Olivier de Sardan, "How to Study Bureaucracies Ethnographically?" *Critique of Anthropology* 39, no. 2 (2019): 244, https://doi.org/10.1177%2F0308275X19842918.

[20] Ibid., 251.

[21] Ibid., 252.

[22] Didier Fassin, "Can States be Moral? Preface to the English Edition," in *At the Heart of the State: The Moral World of Institutions,* ed. Didier Fassin (London: Pluto Press, 2015), x.

[23] Didier Fassin, "Introduction: Governing Precarity," in *At the Heart of the State: The Moral World of Institutions*, ed. Didier Fassin (London: Pluto Press, 2015), 8.

suggests foregrounding two concepts: *moral economy* and *moral subjectivity*, the former representing "the production, circulation, and appropriation of values and affects regarding a given social issue," and the latter referring to "the processes by which individuals develop ethical practices in their relationships with themselves or others."[24] Here these concepts will help comprehend the dilemmas faced by the research interlocutors in making decisions in their day-to-day work.

In sum, the idea of the present article is to examine the regulations, their evolution, and the parameters defining their application—but, ultimately, to ascertain the processes involved in their application to the TCs by a municipal health regulatory team. Emphasis is given to the viewpoint of the supervisory agents, the people who, in practice, are inspecting these localities. The primary focus is on the multiple processes engendered by this encounter between a body of legislation, a supervisory institution, the state employees putting this structure into practice, and the TCs themselves as an object of intervention. In analytic terms, the interest here is in the inspection processes themselves, rather than the processes that led to the health regulations or the public health policies that came to include TCs.

Some of the reflections made by people during the interviews will be used to illustrate particular aspects of the discussion contained in the following sections of the article, in dialogue with the literature and with the documents pertaining to the processes of regulating and inspecting the TCs. The research was carried out in a large municipality in the south of Brazil, whose Municipal Health Department includes a Health Regulatory Coordination Office (Coordenadoria Geral de Vigilância em Saúde)[25] whose broad structure is divided into three areas—environment, epidemiology, and health—with each area possessing separate teams for specific themes. In the health area, for example, there are teams for food, engineering, health-related products, and the surveillance of health-related services.[26] The research's interlocutors were the members of the team responsible for inspecting these "health-related services."

These interlocutors unanimously recognized that the team is small given the large and ever-expanding sphere in which it works, since new TCs have emerged over the years requiring even more inspections. Additionally, a field of irregular institutions is also growing. They stress too that, beside the TCs, the team has to inspect other services classified as "health-related." In other words, there is no team exclusively focused on those entities, nor employees who necessarily possess training or professional experience in the field of care for users of psychoactive substances.

The universe of entities inspected by these health surveillance agents, as estimated by them, is eight TCs—five of which are currently regular, two in the process of regularization, and one recently

[24] Fassin, "Introduction," 9.

[25] Fundação Oswaldo Cruz, "Vigilância em Saúde, Pense SUS," accessed February 16, 2021, https://pensesus.fiocruz.br/vigilancia-em-saude. "In the healthcare field, surveillance is related to practices of care and promotion of the health of citizens and to the mechanisms adopted to prevent diseases. Additionally, it includes diverse areas of knowledge and tackles different themes like policy and planning, territorialization, epidemiology, the health-disease process, the living conditions and health situation of populations, environment and health, and the work process. On this basis, surveillance is distributed between: epidemiology, environment, sanitation, and worker health."

[26] The latter is also divided into services of high complexity (hospitals, laboratories, etc.), medium complexity (nursing clinics, odontology, physiotherapy, etc.) and low complexity (non-surgical clinics, home care services, etc.), and also health-related services (hairdressers, nursing homes for the elderly, TCs, tattoo studios, etc.).

discovered irregular. They also estimate that at least ten other irregular entities exist,[27] which would also be within the scope of the same work team. These irregular entities have helped capture individuals considered undesirable or disposable in urban environments, subject to processes that "make disappear those who clash with the project of the clean, modern city, in partnership with the private sector," as Mallart et al. point out.[28]

The advent of the Covid-19 pandemic prevented a short period of ethnographic fieldwork from being carried out. However, the anthropological perspective remains as the basis for the interpretation of the analyzed data and for the construction of the argument presented here. The experiences of the health surveillance officers are considered, specifically regarding the TC inspections. The focus is on these effective experiences within their specific institutional context. The examination of the data does not set out to produce sweeping generalizations, but seeks to analytically explore concrete problems identified by the interlocutors.

HEALTH REGULATORY AGENCIES AND THEIR RESPONSIBILITIES IN RELATION TO TCS

Health surveillance in contemporary Brazil is based on a legal framework whose underlying structure dates back to the 1970s,[29] although it has been modified since then. At that time, unlike today, there was no national health surveillance system, nor any attribution of supervisory activities to the municipalities. Previously, powers were divided between the state and federal spheres only and were essentially concentrated on inspecting products, with inspection of health-related services gradually added to their remit over the years.

At the federal level, ANVISA was created in 1999, tasked with health surveillance activities, while the Ministry of Health's Health Surveillance Secretariat (Secretaria de Vigilância em Saúde, or SVS) was given responsibility for all other health surveillance activities in the country (surveillance of risk factors for the development of non-transmissible chronic diseases; environmental health surveillance; worker health surveillance; analysis of the health of the Brazilian population; and the National Immunization Program).[30] In 1999 the process of decentralizing health surveillance actions also began, which led to municipalities restructuring their teams to perform these functions. Some activities, previously managed and executed by federal and state employees, began to be increasingly assumed by staff from the health surveillance teams in the municipal health offices, albeit with problems in terms of funding and the distribution of responsibilities.[31]

Currently, the National Health Surveillance System is organized as follows: at the federal level, ANVISA; at the state level, the twenty-seven health regulatory agencies of the state health departments; at the

[27] These are institutions that cannot be classified precisely as TCs but provide care services similar to the TCs or catering to the same public.
[28] Fábio Mallart, Marina Mattar, Taniele Rui, and Vera Telles, "Fazer sumir: políticas de combate à Cracolândia," *Le Monde Diplomatique Brasil*, July 11, 2017, https://diplomatique.org.br/fazer-sumir-politicas-de-combate-a-cracolandia/.
[29] Law 6,360/76, which: "Regulates the Health Surveillance of Medications, Drugs, Pharmaceutical Inputs and Correlates, Cosmetics, Sanitizing Products, and Other Products, and sets out other provisions."
[30] José Agenor Alvares da Silva, Ediná Alves Costa, and Geraldo Lucchese, "SUS 30 anos: Vigilância Sanitária," *Ciência e Saúde Coletiva* 23, no. 6 (June 2018): 1955–56, https://doi.org/10.1590/1413-81232018236.04972018.
[31] Da Silva, Costa, and Lucchese, "SUS 30 anos."

municipal level, the health regulatory services, which vary enormously according to structural specificities, resources, and operational capacity.[32] In general, larger municipalities with more financial resources possess more structure and capacity, especially human resources, to carry out their work.

Although it is common to associate health surveillance exclusively with inspection processes and policing powers,[33] our understanding of its role needs to look beyond this basic function. As Fonseca observes,[34] health surveillance is guided by the same Unified Health System (Sistema Único de Saúde, or SUS) guidelines, which indicate cooperation "with other sectors in healthcare, education, and law, among others, for the promotion of health." In other words, from the perspective of health conceived as a collective good, as advocated by the SUS, health surveillance actions perform an important role in preventing risks to collective health.

Obtaining a clearer understanding of the inspections performed by health regulatory agencies, therefore, requires consideration of a series of factors. The technical and administrative regulations, for example, encompassing codes of conduct, laws, and norms, establish the guidelines for supervisory processes. As Costa and Rozenfeld point out,[35] this regulatory and supervisory apparatus is based on the verification of situations with the potential to pose risks to individual or collective health: products and their fabrication and circulation; ports, airports, and borders; the provision of services directly or indirectly related to health; waste management; the consumption of natural resources and environmental interventions; as well as health risks in work environments. The control and inspection actions are complemented by other resources besides legislation and technical standards, including "communication and health education, information systems, monitoring of the quality of products and services, epidemiological surveillance of adverse events related to work conditions, environmental conditions, and the consumption of medical technologies, water and foods."[36]

In other words, in addition to administrative policing powers, health surveillance performs an educational role, which is a fairly common practice in the case of the TCs. Municipal health surveillance thus encompasses both the state agent who monitors the TCs more systematically, adopting a "policing" approach and imposing sanctions and penalties, and the agent who educates, assisting in the process of improving these locations and, therefore, approximating and including them in the state fabric itself–the left hand and right hand of the state, in Bourdieu's terms.[37] Currently, however, the limit to the range of supervision of TCs is set precisely by how these entities are legally classified within the complex meanderings of the state bureaucracy. As examined below, the TCs are inspected as "health-related services," a classification that implies a less demanding inspection process compared to health services per se.

[32] Marismary Horsth De Seta, Vera Lúcia Edais Pepe, and Gisele O'Dwyer de Oliveira, eds., *Gestão e vigilância sanitária: modos atuais do pensar e fazer* (Rio de Janeiro: FIOCRUZ, 2006).

[33] Policing in the administrative sense—applying fines, issuing infraction reports, and administering penalties, but not penal sanctions leading to imprisonment. If crimes are involved, the relevant police authorities must be notified.

[34] Emilio Prado Fonseca, "Novos Rumos Para a Pesquisa Em Vigilância Sanitária No Brasil," *Vigilância Sanitária Em Debate: Sociedade, Ciência & Tecnologia* 1, no. 2 (2013): 25, https://visaemdebate.incqs.fiocruz.br/index.php/visaemdebate/article/view/27.

[35] Ediná Alves Costa and Suely Rozenfeld, "Constituição da vigilância sanitária no Brasil," in *Fundamentos da Vigilância Sanitária*, ed. Suely Rozenfeld (Rio de Janeiro: FIOCRUZ, 2000), 15–40.

[36] Ibid., 18.

[37] Pierre Bourdieu, ed., *Sobre o Estado* (São Paulo: Companhia das Letras, 2014), 656.

SUPERVISORY REGULATIONS FOR TCS

The TCs seek to promote the subjective-moral transformation of individuals who use psychoactive substances in ways considered harmful or problematic. In these spaces, the cultivation of spirituality for those undergoing treatment is taken to be essential, along with complete abstinence from the use of any psychoactive substances, as the "Profile of Brazilian therapeutic communities" indicates.[38] Other common features observed among these institutions are: social isolation (whether in rural regions or urban centers) during the period of stay; the cultivation of close daily interaction between peers as a therapeutic instrument; the cultivation of order and discipline in everyday life; and the use of work as a therapeutic tool (labor therapy). "Work, discipline, and spirituality," or related terms, are used by the TCs themselves to define the scope of their therapeutic mission.

These entities generally work to induce a kind of moral-subjective transformation guided by religious-spiritual principles. However, it is important to register the increasing absorption of concepts and practices of a technical-scientific (biomedical) nature in these institutions. In many TCs today, as well as the shared characteristics already identified, there are elements that indicate mixed environments with both religious-spiritual and technical-scientific characteristics: the use of the biomedical discourse on disease; the presence of professionals from the areas of healthcare and psychology; the use of individual and group therapies based on psychology; and the use of psychiatric medications.[39] Elsewhere, it has been suggested that sin and illness become mixed in these cases to some extent, which has a number of important implications for the therapeutic process as a whole.[40]

Although TCs have been active in Brazil since the end of the 1960s, it was not until the beginning of the twenty-first century that TCs were subjected to operational norms and rules. The norm that currently regulates the supervision of these institutions is ANVISA RDC 29/2011,[41] which replaced RDC 101/2001. Among the supervision and inspection requirements, contained in both ANVISA resolutions, the following are most notable: possession of an up-to-date health license (permit); a technical manager with a college degree employed among the staff; human resources compatible with the number of residents; staff training; organization of the service; a therapeutic program matching the physical structure and human resources available; assistance procedures; relationships with the public health system; elements of physical infrastructure; respect for resident confidentiality and anonymity; eligibility criteria for admission; and the administration of medications.

Comparing the two ANVISA resolutions cited above, it becomes clear that some demands and requirements were relaxed. While the older resolution established the obligation for a document describing the therapeutic program, specifying set activities and their respective frequency, the current

[38] IPEA – Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017), 25, https://www.ipea.gov.br/portal/images/stories/PDFs/nota_tecnica/20170418_nt21.pdf.

[39] IPEA, *Nota Técnica nº 21*, 21–22.

[40] Jardel Fischer Loeck, "Comunidades Terapêuticas e a transformação moral dos indivíduos: entre o religioso-espiritual e o técnico-científico," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 77–100.

[41] It is important to emphasize ANVISA RDC 29/2011 takes into consideration other norms that are not examined here since they do not pertain to the topic under analysis. For a detailed study of these norms, see the article by Noelle Resende in this series.

RDC 29/2011 abandons the term "therapeutic program" and requires only the record of activities on the resident's card, without defining any fixed schedule. A loosening of conditions was also identified apropos the requirement for the institution to have a technical manager with a college degree: while RDC 101/2001 stipulated a professional with an undergraduate degree specifically in healthcare, the current resolution allows undergraduate training in any area, thus diluting the kind of care that TCs can offer.

Analyzing the two norms comparatively, the most significant alteration is how the TCs are classified for the purposes of health inspections. While in the previous resolution they were labelled "healthcare establishments," in the current resolution they come under "health-related establishments," which entails a series of less stringent requirements in the supervisory processes, as identified above.

ANVISA considers the services provided by "health-related establishments" as "activities that, due to associated risks or the vulnerability of the public they serve, can cause harm or worsen the health of citizens, whether directly or indirectly."[42] As well as the TCs, this category also includes Long-Term Care Institutions for the Elderly (Instituições de Longa Permanência para Idosos, or ILPIs),[43] beauty salons and aesthetics clinics, tattoo studios, and child education establishments like nurseries, as well as gyms, among other facilities providing personal services to citizens, outside the hospital or clinical context, which may pose health risks to users. The TCs and ILPIs are covered by specific regulations, established by ANVISA—namely, the aforementioned RDC 29/2011 vis-à-vis TCs.

Comparing the TCs with the other establishments with the same regulatory classification, the former are the only kind whose primary activity is some form of therapeutic practice. Even the ILPIs–which are the kind of establishment closest to the TCs–cannot be considered providers of *therapeutic services*. The fact that the TCs set out to offer "therapy" for a condition considered pathological would, perhaps, be a sufficient argument by itself for another kind of regulatory classification of these institutions by the health authorities. The idea that it involves an exclusively non-medical therapy is unsustainable. As pointed out previously, very often they are spaces in which disease and sin merge in the adopted approach.

This is the set of norms, then, that regulate the health surveillance of the TCs. But when are these rules applied? What is the health surveillance inspection process like? According to the TC Inspection Best Practices Course,[44] health inspections can be classified as follows according to their motive for being conducted: (1) a routine action or supervision program; (2) action solicited by the TC itself for licensing or regularization purposes; (3) action required following a complaint presented to the Health Regulatory Agency's Ombudsman, Public Prosecutor's Office, Judiciary, or to a Public Security body; (4) a taskforce or similar; (5) monitoring of supervisory actions. The analysis below examines the inspections

[42] Agência Nacional de Vigilância Sanitária, "Biblioteca de temas serviços de interesse para a saúde," accessed February 16, 2021, https://www.gov.br/anvisa/pt-br/assuntos/regulamentacao/legislacao/bibliotecas-tematicas/arquivos/servicos-de-interesse.

[43] The ILPIs are government or nongovernment residential institutions intended as collective homes for people aged 60 or over, with or without family support, respecting their rights to liberty, dignity, and citizenship.

[44] Hospital Moinhos de Vento – Educação e Pesquisa, "Inspeção em Comunidades Terapêuticas." Access to the course material is restricted, available to enrolled participants only. As a researcher, the author enrolled in the course and was able to access the material.

undertaken for issuance or renewal of a health permit, and then turns to those motivated by a complaint.

ISSUANCE OR RENEWAL OF THE HEALTH PERMIT AND ITS IMPLICATIONS

Health licensing, as a "legal act that allows establishments to operate following verification of their compliance with legal and regulatory requirements," is an obligatory requisite for executing any service related to health or that may pose risks to health.[45] This process is undertaken through the issuance of the health permit, which depends on an inspection by the municipal health regulatory authority.[46] During the inspection, various kinds of adaptations may be solicited before the license is granted. These inspections are based on an "inspection script" covering diverse items, which, in the case of the TCs, takes ANVISA RDC 29/2011 as a guide.

A study undertaken in the Goiânia region showed that just eleven of a total of twenty-eight TCs were operating with a current health permit, while another thirteen were waiting for the document to be processed; four TCs in the city were operating irregularly without a health permit.[47] The data indicates that some TCs start operating before obtaining their respective health permits, meaning that there may be entities functioning that are placing at risk the health of individual residents. When questioned about this situation, one inspection officer replied:

> Our work is not just policing, it's also educational. We try to build, help the institution to follow the laws. Very often the process is quite lengthy. But when we see that there is an interest [in adapting], that the person is involved, that "the wheel is turning," as the expression goes, then we continue to monitor its evolution. Until it gets the health permit. Indeed, five of the eight [TCs] that we have [in the municipality] already have a permit, two are being processed, and there is one now, during the pandemic, where there was a complaint, and we're going to have to look at it.

His colleague reported the following:

> Normally when they make the request for a permit, based on what I've observed so far, they are already up and running. They request the permit when they manage to produce all the paperwork […] When all their documents are in order, they come to us to request the inspection part. And this inspection can generate a report that contains numerous situations for them to sort out, many non-compliances for them to resolve. And this may take one, two, or three months for them to complete. Only then do we give the OK and issue the permit. So, it's a long

[45] ANVISA RDC 207/2018, which "Regulates on the health surveillance actions performed by the Federal Government, States, Federal District, and Municipalities, relating to the Authorization for the Operation, Licensing, Registration, Certification of Best Practices, Supervision, Inspect and Regulation, in the sphere of the National Health Surveillance System—SNVS."

[46] According to ANVISA RDC 207/2018, "health surveillance actions related to establishments, products and services with a low health risk should be undertaken by the municipalities," while those involving high-risk health situations should be shared between states and municipalities. The TCs are classified under the first category.

[47] Lara Dias Cavalcante, Maria Eduarda Debiazzi Bombardelli, and Rogério José de Almeida, "Condições sanitárias de comunidades terapêuticas para tratamento da dependência química," *Vigilância Sanitária em Debate 4*, no. 2 (2016): 46, doi: 10.3395/2317-269x.00587.

> process. Not to mention those that only begin the permit process after we discover the place by some other means and notify them that they need to solicit a permit. Sometimes, they are discovered like that, in other ways.

The statements by both interviewees corroborate that some institutions are operating in non-compliance with health regulations, which may indicate other kinds of issues as well. In other interviews, there are also indications that, unless the inspectors discover extremely serious instances of human rights violations, the process of issuing or renewing the health permit continues with the institution allowed to remain open with residents. In some cases, depending on the seriousness of the infractions involved, the TC may be asked to halt resident intake until violations are resolved.

The two statements also show how health regulatory agencies function as an important intermediary in the processes of institutionalizing TCs vis-à-vis the Brazilian state apparatus, given that these agencies expressly indicate which paths an establishment needs to follow to obtain health licensing. This, in turn, can lead to the receipt of public funding, for example.

Another important piece of evidence along these lines is found in the teaching material for the Best Practices Course cited earlier:

> Irrespective of the reason for the action, it should be noted that, as inspectors with an administrative police power, the relationship with the inspected establishment is asymmetric and, consequently, we need to take care when carrying out the action. This care is justified by the history of assistance provided by TCs, when the State was largely absent, and the approach was frequently more religious than therapeutic. The legislation introduced a set of guidelines, and now the health regulatory agency needs to administer and articulate the transition to the current directives and the conducting of the regularization process.

It can be inferred, therefore, that ANVISA has transferred this role to municipal health regulatory agencies, since it is these local bodies that monitor the TCs in Brazil more closely. Nonetheless, the attribution of these functions almost exclusively to municipal health regulatory agencies may not be the best solution. In reality, it may leave unoccupied spaces—vacuums in the inspection process—that are also seen when we consider the lack of careful examination of the everyday life of the TCs and the therapeutic processes that unfold in them in the name of a "interaction between peers" (*convívio entre pares*).

THE LACK OF A QUALITATIVE ASSESSMENT OF THE THERAPEUTIC PROCESS AND ITS EFFECTS

For regulatory purposes, ANVISA RDC 29/2011 considers a central therapeutic instrument of the TCs to be simply the "interaction between peers," without any precise definition of what a satisfactory and adequate "interaction between peers" would be. The use of such a broad and vague category to identify what is being offered as therapy in TCs allows for an indefinite and heterogeneous set of practices. Returning to the idea that the TCs set out to achieve a moral-subjective transformation of individuals, "interaction between peers" can be considered, for analytic purposes, the means used for this transformation.

Examining the items checked during the inspections for issuing or renewing a health permit, there is apparently no precise evaluation for the "therapeutic program" in terms of its specificities and in relation to its everyday practice. Assessment of the therapeutic program is based merely on checking documents, not on qualitative observation of the everyday reality of the TC. Bearing in mind that the therapeutic principle is "interaction between peers," the question arises: who audits or inspects this interaction?

How does one regulate something that is intended to be therapeutic but is guided by moralism,[48] whether in biomedical or religious guise, or a mixture of both? The significant presence of religiosity and spirituality, even when associated with technical-scientific (biomedical) parameters, enables the criteria for validating the therapeutic practice to be individualized to some extent. What is moral in one determined religious symbolic context, albeit mixed with biomedical principles, may not be so in another context. Thus, the reach of health surveillance inspections can only objectively extend so far when evaluating the therapeutic programs of the TCs. This specific aspect is assessed in terms of the adequacy of the TC's bureaucratic management, a process that includes checking the evolution of the medical records of residents and the material conditions needed to achieve what is set out in the therapeutic program.

The work teams of the TCs themselves are part of this interaction between peers, which may be a positive or negative factor. It can be inferred, however, that ANVISA RDC 29/2011, which currently regulates inspections, presumes that mere interaction/coexistence is good by itself. In other words, if there are favorable and adequate health conditions that materially correspond to the proposal set out in the "therapeutic program," "interaction between peers" will automatically be seen as a positive factor in the therapy. Nevertheless, there are obviously an unlimited number of risk situations, not necessarily health-related, with potential negative impacts on the treatment process that derive precisely from such "interaction between peers."[49] The Best Practices Course indicates specifically that health surveillance should not be involved in this type of evaluation:

> It is not the responsibility of the health surveillance team to make a value judgment on whether it agrees or not with a specific therapeutic process. Our responsibility is to evaluate whether what was proposed by the therapeutic community and accepted by the resident is compatible with the structure available for that activity and whether there is any risk to health involved in the process, in which case we should assess whether the risk mitigation and control measures are sufficient.

The account given by one research interlocutor demonstrates the practical dimension of this situation:

[48] Here we can include the imposition of specific moral values relating to the habits, subjectivity, and social relations implicit in the religious and biomedical discourses and practices on the use of psychoactive substances.

[49] In earlier ethnographic field studies, conducted in three different Brazilian TCs, the following situations were observed: (1) an individual who had been a pastor assumed the function of psychologist in the TC after graduating; disrespecting the basic ethical principles of the profession, he narrated private situations experienced by residents in public talks as a way of transmitting "moral lessons;" (2) homophobia expressed by a pastor during worship while a homosexual resident was present; other residents were also homophobic in day-to-day interactions in the presence of the same young man; (3) several uncomfortable episodes (jokes, provocations, thefts) expressed in everyday coexistence; these situations left some residents more withdrawn and reticent about living with the others.

> [In health surveillance] we count the number of beds, the question of food items, whether they are past their use-by date, etc. In Mental Health [when participating in the inspections] we observe whether people are eating, what the access is like. It looked at another dimension. [...] Health Surveillance does not examine the therapeutic question. I visited one place just recently, it wasn't a TC, but I was discussing the matter with my colleague. She said: "I don't examine the therapeutic project; they send it to me; I check to see if the documentation is OK, verification of the water tank, and so on, and afterwards I go there to see the non-compliances.

Another interlocutor reported that the work they carry out is "legalist." In other words, if a particular requirement is not stipulated in the regulations, it cannot be demanded of the TCs. What does this mean? In effect, it implies that an entity may be granted a health permit without any detailed examination of its therapeutic program through a qualitative investigation.[50] This is not due to negligence, but out of strict compliance with ANVISA RDC 29/2011. The health permit, therefore, sometimes ends up legitimizing a therapeutic proposal simply by checking paperwork and the accounts given by the institution's proprietors.[51]

Only in the case of complaints can an inspection be more directed towards a qualitative assessment of the therapeutic processes with a requirement for adjustments to be made, to some extent because these investigations generally involve partnerships between the municipal health regulatory agency and other public bodies, such as the state health regulatory agency, the Public Prosecutor's Office, the Public Defender's Office, the municipal mental health office, and the RAPS equipment management team, among others. Waiting for complaints before launching more substantial investigations of the therapeutic processes can have tragic consequences.

COMPLAINTS AND THE GREATEST REGULATORY CHALLENGE IN THE TC FIELD: CLANDESTINE INSTITUTIONS

Although inspections triggered by complaints tend to focus on specific aspects relating to the substance of the complaint reports, it is notable that they use an inspection script similar to the standard one used for regular issuance of a health permit. According to research interlocutors, if the complaint was not related to aspects of the therapeutic process, or the "interaction between peers," no detailed verification of these factors is likely to take place. However, observing some of the data relating to the complaints about TCs, an important question emerges, as exemplified in the following excerpt from the Report on Complaints in Health-Related Services,[52] published by ANVISA:

[50] Here the term "qualitative" refers to a multidisciplinary examination of TCs, observing both the internal processes more carefully, and also the relationships between TCs and other actors from the care network for drug users, as it occurs, for instance, in the TC accreditation processes for public funding.

[51] This is not meant to imply that municipal health regulatory agencies possess this remit but fail to fulfil it; rather, the range of their remit is somewhat insufficient. The research interlocutors were unanimous in identifying the need for partnerships with other public authorities to improve the inspection process for issuing health permits, given that a more detailed examination of the therapeutic aspects is not within the scope of health surveillance.

[52] Agência Nacional de Vigilância Sanitária, "Relatório Anual–Denúncias em Serviços e Interesse para a Saúde, nº 7," 2019, accessed February 16, 2021, https://www.gov.br/anvisa/pt-br/arquivos-noticias-anvisa/345json-file-1.

> Although Therapeutic Communities do not form as large a universe as other health-related services (such as aesthetic and beauty services, nurseries, tattoo studios, or even Long-Stay Institutions for the Elderly), attention is drawn to the percentage of extremely serious complaints coming from these establishments,[53] especially those related to the abuse of rights, diverse forms of violence (physical and psychological) and involuntary internments, situations directly contravening the provisions of RDC 29/2011, as well as the recent changes made to the Anti-Drugs Law (11,343/2006) introduced by Law 13,840 of 2019.

In other words, it is only after complaints and denunciations are made that issues emerge that apparently evade the health inspections conducted for issuing or renewing health permits.[54] As observed above, in the case of TCs, most of the complaints relate to serious circumstances. It is worth stressing that the aforementioned report covers only the known institutions registered as a Health-Related Service with the health regulatory agency. However, the extent of such irregularities may be even larger since institutions not yet regularized as TCs may be taking in residents even before any request is made for issue of the health permit, a process that can involve months of bureaucracy.

The universe of complaint-based inspections also highlights another situation, even more serious: the existence of a series of localities whose classification is indefinite—institutions that cannot be legally classified as TCs, but which house various people, in diverse conditions, operating on the fringes of regulation. Even in these cases the health regulatory agency may provide assistance towards regularizing the locality—which reflects a chronic problem in Brazil, namely the shortfall of social welfare and mental health networks in providing care for people with a high degree of social vulnerability, whether elderly people, those living in the street, people with mental disorders, drug addicts, or others. This situation becomes a fertile terrain for clandestine, non-regularized services, which sometimes end up occupying the spaces left vacant by the state.

The research interlocutors report that the complaints reach the health regulatory agency from diverse sources, including the city hall ombudsman's office, the Public Prosecutor's Office, professional associations, or via the state health regulatory agency. It is important to note that when the complaints arrive via the latter entity, the municipal health regulatory agency tends to be the first body to visit the reported institutions.

One of the interviewees identifies the biggest problem in this field today—namely, the sheer number of irregular institutions that they learn about and visit following some kind of complaint:

> Mixed things are emerging, neither one thing nor another, and we arrive at the locality and nobody knows, nobody assumes responsibility for the place, it's a mess. If I must close it, fair enough, we'll close it, because they do not exist in legal terms. But then what? Where will these people go? Everyone disperses. There is no entity, no management, no attention paid in this area, including in terms of absorbing irregular situations where the establishment has to shut

[53] In the cited report, complaints are classified in accordance with the priority assigned to resolving the risk situation: the greater the risk, the higher the priority for resolution. The classification ranges from P1 (highest priority) to P5 (lowest priority). In the case of TCs, the breakdown of complaints for 2019 was as follows: P1 (35.5 percent), P2 (31.3 percent), P3 (18.8 percent), P4 (12.5 percent) and P5 (0 percent).

[54] This topic is also explored in the present series by Carolina Duarte and Mathias Glens in their analysis of the work of the Public Defender's Office of the State of São Paulo during inspection of TCs.

> due to a serious situation…. We cannot just close the place if there is nowhere for these people to go, because that's not within our remit. Our bit is easy, but how can I close down a place without anywhere to send them?

Another interlocutor observes the situation in similar fashion, emphasizing the difficulty of classifying some localities, and the problem of successfully closing even those establishments that are not complying with health norms or that have been the subject of serious denunciations:

> It's not simple, sadly it isn't so. Because these places that provide care in this more clandestine form, which we discover when we follow up on some complaint, normally mix various types of, not pathologies, but various types of conditions. They literally gather people up from the street, people who are homeless due to clinical conditions, drug abuse, mental disorders. They produce a mixture and take these people to some place and normally get them to pray all day. We turn up and are unable to classify them as a therapeutic community. There are people with physical disabilities, mental disabilities. It really is a huge mixture of people, which hinders our work considerably…. We have already done this type of work, but, as a health surveillance team, you cannot simply close the place of the activity because there are people inside. And these are people who you have nowhere to send. Many are homeless. You can't put these people back on the street just to close the place. But neither can you let that situation carry on the same way. So it's very complicated, it's a very complicated situation.

From the moment when the health regulatory agency learns about the existence of these places, a regularization process is initiated—when the situation is not extremely serious[55]—in an attempt to fit them into a delimited area of activity, whether a home for the elderly or a TC, depending on the public that is being provided with care at the moment of the complaint and the conditions of the locality's space and work team. Again, the role of the health surveillance here is that of an intermediary in the institutionalization not only of the TCs but also of other services. And once again, this entails a process that, between comings and goings, may last months or even years, according to the research interlocutors, and which only applies to the less serious cases. More extreme and problematic situations exist when the denunciation involves clandestine institutions that are run in perverse ways, as identified in one of the interviews:

> What do we observe? Normally these [entities] keep the benefits [sickness allowances or pensions] of these patients. And sometimes people have to pay additional costs. But normally for these needy or most needy people, it's the benefit. Very often there are some [entities] that try to adapt since they want to receive patients from the public service too, because it generates more income. The benefit is a very small amount. They end up having problems paying for their maintenance, but they continue with the patients. Including when they disappear—because sometimes this happens when we follow up on a complaint and search at an address. It has already happened to me three times over this one year I have been here: we arrive at an address and the patients, the owner, the proprietor, during the night, normally from Saturday to Sunday, has taken all the patients to another locality, nobody can say where. My personal opinion, but it seems like they think: "I'm leaving because the inspection team found me, they're after me; but I'm taking the goose that lays the golden eggs with me, I'm not leaving it here." In two places where we managed to talk to the neighbors, that was precisely what

[55] When crimes have occurred in the inspected locality, for example, closure is recommended.

> occurred. A bus turned up between Saturday and Sunday, stuffed everyone inside, and left. Nobody knows where they are now.

In other words, when the inspection team applies pressure and a risk exists of the institution being closed, a clandestine transfer of people may take place, sometimes even to another municipality, for the owner to keep receiving the benefits of the residents such as their sickness allowances or pensions. There are places that do not want any kind of relationship with public authorities, as exemplified in these accounts. The relocation of an entire institution, including its "patients," means that the proprietors or those legally responsible for the locality avoid any administrative or criminal processes, effectively hiding from the authorities. Many of these cases may also involve crimes of kidnapping and human trafficking.

An inspector described a similar situation, but with an even more tragic outcome. It all began with a fairly tense process involving the closure of an institution following an inspection, triggered by a denunciation, in a coordinated action by the health regulatory agency, the Mental Health Coordination Office, and the Public Prosecutor's Office. A room was discovered at the locality that served as "solitary confinement" to punish residents, among other human rights violations. At the end of the process, the place was closed. A month later, in another municipality, a tragedy occurred. An institution, supposedly a TC, was struck by fire. Some of the residents were imprisoned in locked rooms and unable to escape the fire, resulting in the death of seven people. The proprietor of this locality was the same as the institution that had been closed a month earlier in the municipality analyzed here.

This entire tragic sequence of events points to another complex situation, which relates to the accountability and penalization of the individuals responsible for these establishments. A proprietor of a TC closed by public authorities in circumstances like those narrated above should not simply be able to open a similar establishment somewhere else. The possibility of opening a space, receiving residents, and only subsequently making a request for a health permit appears to allow situations like this to develop. As explored above, this is because the municipal health regulatory agency is the public entity responsible for establishing the first contacts with this kind of institution, before other government agencies can step in and exercise stricter controls, if needed. In short, it is clear that closer state control of these institutions is necessary, and that municipal health regulatory agencies cannot perform this function alone, as it seems to be the case in many situations.

FINAL CONSIDERATIONS

Though improvements have been made in recent years, the supervision of TCs presents serious problems. If a TC does not receive public funding, or has not been reported, it will probably only be visited annually by the municipal health regulatory agency, or twice at most when renewing the health permit. This circumstance demonstrates the important role played by health regulatory agencies in the process of institutionalizing the TCs as a therapeutic method for people who make use of use psychoactive substances in problematic/harmful ways.

In routine inspections, or at the request of the TCs themselves to issue a permit, evidence shows that what the TC offers as therapy is not supervised. A considerable difference exists between just reading a printed therapeutic program and records of individual residents, and undertaking an on-site investigation of the everyday processes in which the "therapy" takes place. The inspection does not

assess typically essential points like day-to-day life in the TC and the therapeutic process itself. Although the place where the therapy occurs is inspected, no authority of any kind inspects the therapy itself.

There are some exceptions to this superficial assessment of what is applied in therapeutic terms–adding what the research interlocutors called a "qualitative examination" of the processes inside the TC, such as its therapeutic resources and the relation with the psychosocial care network: these pertain to institutions that have signed agreements with city halls, state governments, or the federal government for the receipt of public funds. As Barroso points out,[56] the public bidding processes identify specific criteria and usually place other public bodies, in addition to the municipal health regulatory agency, in closer contact with the contracted institutions. Another exception are those inspections arising from complaints relating to therapeutic issues or human rights violations, which may lead to partnerships between the Public Prosecutor's Office, the Public Defender's Office, professional associations, the mental health coordination office, the social welfare coordination office, and even police in the case of reported crimes.

The situations presented over the course of this article exemplify the considerable challenge involved in regulating and supervising entities that generically provide what they call *acolhimento* (reception, welcome, shelter). It is relatively easy for anyone with a minimally structured space and with little public visibility to begin to receive people unbeknownst to supervisory agencies. Many of these spaces provide refuge to users of psychoactive substances and base themselves, albeit extremely precariously, on the operational model of the TCs.

Closing noncompliant establishments is not easy either, even when, in the personal assessment of the health surveillance agents, closure is recommended. Each of the research interlocutors pointed to this same dilemma. Fassin provides an insight into the problem: "At the macrosocial level, moral economies correspond to how values and affects are produced, circulate, and are appropriated around a given situation that society construes as a problem"—in this case, the way in which the accommodation ("making disappear")[57] of "undesirables" is effected. At the same time: "At the microsocial level, moral subjectivities reveal the values and affects involved in the ethical issues and dilemmas faced by the agents with respect to these problems."[58]

In other words, setting out from the idea that "for the undesirables, anywhere is better than the street," the decision is taken to allow these people to stay in localities without the minimum conditions for health and human dignity. What the discussion in this article has shown is that public policies are defined by precisely these legal and regulatory loopholes in the instruments. Evidence shows that clandestine establishments lend themselves to taking in people considered "disposable" or "undesirable," since this comprises a large population outside the net cast by the social welfare, mental health, and health systems, among others.

It is important to stress that some entities representing TCs, such as the Brazilian Federation of Therapeutic Communities (Federação Brasileira de Comunidades Terapêuticas, or FEBRACT), have made

[56] Priscila Farfan Barroso, "Comunidades terapêuticas como política de estado: uma análise sobre a inclusão deste modelo de cuidado nas políticas sobre drogas no Rio Grande do Sul" (PhD dissertation, Universidade Federal do Rio Grande do Sul, 2020), 152.
[57] Mallart et al., "Fazer sumir."
[58] Fassin, "Can states be moral?," x.

efforts to improve the services provided by the associated institutions, both in terms of their structure[59] and in terms of human resources.[60] However, this endeavor seem to have been insufficient since disputes exist within the sphere of Brazilian TCs.[61] Even when only those institutions that attempt to comply with health regulations and observe the regulatory frameworks are considered, the health inspections, as they are currently organized and legally coded, are unable to assess all the processes involved in the everyday life of a TC. This is especially the case when the inspections occur, as is standard, without any partnership with other public authorities such as the Public Prosecutor's Office, the mental health offices, the Public Defender's Office, professional associations and so on.

This was one of the recurring complaints among all the interviewees: the lack of permanent partnerships for inspecting and monitoring these institutions. Sporadic partnerships, formed when investigating complaints, should be permanent, in their view. All the research interlocutors made the same point that partnerships with the mental health coordination offices of the municipalities, which occur with those institutions that receive public funding, was essential to improving the work of inspecting TCs. Moreover, permanent partnerships with the Public Prosecutor's Office and the social welfare departments might strengthen the consolidation of more dignified futures for the residents of these clandestine entities, transferring them to public care networks.

Another possibility identified for improving the inspection system was a review, whether by the health regulatory agency or by other bodies, of municipal law, since this is the legislation that regulates the practice of monitoring TCs. One of the points would be to make intersectoral cooperation in the supervision of these institutions mandatory.

The approach proposed here obviously has its limitations: the exclusive focus on health surveillance processes without exploring them from the viewpoint of the TCs; the limiting of the empirical field to a single municipality, making comparisons and generalizations more difficult; the lack of ethnographic fieldwork. Methodological choices, time limits, problems obtaining approval from the ethics committee, and the Covid-19 pandemic all influenced the research design.

Despite its limitations, this research contributes to the field of studies on TCs. The inquiry into the practices of employees of the health regulatory agency as a form of intervention of the state in the TC sphere points to major loopholes that need addressing. A huge responsibility is being imposed on the health regulatory bodies, possibly beyond their capacity and skill. Furthermore, the bureaucratic processes for licensing and regularization enable the operation of establishments with serious structural

[59] FEBRACT, "Consultoria," accessed February 13, 2021, https://febract.org.br/portal/consultoria/. On its website, FEBRACT offers consultancy services for qualifying TCs in the following terms: "Comprises one or more technical visits by a professional from FEBRACT to the contractor TC, initially seeking to produce an Institutional Evaluation, through which the potentialities and main difficulties of the TC as an institution can be detected and analyzed."

[60] FEBRACT, "Programa de Certificação," accessed February 13, 2021, https://febract.org.br/portal/programa-de-certificacao/. On the same site it also offers the FLACT/OEA/CICAD Certification Program with the following objective: "Standardization of the capacities and skills of our workers and professionals to guarantee and assure that the treatment/shelter programs, irrespective of the country, are in accordance with the principles and values of the TC model, are opportune, and are high-quality."

[61] Priscila Farfan Barroso, in this series, offers some reflections on this scenario. It is important to note that FEBRACT's position is a minority and that internal disputes exist between the different federations and confederations representing the TCs concerning the topic of supervision.

problems, which sometimes are distant even from the more consolidated—but no less controversial—TC model.

INSPECTING THERAPEUTIC COMMUNITIES: AN ANALYSIS OF THE EXPERIENCE OF THE PUBLIC DEFENDER'S OFFICE OF THE STATE OF SÃO PAULO

CAROLINA GOMES DUARTE[1] AND MATHIAS VAIANO GLENS[2]

As set forth expressly in both the Brazilian Federal Constitution and the constitution of the state of São Paulo,[3,4] the Public Defender's Office is the agency responsible for providing legal advice and promoting human rights in a comprehensive way and free of charge to all those requiring its assistance. Among its various powers and responsibilities,[5] it is important to highlight the inspection of localities intended for the care of people with a problematic use of alcohol and drugs,[6] especially those known as therapeutic communities (TCs), defined as a "health service designed to offer continuous healthcare of a temporary residential nature for up to nine months for adults with stable clinical needs arising from the use of crack, alcohol, and other drugs."[7]

The Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS), instituted for the purpose of "creating, expanding, and coordinating healthcare centers for people with mental health issues or disorders and with needs arising from the use of crack, alcohol, and other drugs, within the scope of the Unified Health System (Sistema Único de Saúde, or SUS),"[8] presents a range of services within the following areas of care: Primary, Specialized Psychosocial, Urgent and Emergency, Transitional Residential Care, and Hospital Care, in addition to Deinstitutionalization Strategy and Psychosocial Rehabilitation. Furthermore, following Directive 3088/2011 of the Ministry of Health, TCs must operate in close coordination with primary care and with the Psychosocial Care Centers (Centro de Atenção Psicossocial, or CAPS). It is worth noting that in this norm no mention is made of the term "clinic," which nonetheless is commonly used by these institutions.

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[3] Supplementary Law 80/1994: "Creates the Public Defender's Office of the Federal Government, the Federal District and the Territories, sets out general rules for its organization in the States, among other measures."

[4] State Supplementary Law nº 988/2006: "Creates the Public Defender's Office of the state of São Paul and institutes the legal framework for the career of State Public Defender."

[5] Supplementary Law 80/94, Arts. 4, X and XVII; 108, Sole Paragraph, IV; and 128, VI.

[6] Luís Fernandes and Maria Carmo Carvalho, "Por onde anda o que se oculta: o acesso a mundos sociais de consumidores problemáticos de drogas através do método do snowball," *Revista Toxicodependências* 6 (2000):17-28, https://repositorio-aberto.up.pt/bitstream/10216/14532/2/83651.pdf. The term "problematic use" encompasses the consumption of psychoactive substances associated with social or health risks to the user or third parties.

[7] Consolidation Directive 3/2017 of the Ministry of Health, Art. 9, II, Appendix V.

[8] Directive 3,088/2011 of the Ministry of Health: "Institutes the Psychosocial Care Network for people with mental health issues or mental disorders and with needs arising from the use of crack, alcohol, and other drugs, within the scope of the Unified Health System (SUS)."

In the context of the Brazil's National Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, or ANVISA), the TCs are regulated by Board of Directors' Resolution (Resolução da Direção Colegiada, or RDC) 29/2011. Additionally, in the state of São Paulo, they are also regulated by State Health Department Resolution 127/2013,[9] and by the Directive of the Health Surveillance Center (Centro de Vigilância Sanitária, or CVS) of the state of São Paulo—Directive 1/2019,[10] which defines them as health-related therapeutic communities (National Classification of Economic Activities—CNAE 8711-5/03) and social-related therapeutic communities (CNAE 8720-4/99).[11] In theory, to admit inpatients, health establishments must follow ANVISA RDC 50/2002.[12]

As can be seen from the abovementioned regulatory framework, the services providing residential care in the health sector must follow rigorous guidelines that oblige them to coordinate among themselves to ensure adequate referral of those requiring their care. Disregarding these norms can lead to serious situations insofar as these establishments lack the clinical structure and medical care necessary to deal with complications arising from more severe health scenarios. The controversy surrounding the institutionalization of treatment in TCs—which indeed also receive public investments[13,14]—involves the number of reports of rights violations.[15,16,17,18] On this point, it is important to underline that of the eighteen TCs whose inspection processes will be analyzed in this article, indications of human rights violations were encountered in all but one of them.

This topic is particularly relevant to the political debates and disputes surrounding the field of care for people with problems related to the use of alcohol and drugs. Although principles and methodologies advocated by the legislation and by the scientific literature on TCs may be the subject of discussion and

[9] Resolution 127/2013 of the State Health Department: "Provides for complementary health security requirements for the functioning of institutions providing care services to people with disorders arising from the use, abuse, or dependence on psychoactive substances within the area of the state of São Paulo."

[10] Directive 1/2019 of the CVS: "Regulates, within the scope of the State Health Regulatory System—SEVISA, the licensing of health-related establishments and sources of ionizing radiation, and provides related measures."

[11] São Paulo State Government, Department of Justice and Citizenship Protection, State Council for Drugs Policy, "Comunidade terapêutica: manual para instalação e funcionamento do serviço no Estado de São Paulo" (2020), MANUAL-CTS-1.8-EBOOK.pdf, justica.sp.gov.br.

[12] ANVISA RDC 50/2002: "Provides for the Technical Regulation for planning, programming, elaborating and evaluating the physical projects of healthcare establishments."

[13] On the issue of funding, see the article by Renata Weber in this series.

[14] São Paulo Government, "Comunidade terapêutica," 9. "The Therapeutic Communities Manual not only conceptualizes this model for the purposes of financing and structuring public policies for the State of São Paulo, but also makes clear the relevance of this model as a strategy for psychosocial care and reintegration."

[15] Conselho Federal de Psicologia,, *Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas* (Brasília: CFP, 2011).

[16] Conselho Federal de Psicologia, Mecanismo Nacional de Prevenção e Combate à Tortura, and Ministério Público Federal, *Relatório da Inspeção Nacional em Comunidades Terapêuticas—2017* (Brasília DF: CFP, 2018).

[17] Amanda Audi, "Pastores Fingem ser PMs para internar usuários de drogas à força em Brasília," *The Intercept Brasil*, accessed August 5, 2020, https://theintercept.com/2020/08/05/pastores-fingem-ser-pm-brasilia-batalhao-patrulha-paz/.

[18] Technical Note CSIPS/GGTES/ANVISA 2/2020, which sets out: "Explanations and guidelines concerning the functioning of institutions that provide care services to people with disorders arising from the use, abuse, or dependence on psychoactive substances known as Welcoming Therapeutic Communities—ANVISA RDC 29, June 30, 2011."

questioning,[19, 20, 21] there is also the practical problem of how the treatments are effectively implemented in the day-to-day work of the TCs.

An initial challenge is related to the very legal/formal definition of TCs.[22] In the inspections, some establishments, when questioned about the motives for carrying out involuntary and compulsory admissions (something prohibited for TCs),[23] alleged that they were "clinics" rather than TCs,[24] although they failed to meet the requirements of ANVISA RDC 50/2002 or Resolution 2,170/2017 of the Federal Council of Medicine (Conselho Federal de Medicina, or CFM).

Given the ambiguity surrounding rules and definitions, for the inspection purposes of the Public Defender's Office any establishment not presenting the robust structures demanded for admission regimes (how to execute and record daily medical care, for example) by RDC 50/2002 was legally or administratively classified as a TC on the basis that it effectively operates as such and receives funds or benefits under this designation, thus making it liable to inspection in accordance with RDC 29/2011.

Because of the discrepancy between the regulatory provision and the concrete practice of these establishments, TC inspection emerges as an ideal instrument to reveal how they actually operate. In this sense, exploring the findings in this inspection process is essential to characterize the debate on the problems encountered and to understand the role that bodies like the Public Defender's Office play in this context.

The objective here, therefore, is to comprehend how the eighteen TCs inspected in the state of São Paulo by the local section of the Public Defender's Office and the Regional Psychology Council of the state of São Paulo (Conselho Regional de Psicologia de São Paulo, or CRP-SP) between 2013 and 2019 presented themselves,[25] what patterns of human rights violations were identified, and what kind of justifications were presented by these entities, as well as discuss some of the difficulties encountered in conducting these inspections.

[19] Andrew Aurélio Pinto de Almeida Costa, "O discurso hegemônico de combate ao crack na internet e a política de internação compulsória no Brasil" (MA thesis, Universidade Federal Fluminense, 2017).

[20] Helenice Pereira Lopes and Aline Moreira Gonçalves, "A política nacional de redução de danos: do paradigma da abstinência às ações de liberdade," *Pesquisas e Práticas Psicossociais* 13, no. 1, (January–April 2018): 1–15.

[21] Dartiu Xavier, "A internação compulsória é sistema de isolamento social, não de tratamento," *Caros Amigos*, January 11, 2013, http://www.carosamigos.com.br/index/index.php/politica/2888-entrevista-dartiu-xavier-a-internacao-compulsoria-e-sistema-de-isolamento-social-nao-de-tratamento.

[22] On this topic, see the article by Noelle Resende in this series.

[23] Prohibited by Art. 26-A, II, of Law 13,840/19; by Art. 2, I, of Resolution 1/2015 of the National Council for Drugs Policy (CONAD); by Art. 19, III, of ANVISA RDC 29/2011; and by Art. 13 of Appendix XCI of Consolidation Directive 06/2017 of the Ministry of Health.

[24] Legally, "clinics" cannot admit inpatients. As a rule, they provide an outpatient service without beds for staying overnight or long-term admission, under the terms of CFM Resolution 2,170/2017, which defines medical clinics providing outpatient care, including so-called popular clinics, as medical companies and sets criteria for their functioning and registration with the Regional Medical Councils.

[25] For reasons of confidentiality, the TCs are numbered and cited in this form over the course of the text.

METHODOLOGY

During the first inspections of TCs by the Public Defender's Office in 2013, few experiences and little literature were available since the theme was relatively new. The partnership with CRP-SP was fundamental to developing joint inspection strategies, although the inspection activities of CRP-SP are limited to the professional work of psychologists. Consequently, the possible rights violations observed were sent to other bodies like the Public Prosecutor's Office.

Only with practical work and the resulting deeper knowledge of the subject was the group itself able to create the support tools it needed, based on the norms and minimum requirements for the functioning of these institutions and on the most frequent and significant violations, thus organizing a division of responsibilities. As well as an individual care record card, a term of declaration of interest in the work of the Public Defender's Office of the State of São Paulo was collected from each person.[26] The practice was adopted of dividing the inspection teams into two group so that the interviews with the institution's residents and its technical/management team could occur simultaneously and in separate places, enabling the confidentiality of the information to be maintained and avoiding possible embarrassment.

The process of inspecting the TCs by the Public Defender's Office was based on the legal norms listed in Table 1.

Table 1. Legal framework for TC inspections.

Legislation	Subject
Law 10,216/2001	Provides for the rights of people with mental disorders and redirects the mental healthcare model.
Law 13,146/2015	Establishes the Brazilian Law for the Inclusion of People with Disabilities (Disabled Person's Statute).
ANVISA Board of Directors' Resolution (RDC) 29/2011	Provides for the health security requirements for the functioning of institutions providing care services to people with disorders arising from the use, abuse, or dependence on psychoactive substances.
Consolidation Directives 3/2017 and 6/2017 of the Ministry of Health	Consolidate the norms concerning SUS networks.
CONAD Resolution 1/2015	Regulates, within the scope of the National Drug Policy System, the entities that host people with problems associated with the harmful use of or dependence on psychoactive substances, characterized as therapeutic communities.
UN Resolution A/46/49	Principles for the protection of people with mental disorders and for the improvement of mental healthcare.

Source: Inspection reports and forms of the Public Defender's Office of the state of São Paulo.

As well as the data obtained from application of the aforementioned regulations, the present article is based on research using diverse sources of information (reports, forms, official letters, recommendations,

[26] The Public Defender's Office can only act on behalf of someone if the latter grants authorization for it to do so, which is why this term of interest is necessary.

lawsuits, minutes of meetings, etc.) obtained from the Public Defender's Office of the state of São Paulo, specifically the Citizenship and Human Rights Specialized Unit (Núcleo Especializado de Cidadania e Direitos Humanos, or NCDH),[27] and also on the reports issued by the CRP-SP, contained in the institutional records dating from 2013 to 2019.[28] Table 2 indicates the year in which each TC was inspected.

Table 2. Chronology of inspections.

2013	2014	2015	2016	2017	2018	2019
TC 1 TC 16	TC 5 TC 6 TC 10 TC 13	TC 11 TC 9	TC 3	TC 12 TC 14 TC 17	TC 2 TC 4 TC 7	TC 8 TC 15 TC 18

The authors of this article are involved[29] with the theme of inspections and participated in some of the actions in TCs as members of the technical body of the Public Defender's Office from 2013 to 2019, an experience that allows them to contextualize and deepen the formally obtained data. As a result, as well as counting on the available official documentation, the employed methodology was also based on memories and fragments of the professional experience of the authors in these TC inspection processes, making use of this absorbed knowledge to supplement the documentary and regulatory analysis.

Based on this data, analytic categories were formulated capable of describing the universe of the inspected TCs. Choice of the categories was determined by qualitative criteria (relevance and importance of the information) and quantitative criteria (information repeated in various institutions).

PROFILE OF THE INSPECTED TCS

As a guide to the work, Table 3 lists the main analytic categories applied to the data on the eighteen TC inspections examined in this article.

[27] Access to the data was obtained via a public solicitation by email, sent to the Citizen Information Service (Serviço de Informações ao Cidadão, or SIC) of the Public Defender's Office of the state São Paulo, on June 26, 2020, instituted as stipulated by the Access to Information Law (Federal Law 12.527/2011), which allows documents and data relating to Public Administration bodies and agencies to be requested. The request was made using the form available on the Public Defender's Office website, soliciting access to the materials related to inspection of therapeutic communities held by the institution's Citizenship and Human Rights Specialized Unit, notably the contents of Administrative Procedure 75/2014.

[28] It is worth emphasizing that, due to the small size of its team, the Public Defender's Office received more complaints that are still being investigated; at the time of submitting this article, eighteen TCs had been inspected, precisely the number of cases analyzed here.

[29] Roberta Carvalho Romagnoli and Simone Mainieri Paulon, "Escritas Implicadas, pesquisadores implicantes: notas sobre os destinos da subjetividade nos desatinos da produção científica," in *Psicologia em Pesquisa: cenários de práticas e criações*, ed. Magda Dimenstein and Jáder Ferreira Leite (Natal: EDUFRN, 2014), 23–42.

Table 3. Type of establishment by CNES classification, origins of complaints, number of vacancies, and monthly fees.

Therapeutic Community	Type of establishment by CNES classification	Origin of complaint to Public Defender's Office	Number of vacancies	Monthly fees (average)
TC 1	Polyclinic	CRP-SP	74	No information
TC 2	Specialized Hospital	CRP-SP	65	No information
TC 3	Unregistered	No information	24	R$ 900 to R$ 1,500
TC 4	Clinic/Specialized Center "Others" subtype	CRP-SP	No information	R$ 1,000 to R$ 2,000
TC 5	Clinic/Specialized Center (Specialized Rehabilitation Center subtype)	CRP-SP	No information	R$ 2,000 to R$ 3,000
TC 6	Dedicated Office/Practice	No information	No information	Monthly minimum wage + basic food package
TC 7	Unregistered	CRP-SP	52	R$ 600
TC 8	Unregistered	CREAS Staff	No information	No information
TC 9	Dedicated Office/Practice	Relatives of the TC psychologist	50	R$ 600,00 to R$ 1,000,00
TC 10	Clinic/Specialized Center (2 registrations) Dedicated Office/Practice (1 registration) (Specialized Rehabilitation Center subtype)	CRP-SP	No information	R$ 2,000 to R$ 2,500
TC 11	Day Hospital	CRP-SP	No information	R$ 0 (social vacancy) to R$ 2,000
TC 12	Unregistered	CRP-SP	70	R$ 4,000 to R$ 15,000
TC 13	Clinic/Specialized Center "Others" subtype	No information	No information	No information
TC 14	Polyclinic	No information	62	No information
TC 15	Disease Prevention and Health Promotion Pole	CRP-SP	30	No information

Therapeutic Community	Type of establishment by CNES classification	Origin of complaint to Public Defender's Office	Number of vacancies	Monthly fees (average)
TC 16	Unregistered	Public Prosecutor's Office	No information	No information
TC 17	Unregistered	CRP-SP	52	No information
TC 18	Unregistered	No information	40	No information

Source: CNES; Inspection reports and forms of the São Paulo State Public Defender's Office and CRP-SP.

After analysis of the records of the inspected TCs, it was found that no pattern exists in terms of how these services identify themselves, which places them in a limbo between providing a place/hosting and healthcare.[30] Directive 1,482/2016 of the Ministry of Health determines that TCs must register with the CNES (National Register of Health Establishments). It was observed, however, that not all of them were registered or, when they were, they were out of data. When these registrations exist, the types of establishment registered vary considerably, which adds to the difficulty of defining the TCs.

TC 3's articles of association specifies that it is a female clinic[31] for treating chemical dependence, alcoholism and associated disorders,[32] the latter being, in theory, prohibited to TCs. Intended for people with a higher degree of autonomy who can manage to observe all the proposed rules and activities, the presence of comorbidities that may demand care from unavailable health services. The recommendation in the manual for installation and operation of the service in the state of São Paulo is categorical:[33] during the triage process, the individual cannot "*present psychotic symptoms, signs of acute intoxication or of serious withdrawal syndrome, or levels of serious cognitive impairment.*"[34] Similarly, TC 4 presented itself for inspection as an establishment that provides care for people with psychiatric disorders, identifying itself as "a private clinic for Class C patients."[35]

At TC 7, the psychologist in charge presented the locality as a "Twelve Step Clinic," even though it is registered as a "Dedicated Office/Practice" (*consultório isolado*).[36]

TC 10 was registered twice in the CNES: as a "Clinic/Specialized center," with the subtype "Center Specialized in Rehabilitation," an institution intended for people with disabilities, and also as a

[30] On this topic, see the article by Noelle Resende in this series.
[31] None of the TCs that call themselves "clinics" meet the legal parameters of care norms relating to the regime for inpatient care, such as, for example, executing and registering daily medical care.
[32] ANVISA RDC 29/2011, Art. 16, Sole Paragraph.
[33] The manual can be found at https://justica.sp.gov.br/wp-content/uploads/2020/05/MANUAL-CTS-1.8-EBOOK.pdf.
[34] São Paulo, *Comunidade terapêutica*, 55.
[35] As stated in the inspection report made by the NCDH of the Public Defender's Office. (Translator's Note: Class C here refers to one of the five socioeconomic classes (A-E) into which the Brazilian population is typically divided by analysts, with Class C approximately corresponding to middle- and lower-middle-class workers employed in service industries)
[36] According to the CNES of TC 7.

"Dedicated Office/Practice." On its website, however, it presents itself as "a serious company with vast experience in treating diseases related to chemical dependence and alcoholism, whose target public are adults, and possesses a unit for children and teenagers with low to moderate impairment, as provided for RDC 29/2011."

Usually, the complaints are submitted to professional organizations, especially CRP-SP, which also participated in the inspections and shared its inspection reports, or other institutions from the justice system or the human rights safeguarding system, as indicated in Table 3.

It can be observed that among the inspected cases, the complaints are rarely made by the people themselves whose rights have allegedly been violated. This circumstance is worth noting insofar as it involves people in a situation of vulnerability, albeit circumstantial, who, in theory, could themselves have gone to the Public Defender's Office or other agencies safeguarding rights.

The fact that the people who suffered human rights violations inside the TCs are not the main source of complaints may indicate that the Public Defender's Office (and the justice system as a whole) is not seen as an institution capable of helping them in this situation. Another possible explanatory factor is the fear of reprisals: during the inspections, many residents reported that they were afraid to report the violence suffered.

It is also possible that many of these people are unaware that their rights have been violated. In some inspections, for example, when we presented ourselves to residents as members of the Public Defender's Office and explained we were there to prevent possible rights violations, they frequently replied: "but what are my rights?" This difficulty is commonly encountered not only by those involved in conducting TC inspections, but also a problem for the people living in vulnerable conditions: the lack of self-recognition as an individual with rights. How can someone who has never been told about their rights claim them?

In terms of the rights that compose citizenship in Brazil, it is worth underlining that, for Carvalho,[37] "the lack of guarantee of civil rights is found above all in relation to individual safety, physical integrity, and access to justice."[38] This absence of guarantees has an even more violent impact on the marginal population of the large cities, who are at the base of the economic pyramid and who for years have seen their civil rights ignored or systematically disrespected, such that "they do not feel protected by society or by the laws. They are afraid of contact with agents of the law since experience has taught them that it is almost always to their detriment."[39]

Having an abstract knowledge of one's own rights does not, of course, imply being able to exercise them in full. In this sense, education in rights, at the same time as being a right in itself, is an essential instrument for accessing other rights. It is a fundamental and effective strategy for accessing justice and,

[37] José Murilo de Carvalho, *Cidadania no Brasil: o longo caminho*, 21st ed. (Rio de Janeiro: Civilização Brasileira, 2016), 213.
[38] Those related to individual freedom, in accordance with the Federal Constitution, Art. 5: "All persons are equal before the law, without any distinction whatsoever, Brazilians and foreigners residing in the country being ensured of inviolability of the right to life, to liberty, to equality, to security, and to property."
[39] Carvalho, *Cidadania no Brasil*, 218.

consequently, the promotion of citizenship, which encompasses civil, social, and political rights, as well as public policies.

Associated with this panorama, among the list of social rights[40] is the right to health, which is generally not associated with people who make problematic use of drugs, since this use is not commonly considered from this viewpoint of public health but from a repressive penal/criminal viewpoint.
Another issue deserves highlighting: where do the complaints triggering inspections come from? In the cases of TCs 2, 7 and 9, CRP-SP received the complaint from the Public Prosecutor's Office (Ministério Público, or MP). In the case of TC 4, CRP-SP had received the complaint from the Labor Public Prosecutor's Office (Ministério Público do Trabalho, or MPT) for suspected work conditions analogous to slavery.

According to legislation, the MP can request information and documents (even confidential material like medical records); notify people to give evidence; recommend the adoption of particular practices; and, above all, inspect places of collective admission with unrestricted access to all the facilities and autonomy to file a public civil action to place injunctions on these establishments, among other powers.[41] Given the powers of inspection held by the MP, the question remains: why did the entity send requests for inspections to the CRP-SP rather than carry them out itself, or at least in conjunction with the other competent bodies?

It should be emphasized that the MP was routinely invited to take part in the inspections, but this participation did not take place. Together, this information indicates a lacuna in the work of the São Paulo MP in terms of its responsibility to inspect TCs and other entities of the kind, a serious problem given the entity's importance.

Notably, the complaint against TC 8 arrived through CREAS technical staff who assisted a young man in compliance with a socio-educational measure; in other words, through the support network. This was only possible, though, because of the support of a psychologist from the Public Defender's Office itself, who was present at the consultation where the abuses were related. This circumstance indicates that the network of services does not typically report complaints to the justice system.

The data collected for the study also suggests obstacles to establishing a process flow for complaints, both in terms of them reaching the justice system and in terms of their appropriate referral within the legal institutions. In this sense, the absence of (state and municipal) health regulatory agencies in the flow of inspections should also be emphasized, considering these are strategic agencies that possess "policing power" over health issues and are well distributed across the state.[42]

[40] These concern the collective rights to be assured by the State through public institutions and policies, defined under Art. 6 of the Federal Constitution. They comprise "positive state benefits, set out in constitutional norms, that enable better living conditions for the most vulnerable, rights that tend to redress unequal social situations." José Afonso da Silva, *Curso de direito constitucional positivo* (São Paulo: Malheiros, 2000), 289.
[41] Renata Corrêa Britto, "A internação psiquiátrica involuntária e a Lei 10.216/01. Reflexões acerca da garantia de proteção aos direitos da pessoa com transtorno mental" (MSc thesis, Escola Nacional de Saúde Pública, 2004).
[42] The technical norm regulating this question is Directive 04/2011 of the CVS, which "provides for the State Health Monitoring System (SEVISA) and regulates the economic activities that are subject to registration and/or licensing by the health monitoring agencies."

Although many of the inspected TCs received an operational permit from the health regulatory agency, demonstrating that they had been inspected, it is notable that the agency had not identified the serious violations that were subsequently discovered—which suggests that the inspection methodology of the body in question may possess lacunas or some degree of economic and political fragility vis-à-vis the TCs,[43] considering that inspection is usually carried out by the municipal health regulatory agencies.

Based on the data presented in Table 3, it is evident that the TCs are primarily characterized by their indeterminacy. As mentioned, the ambiguity of the official registers prevents any clear definition, greatly increasing the difficulty for the inspection teams evaluating these spaces.

Table 3 also provides a profile of the structure of the inspected TCs. These TCs possess different numbers of vacancies, with the smallest (TC 3) offering twenty-four spots and the largest (TC 1), seventy-four. As no correlation was found between violations and the number of places, it is possible to affirm that, in the inspected TCs, human rights violations occur independent of their size. None of the TCs had more people admitted than the number of available places.

In terms of their territorial localization, most of the denounced TCs were found to be situated in locations far from urban centers, whether on the fringes of Greater São Paulo, as in Parelheiros and Cajamar, or in towns in the interior of the state. As well as being more distant, notably the inspected TCs are generally situated in more difficult to access locations. This characteristic is also associated with the frequency of involuntary admission in these institutions, as discussed later. After all, distance and remote access function as barriers impeding any attempt to escape, as well as hindering coordination with the health service network. This isolation makes it difficult for families to visit and, consequently, for them to keep a check on any mistreatment. As in the mental asylums of the past, the TCs where the biggest human rights violations were found to be isolated institutions with asylum-like characteristics.

High walls, fences, barbed wire, electric fences, bars on windows, metal doors, chains, locks, and padlocks are all elements commonly encountered in the investigated TCs. Again, these features can be inferred to be connected to the involuntary admissions insofar as they are mechanisms that restrict the right to come and go. In some of them, specifically TCs 8 and 10, other units were discovered, distant from the main facility where the inspections occurred, to which people involuntarily admitted and more inclined to report abuses were sent, comprising another mechanism that hinders inspection.
It was considered relevant to gather data on the socioeconomic profile of the people staying in these institutions. For this purpose, the contracts for the services provided by them are an important source of information. Many are extremely costly for their clients, setting fines for quitting treatment, for example. As a consequence, a joint opinion was produced by the Human Rights Unit and the Consumer Protection Unit of the Public Defender's Office to guide the work of public defenders with regard to the abuses in these contracts, especially the stipulation of fines.[44]

Several of these contracts had not been signed by the resident and even when duly signed, some people reported that the signature was given under pressure from family or the TC team. None of the contracts analyzed included the possibility of termination at any moment or made reference to ANVISA RDC 29/2011, thus violating the general principle of voluntary admission that regulates the TCs. As these institutions have few or no connections with the public health network and make it difficult to refer

[43] On this topic, read the article by Jardel Fischer Loeck published in this series.
[44] This report is an internal document of the Public Defender's Office.

their users to doctors or emergency rooms, many medical procedures or supplies, when they become necessary, are charged separately. The residents of TCs 14 and 18 reported that any medical care received outside the institution, like those arising from abdominal pains or flu, for example, were subject to additional charges.

During the inspections, access to contracts was limited and information on the amounts charged was only available for some of the TCs, as summarized in Table 3. Even so, it was possible to observe that although there was no standard monthly fee, most of the inspected TCs charged between R$ 600 and R$ 2,000, which suggests they provide services to a lower-class public or, to a lesser extent, middle-class.

OPERATIONAL CHARACTERISTICS

For a better visualization and comparison of the collated information, Table 4 summarizes the analyzed items below:

Table 4. Notification to the MP, use of "rescue," modalities and period of admission, and public funding.

Therapeutic Community	Was admission voluntary?	Use of "rescue"?	Notifies Public Prosecutor's Office?	Average period of admission	Receives public funding (state or municipal)?
TC 1	Voluntary and involuntary	No information	No	No information	Yes
TC 2	Involuntary	No	Yes	Less than one month	No
TC 3	Involuntary	Yes	No	Between one and six months	No
TC 4	Involuntary	Yes	No	More than one year	No
TC 5	Involuntary	Yes	No	Between one and six months	No
TC 6	Voluntary	No	No information	Between one and six months	No
TC 7	Voluntary and involuntary	Yes	No	Between six months and one year	No
TC 8	Involuntary	Yes	No information	No information	No information

Therapeutic Community	Was admission voluntary?	Use of "rescue"?	Notifies Public Prosecutor's Office?	Average period of admission	Receives public funding (state or municipal)?
TC 9	Voluntary, involuntary, and compulsory	Yes	No information	Between six months and one year	No
TC 10	Voluntary, involuntary, and compulsory	Yes	No	Between one and six months	No information
TC 11	Voluntary and compulsory	No information	No information	Between six months and one year	Yes
TC 12	Voluntary and involuntary	No information	No information	No information	No information
TC 13	Voluntary, involuntary, and compulsory	Yes	No	Between six months and one year	No
TC 14	Voluntary, involuntary, and compulsory	Yes	Yes	Between six months and one year	Yes
TC 15	Voluntary and involuntary	Yes	No information	Between one and six months	No
TC 16	Voluntary and involuntary	Yes	No	No information	No information
TC 17	Voluntary and involuntary	Yes	No	No information	No information
TC 18	Voluntary and involuntary	Yes	No information	No information	No information

Source: Inspection reports and forms of the Public Defender's Office of the state of São Paulo and CRP-SP.

Inpatient care is a practice specific to health services and, as seen previously, the TCs in practice do not qualify as such under RDC 50/2002—that is, strictly speaking they do not comprise "health services." However, as this article focuses on inspection processes and evidence was found of large-scale involuntary and compulsory admissions on these occasions, the terms "inpatient care" and consequently "inpatient" are maintained in reference to those receiving who were at the TCs.

According to Law 10,216/2001, three modalities of admission exist: voluntary, involuntary, and compulsory. The first, as the name itself implies, occurs with the consent of the person being admitted.

The involuntary and compulsory modalities, however, happen without their consent, with involuntary admission carried out at the request of a third party and compulsory admission determined by a judge. In all cases, a medical report is necessary.[45] Involuntary and compulsory admissions are among the most common and most serious complaints identified, since TCs cannot receive people under these modalities.[46]

However, as can be observed in Table 4, practically all the inspected TCs presented involuntary and compulsory admissions. Most times, this was the main reason behind the complaint, the illegal occurrence of these admissions being one of the main characteristics of the inspected TCs—other violations frequently serve to enable people to be admitted against their will.

Many of the TCs admit people under more than one modality of admission, which hinders the inspection processes since the irregular cases tend to be concealed among the medical records as a whole, which mix those people staying voluntarily and those admitted against their will.

In terms of everyday operationalization of the admissions, situations were identified in which involuntary admissions were requested by psychiatrists from the TC itself after the person had already been taken to the establishment by force. It was also observed that these medical reports were produced days after the person was already resident at the establishment, since, at most TCs, a doctor is only present on a weekly or fortnightly basis.

As well as being contrary to the legislation, which requires a prior medical report, this situation is ethically problematic given the likely partiality of the report: as a private company, which profits from admission, there is a conflict of interests.

There were also reports of people signing the terms of consent for their admission, another legal requirement, under duress. The CRP-SP report observes that during the interviews with approximately forty people staying at TC 1, most declared that they had come involuntarily and did not want to remain there. TC 3 informed the MP that admissions are voluntary, "although the majority does not accept it and, therefore, the team persuades the family members of the necessity." At TC 5, it was reported that the terms of consent were made available for signing one month after the admission. Meanwhile, at TC 6, people reported that they had not signed a term of consent at the time of admission. On analyzing the medical records, however, these terms can be discovered, which may denote that the admission was made in unadvised—or, in reality, in compulsory—form. At TC 15, the inpatients reported being drugged at the time of signing the terms of consent.

It can be concluded that, in an inspection, simply verifying the terms of consent is insufficient to confirm, by itself, the voluntariness of the admissions. The inpatients need to be heard, assuring confidentiality to avoid duress or punishments. This is an important point since "consent must be free, voluntary, conscious, without distortions or errors. It cannot be obtained through physical, psychological, or moral coercion or through simulation or deceptive practices, or any other forms of manipulation that restrain the free manifestation of an individual's will."[47]

[45] Law 10,216/2001, Art. 6.
[46] Law 13,840/2019, Art. 23, § 9, and ANVISA RDC 29/2011, Art. 19, III.
[47] Paulo Antonio de Carvalho Fortes, "Reflexões sobre a bioética e o consentimento esclarecido," *Bioética* 2, no. 2, (1994):129–35, https://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/458/341.

Another important aspect for this analysis is the lack of awareness of the inpatients themselves concerning the criterion of voluntary admission. Many did not know that involuntary stay in TCs is illegal, while others declared that they were at the institution because they wanted to be. However, when asked whether they wanted to leave the locality if they could, these people were unanimous in saying yes.

Many discourses justifying involuntary admission were also heard—perhaps the most telling of which was verbalized by the director of the TC 14, when he asserted that the "involuntary becomes voluntary when they arrive here." Something almost invariably denied by the inpatients themselves, but which reveals an attempt to legitimize forced treatment.

The seriousness of this practice is evident. During the inspections of TC 13 in 2014, it was discovered that an inpatient died from a cardiac arrest a few days after his admission (a complication relatively common during withdrawal, especially in relation to alcohol). Had he been hospitalized, as the norm provides, he could have benefitted from resources unavailable in the TCs, such as respirators, defibrillators, and so on, and his death might have been avoided.

In mental health practices, involuntary admission, especially when related to the problematic use of substances, is utilized with the justification that the person using drugs is incapable of deciding for themselves and poses a danger to others. As the TCs are prohibited from providing this service and involuntary hospitalizations are short, some have operated on the margins of the law to profit from this demand for "treatments" contrary to the person's will, especially at the request of family members.

Involuntary admissions also occur at "high-quality" TCs. The monthly stay in a collective room at TC 12, for example, cost, in 2019, between R$ 4,000 and R$ 5,000. An individual room cost as much as R$ 15,000. Although this type of establishment targeted at the upper class is a minority among the institutions discussed in this article, it is interesting to note that the acceptance of forced treatments persists.

It can be noted that, in "luxury" establishments, the absence of criticism in relation to the need for the voluntary nature of treatment is practically the same as in less expensive TCs. The difference is in the sophistication of the coercion exerted to obtain the inpatient's consent.

Compulsory admissions, determined by court order, were less numerous than involuntary admissions, yet even so were present in various institutions, suggesting that the judiciary also perpetuates the culture of forced admission. The local executive powers are obliged to comply with the determination of the compulsory admissions to entities that, legally,[48] should not admit them. Seen more broadly, an articulation can be observed between the judiciary, which issues the legal ruling, and the executive, responsible for complying with a demand that, for its part, produced a form of intervening in the problem (a "treatment" proposal), which ends up being validated by a doctor. This dynamic occurs contrary to the provisions of Art. 9 of Law 10,216/2001: "Compulsory admission is determined, in accordance with the legislation in force, by the competent judge, who will take into account the security conditions of the establishment with regard to the safeguarding of the patient, other hospitalized patients, and employees."

[48] Law 13,840/2019, Art. 23, § 9, and RDC 29/2011, Art. 19, III.

This problematic process was recognized by the state coordinator of mental health, who, in a public hearing on TCs held at CRP-SP on December 17, 2015, explained that the state of São Paulo's funding for TCs mainly derived from compliance with judicial measures. In fact, compulsory admissions were only identified in TC 11, which had an agreement with the Referral Center for Alcohol, Tobacco and Other Drugs (Centro de Referência de Álcool, Tabaco e Outras Drogas, or CRATOD), linked to the State Health Department. In 2015, however, the state of São Paulo had already implemented the New Start Program (*Programa Recomeço*), intended to fund places in TCs for people wishing to be admitted, meaning that public funding exists for TCs for both voluntary and compulsory admissions by determination of the judiciary.

It is important to observe that the denial of freedom by means of forced admission is contrary to the care strategy of public health:

> …from a public health perspective [it] is important to distinguish a care strategy in which admission—particularly involuntary—may comprise an extreme care measure, taken at a circumstantial moment of a person's life and whose aim is solely to protect life, from a practice that, under the false guise of care, actually constitutes a denial of freedom incongruent with public health guidelines.[49]

"Rescue" or "removal" are terms used by the TCs and other entities to describe the process of taking someone to the establishment by force. Very often involving invasion of the home, in practice it amounts to the kidnapping of someone making problematic use of drugs at the request of someone from the family. Not infrequently, the transfer involves drugging the person against their will and immobilizing them using ropes or even a straitjacket.

During these procedures, there were reports of people being handcuffed, strangled, and overmedicated. In some situations, other inpatients were used to carry out the "rescue," as observed in TCs 13 and 16. This practice is connected to the involuntary admissions since it is precisely what enables them. And as Table 4 shows, it was a recurrent practice among the inspected TCs.

At TC 5, more than half of the inpatients arrived at the institution by this "method." The authors were informed that the institution had partnered with two companies that provide this service, which also happens at TC 9. It is important to underline the seriousness of this information: companies whose specialty is kidnapping people. This was also found at TC 18, which does not carry out "rescues" but does not prohibit people from arriving at the institution in this way. Similarly, TC 16 related that it does not practice "rescues" but recommends to relatives some companies who provide this service "with quality." As indicated, there is a kind of "outsourcing" of violent practice, an attempt by these TCs to disclaim responsibility for the practice.

It becomes clear that the mechanisms that enforce treatment of people who make problematic use of drugs is becoming more complex with different institutions specializing in different services. In this sense, we can note the need for the inspection bodies to broaden their scope beyond the TCs, inspecting these companies too.

[49] Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*, 145.

Another aspect demonstrated in Table 4 concerns the notification to the Public Prosecutor's Office. Involuntary admission must be communicated to the MP within 72 hours by the establishment where it occurred, with the same procedure applying when the person is released.[50] This norm has been carried out by the health services in the city of São Paulo in public and private hospitals: between February 2002 and December 2006, approximately 5,000 involuntary admissions were conducted in which a "Term of Communication of Involuntary Psychiatric Admission" was attached to the medical documents needed for the admission to proceed.[51]

Although two of the inspected TCs communicated involuntary admissions to the MP, the respective Terms of Consent were not found in any medical record or documentation. If this communication did actually take place, such a circumstance would reveal problems on the part of the MP in comprehending the illegality of involuntary admissions to this type of entity. Therefore, although possible failures can be seen in the supervision of the TCs, it is illogical to expect TCs to communicate to the MP, as a supervisory body, an event that would amount to reporting their own illegal activity.

It should be mentioned that in 2019 a legislative change added the Public Defender's Office to the list of bodies to be informed about involuntary admissions, also within a period of 72 hours.[52] This notification, if effectively carried out, could become an important mechanism for preventing illegal admissions. As a recent alteration, the new law did not cover the period of the studied inspections.

CONAD Resolution 1/2015 stipulates that the maximum admission time is twelve months (Art. 6, § 1). Consolidation Directive 3/2017 of the Ministry of Health, Appendix V, though, sets the limit lower at just nine months (Art. 9, II), while Consolidation Directive 6/2017 of the Ministry of Health, Appendix XCI, fixes the limit at six months, extendable to nine months under exceptional circumstances. However, "due to the hierarchy of legal norms, the time limit to be observed is a maximum of 90 (ninety) days (Art. 23-A, § 5, III of Law 13,840/2019)."[53] As a general principle, in line with Law 10,216/2001, the person must return to his or her community as quickly as possible. In other words, there should be no minimum period of stay.

The study also sought to evaluate whether longer periods of admission are associated with human rights violations. The data collected indicates that it is not possible to make this correlation—in other words, human rights violations happen in TCs that work both with short stays and with long stays (over ninety days). Nonetheless, the qualitative data is more revealing on this aspect. At TC 6, for example, one individual had been resident for twelve years, corresponding to a form of asylum. At TC 11, there were inpatients who had been there for five years. Hence, very disparate periods of admission coexist, far beyond the period declared by the TCs, which indicates a failure to communicate to authorities the admission of people with comorbidities, in a situation of abandonment, and who should be in therapeutic residences or in Long-Term Care Institutions for the Elderly (Instituições de Longa

[50] Law 10,216/2001, Art. 8, § 1, and Directive 2,391/2002 of the Ministry of Health, Art. 4, I.
[51] Mauro Aranha de Lima, "Internação involuntária em Psiquiatria: legislação e legitimidade, contexto e ação," in *Ética e Psiquiatria*, 2nd ed. (São Paulo: CREMESP, 2007), 115–26.
[52] Law 13.840/2019, Art. 23–A, § 7.
[53] Laércio Melo Martins, "Corpos, instituições e necropolítica: reflexões contemporâneas sobre a internação involuntária da pessoa com deficiência mental e as Comunidades Terapêuticas," *Revista Teoria Jurídica Contemporânea* 5, no. 1 (January–June 2020): 202, https://doi.org/10.21875/tjc.v5i1.27984.

Permanência para Idosos, or ILPIs).[54] On discovering these situations of asylum, the Public Defender's Office mobilized the CAPS in the region and other actors from the health and social welfare networks, seeking to ensure the relocation of people unable to return to their families.

With the "Crack, You Can Beat It" program,[55] launched in 2011, the federal government made it possible for TCs to receive public funding, a development in the institutionalization of TCs that has proven controversial.[56] This analytic category allowed the research to verify whether the inspected TCs received public funding and whether this analytic criterion shows any correlation with the occurrence of rights violations. It is important to emphasize that the scope of the analysis only covers establishments in the state of São Paulo, meaning that we cannot extrapolate the findings to other parts of the country.

Table 4 indicates that among the eighteen inspected TCs only three received public funding (TCs 1, 11, and 14), although six others did not provide the requested information.[57] It can be inferred that the bureaucratic requirements (documents, licenses, etc.) needed to receive public funding lead to the majority of the inspected TCs not seeking this source of funding. This is an important observation, especially at the current moment when the pertinence of this funding is under debate. Among the inspected TCs, though, the majority did not try to access public funding. These institutions not seeking out public funds are able to remain in the shadow of the law and keep themselves open because their target public does not depend on this financing: desperate families trying to deal with a relative's problematic relationship with the use of drugs see forced admission as a solution. In other words, the TCs that most frequently violate rights work almost exclusively in the private sphere: they are private institutions that fund themselves in the private world (families).

This situation, however, does not mean that the institutions that receive public funding do not present irregularities or even signs of violations. Among the three TCs that obtain public resources, it was found that TC 14 practices "rescues," TC 1 does not notify the MP when involuntary admissions take place, and TC 11 exceeds the permitted time limit on admission. At TC 11, moreover, most people had been homeless before their admission, which suggests that the establishment functions, in part, to meet the social demand for the removal of undesired populations from city streets. At TCs 1 and 14, the local city councils reached agreements with the inspected TCs for them to receive people subject to compulsory admission decisions, which again indicates a problem in the justice system in understanding the illegality of forced admissions at TCs.

[54] The ILPIs are government or non-government residential institutions intended for the collective accommodation of people aged 60 and over, with or without family support, in a condition of freedom, dignity, and citizenship.
[55] Plan available for consultation at https://www.gov.br/planalto/pt-br.
[56] For a deeper discussion of the TC financing mechanisms, see the article by Renata Weber in this series.
[57] Despite being included on the standard form used in the inspections, the question of funding was not always investigated. Each inspection has its own dynamic (sometimes other questions have more prevalence) and not always the same people carried them out. Consequently, this information was not contained in all the inspection reports analyzed for this research.

TROUBLE SPOTS

The admission of adolescents to TCs was not permitted by legislation at the time when the inspections analyzed here were carried out. More recently, CONAD Resolution 3/2020 allowed this provision and,[58] though not yet in force, the issue has generated considerable controversy,[59] since this demographic requires specific institutional forms of care and investment. Though not backed by regulations at the time, adolescents were found to be staying at seven inspected localities, namely TCs 5, 9, 10, 13, 14, 15, and 18. In other words, the practice of admitting adolescents in TCs already existed before the regulatory provision.

Studies[60] indicate that the court order for compulsory admission of adolescents plays a dual role: on one hand, it is adopted as a strategy for accessing the health service; on the other hand, it is utilized as a form of punishment, referral serving as an additional resource for disciplining adolescents and thus blurring the boundaries between "medication" and "punishment." These adolescents do not attend school and have to share the same space as adults. Both practices constitute violations of the Statute of the Child and Adolescent. Despite many TCs already admitting adolescents, this has occurred without adequate preparations for the admission of this specific demographic profile. Schooling and separation from adults are practices guaranteed even in custodial institutions such as those that detain adolescents who have broken the law.

Another equally complex issue is the work obligatorily undertaken by inpatients in all the inspected TCs. Commonly called "labor therapy," it constitutes a form of "treatment" through labor, forming one of the pillars of the work of the TCs,[61] along with activities of spirituality. In the specialized literature,[62] the condition for work to be therapeutic is the meaning that it must have for the person executing it. Ideally, the person who engages in "labor therapy" encounters stimuli for treatment in the undertaken activities, not the reverse. This work cannot be exhausting, repetitive, or used as a punishment.

[58] CONAD Resolution 3/2020: "Regulates, within the scope of the National Drug Policy System—SISNAD, the admission of adolescents with problems arising from the use, abuse, or dependence on alcohol and other drugs in therapeutic communities."

[59] Agência Câmara de Notícias, "Debatedores criticam internação de adolescentes em comunidades terapêuticas," December 15, 2020, https://www.camara.leg.br/noticias/716171-DEBATEDORES-CRITICAM-INTERNACAO-DE-ADOLESCENTES-EM-COMUNIDADES-TERAPEUTICAS.

[60] Ana Lúcia Seabra Bentes, "Tudo como d'antes no quartel de Abrantes: um estudo das internações psiquiátricas de crianças e adolescentes através de encaminhamento judicial" (MSc thesis, Fundação Oswaldo Cruz, 1999); Andrea Cristina Coelho Scisleski and Cleci Maraschin, "Internação psiquiátrica e ordem judicial: saberes e poderes sobre adolescentes usuários de drogas ilícitas," *Psicologia em Estudo, Maringá* 13, no. 3, (July–September 2008): 457–65, doi:10.1590/S1413-73722008000300006; Andrea Cristina Coelho Scisleski, Cleci Maraschin, and Rosane Neves da Silva, "Manicômio em circuito: os percursos dos jovens e a internação psiquiátrica," *Cadernos de Saúde Pública* 24, no. 2, (2008): 342–52, https://doi.org/10.1590/S0102-311X2008000200013.

[61] See Maria Paula Gomes dos Santos, "Comunidades terapêuticas: unidades de privação de liberdade?" IPEA, *Boletim de Análise Político-Institucional* 10 (2016): 39–46, http://repositorio.ipea.gov.br/handle/11058/7653.

[62] Fernando Sfair Kinker, "Enfrentamentos e construção de projetos de trabalho para a superação da laborterapia," *Cad. Ter. Ocup. UFSCar, São Carlos* 22, no. 1 (2014): 49–61, http://dx.doi.org/10.4322/cto.2014.006; *Maria Luiza Gava Schmidt, "*Laborterapia na promoção da saúde no trabalho sob a perspectiva da socionomia," *Revista Psicologia, Diversidade e Saúde* 5, no. 2 (December 2016): 193–97.

The therapeutic use of work was systemized as a field of knowledge in the eighteenth century by Pinel,[63] who argued for inpatient care (isolation) as the best response to madness. He proposes that rigorously executed mechanical work could guarantee health, returning the sick person to rational thought, because it reestablished their health habits. Studies and reports unfavorable to labortherapy due to the absence of scientific evidence of its effectiveness have intensified,[64,65,66] indicating that this practice is rooted more in moral and disciplinary premises. The report of the 4th Inspection conducted by the CFP indicates:[67]

> In labor therapy, work acquires the same signification attributed by the mental asylum and the prisons, the character of a pure moral imperative. People work to combat idleness, curtail freedom, and submit to order. But people also work to make profits for others, people work without the right to remuneration or any form of protection.

In the inspections, TCs were identified in which cleaning, the organization of physical space, and the preparation of meals was carried out entirely by the inpatients—routines described by one of them: "weed, clean toilets, wash clothes, clean bedrooms and refectories."

Even if one considers that the activities of the TCs are supposedly based on the engagement of the inpatients in the upkeep of their space of coexistence, this collaboration must be absolutely voluntary and supplement the work of the institution's staff, hired for this purpose. In voluntary admissions, it may be inferred that, in theory, the person agreed to all treatment, including the labortherapy. However, the most common profile encountered is that of involuntary admissions and, therefore, the idea of any voluntary engagement in the activities of organizing and cleaning the facilities becomes unsustainable, as well as being a type of imposition that becomes reflected in other spheres:

> It is not just a matter of consent to admission but also to each procedure or therapeutic action, such as the prescription of medicines, individual care, group care, workshops… the dimensions related to the Institutional Technical Project (ITP), the Singular Therapeutic Project (STP), and the everyday activities of the visited institutions.[68]

The central issue is that labor therapy is adopted by the TCs as a "therapy" and, therefore, is not understood by these institutions as a practice that must follow the guidelines of labor legislation. In reality, though, another scenario is encountered: people admitted involuntarily are forced to work without pay. Hence, this practice should be classified as labor and be regulated, therefore, from the viewpoint of the Consolidation of Labor Laws (Consolidação das Leis do Trabalho, or CLT).

In this context, the partnership with the MPT in inspection processes is essential to investigate these occurrences, since there is no formal recognition of the activities carried out inside the

[63] Philippe Pinel, *Tratado médico-filosófico sobre a alienação mental ou a mania* (Porto Alegre: Universidade UFRGS; 2007).
[64] Conselho Federal de Psicologia, *Relatório da 4ª Inspeção Nacional*.
[65] Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*.
[66] María del Carmen Castrillón, "Entre 'teoterapias' y 'laicoterapias': comunidades terapéuticas en Colombia y modelos de sujetos sociales," *Psicologia e Sociedade* 20, no. 1 (2008): 80–90, http://dx.doi.org/10.1590/S0102-71822008000100009.
[67] Conselho Federal de Psicologia, *Relatório da 4ª Inspeção Nacional*, 192.
[68] Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*, 147–48.

TCs. Consequently, this practice can be recognized as work analogous to slavery, as defined under Art. 149 of the Penal Code (PC), noting that the MPT itself sent CRP-SP a request to inspect a complaint of this nature at TC 4.

Another situation also appeared problematic: the use of inpatients as monitors. These people work in the institutions as security guards, supervisors, discipline enforcers, and so on, and, as they show their compliance with the internal norms of the TC, rise in the existing hierarchy, gaining power, prestige, and rewards. The TCs justify this process as part of the labor therapy. In the inspected TCs, this practice is also unpaid, another point that leads to rights violations since the inpatients themselves are used as a free workforce. The monitors are chosen from among the inpatients who behave well and are at more advanced stages of treatment. In exchange they gain benefits (excursions from the TC, extra hours of television, better accommodation and food, more family visits, and so on), as well as status and protection.

Numerous complaints about the monitors were recorded. At TC 1, one of the inpatients reported that "the monitors hit me in the face." At TC 9, one inpatient related that she had been beaten three times, as well as sworn at constantly. At TC 15, it was reported that the monitors were not trained to deal with the inpatients, no training courses were given, and they dealt with conflicts through the use of violence. What was observed in the inspections were inpatients coopted into "therapeutic" work, whether with punishments (containment room and suspension of access to the canteen, cigarettes, phone calls, and even visits), or with the offer of rewards. At TC 1, it became clear how the penalties are applied: it was reported by one of the inpatients that a weekly points system exists for those who break rules, among them the labor therapy activities (1 point—receives warning, 2 points—loses cigarette, 3 points—loses cigarette and leisure for two days, 4 points—loses phone call, and 5 points—loses visit). In most of the locations, few staff were hired by the institution, which seems to corroborate the excessive structural dependence on labor therapy and on this system of monitoring as a form of labor supply.

FINAL CONSIDERATIONS

By analyzing the inspections carried out by the Public Defender's Office of the state of São Paulo in eighteen TCs between 2013 and 2019, the study found that the most frequently encountered rights violations, especially those involving involuntary admissions, are associated with the confusion surrounding their definition and regulation, revealing a discrepancy between theory/law and practice. Problems were also identified in the inspection process in terms of the frequency of inspections and the coordination between the agencies involved, with some significant gaps. It was inferred that more adequate continuous, planned, and structured inspections are necessary, not just those prompted by reports of rights violations.

The present study corroborates the findings of other inspection initiatives,[69] though it is more specific in relation to the aspects evaluated in the act of inspecting. The practice of forced admission (involuntary and/or compulsory) in seventeen of the eighteen inspected TCs points to a worrying picture: a complete lack of prior inspection, disregard for free consent, and the widespread demand for this type of "treatment" among diverse social classes. In this regard, it is worth emphasizing the importance of

[69] Conselho Federal de Psicologia, *Relatório da 4ª Inspeção Nacional*; and Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*.

verifying the inpatient's consent from the viewpoint of the right to informed choice, since the right to be informed about, decide on, and choose which treatments to accept and which to reject are essential elements to exercising autonomy.

Also observed was the leading role played by the CRP-SP, a professional association representing psychologists in the State of São Paulo, as the primary entity for receiving complaints and investigating them in conjunction with the Public Defender's Office. It was shown that it is essential to establish a process flow for complaints and for the responsible bodies to work together to inspect in their respective areas of activity, highlighting health surveillance.[70] A lacuna in the work of the Public Prosecutor's Office was found, a problematic fact considering the relevance of its inspection powers and responsibilities in preventing illegal actions and rights violations in entities like the TCs.

It was also observed that the judiciary has itself very often violated individual rights by ordering compulsory admissions—commonplace even for adolescents—in disregard of the existing legal framework. There is clearly an urgent need for a critical discussion on the interactions between the legal, healthcare, and social protection fields entailed by compulsory admission, since this practice to some extent responds to the social and media demand for the exclusion and control of specific populations, ensuring a supposed feeling of security.

In terms of the work of the Public Defender's Office, difficulties were identified arising from its limited operational capacity relative to a huge area of coverage, especially when compared to the Public Prosecutor's Office. It should be mentioned that, had the legal obligation to communicate involuntary admissions been met, the institution could act in individual defense of those illegally admitted and, when necessary and applicable, propose legal action for indemnities. Furthermore, it is essential to recall its duty to educate in rights, officially established to ensure access to justice, including providing the necessary knowledge for people to be able to demand their rights and defend them. Likewise, it is fundamental to improve the inspection infrastructure in accordance with Law 13,840/2019.

The legal path for accountability did not show itself to be entirely effective given the slowness of the justice system and its typically conservative view concerning the care and treatment of people who make problematic use of drugs. In this setting, administrative solutions were prioritized, but the work is timid and demands a structural debate on the treatment given to this population by the state. It is worth highlighting some of the results of the inspections: the closure of one TC, and recommendations for improvements to others, partially fulfilled. TC 4 is an emblematic case of judicial action: after a series of partial injunctions and attempts by the owner to adequate the space to health regulatory standards, it was recently reported that it had been closed and an ILPI had been opened on the same site, by the owner, which does not guarantee compliance with the regulations but rather a possible change in category to evade inspection.

As we have seen, in the inspected TCs the rights of people have been usurped, while duties were imposed under penalty of punishments and torture. The use of terms like "labor therapy" or "rescue," among others, should not be allowed to mask what was actually found: obligatory unpaid work, kidnapping, and false imprisonment. In this context, we find individuals deprived of their freedom for non-criminal motives, without due process, sentencing, or the right to defend themselves. It is

[70] For further reflections on this point, see the article by Jardel Fisher Loeck in this series.

necessary, therefore, to have a regulatory standard that permits robust, continuous, and coordinated inspection of this type of institution without waiting for complaints to be filed.

"WE'RE SHARING EXPERIENCES!": CONVERGENCES AND DIVERGENCES IN THE POLITICAL ARTICULATION OF TC REPRESENTATIVES IN BRAZIL

PRISCILA FARFAN BARROSO[1]

This article discusses the political articulations and mobilizations of the social actors linked to therapeutic communities (TCs) at the national level in Brazil in their search for social recognition of their institutions and public funding for admitting drug users[2] to their facilities—a process commonly referred to as *acolhimento*[3] by TC representatives. The organizational field of the TCs shows various convergences between the social actors connected to the area, but also divergences that have emerged as these actors negotiate with the state bureaucracy to include the TC model within public policy initiatives. Since 2000, this discussion has acquired increased public visibility, which provides a clearer understanding of its finer details.

Following the Psychiatric Reform Law,[4] public policies aimed at drug users have emphasized care through community-based services like the Psychosocial Care Centers (Centros de Atenção Psicossocial, or CAPS), rather than inpatient care in closed institutions, such as clinics and psychiatric hospitals, or in TCs. It is worth underlining that specific services exist for drug users: among the CAPS are the CAPSad, designed for users of "alcohol and other drugs"; and beds are allocated among the general and psychiatric hospitals for admission of drug users.[5] The community-based services advocate outpatient treatment, conducted by multidisciplinary teams and guided by a harm reduction approach in which users do not necessarily have to stop using drugs to initiate treatment. Inpatient-based treatments, by contrast, require the person's reclusion in the institution and enforce abstinence as a condition for starting treatment.

Confronted by the alleged "crack epidemic" at the end of the 2000s,[6,7] however, conceptions about the treatment of drug users became an issue again and inpatient care was once more presented in the public debate as part of the solution to the "drugs problem." While this discussion was unfolding in the public policy sphere, TCs continued to provide care to drug users. In this setting, they saw the chance to

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[2] The expression "drug users" will be used to refer to this target population of the public policies.

[3] *Acolhimento* (Translator's Note: reception, welcome, care, sheltered care) is an emic term used by the researched group but is also present in the regulations referring to the functioning of TCs.

[4] Law 10,216/2001: "Provides for the protection and rights of people with mental disorders and redirects the mental healthcare model."

[5] As well as these services, there are the Reception Units (Unidades de Acolhimento, or UAs) for people with needs arising from the use of crack, alcohol, and other drugs, created by Directive 121/2012 of the Ministry of Health, which provide treatment in a residential regime.

[6] Edward Macrae, Luiz Alberto Tavares, and Maria Eugênia Nuñez, eds., *Crack: contextos, padrões e propósitos de uso* (Salvador: EDUFBA/CETAD, 2013), accessed February 12, 2021, https://repositorio.ufba.br/ri/handle/ri/16089.

[7] The term comprises a generic definition of crack use, implying a social harm and projecting this situation as threatening—however, there is an absence of epidemiological data to support this idea.

meet the demands of the public sector as funding became available.[8] The TCs provide admission for drug users within a residential regime for periods usually lasting between six and twelve months, placing an emphasis on everyday interaction between peers—that is, with other users who want to reduce their dependence on drugs. Advocates of the CAPS argue that the TCs violate rights because they enforce the reclusion, segregation, and social isolation of the individuals under their care by imposing long-term stay at the institution, as well as being generally located in a rural environment, far from ready access to transport, services, and society as a whole, and also because they demand observance of strict rules and complete abstinence.[9,10,11]

TCs have been active in Brazil for more than fifty years and had already become politically organized at the start of the 1990s through the former Federal Narcotics Council (Conselho Federal de Entorpecentes, or COFEN), today the National Drug Policy Council (Conselho Nacional de Políticas sobre Drogas, or CONAD). As members of civil society active in these councils, they contributed to the discussion that eventually led to publication of Board of Director's Resolution 101/2001 by the National Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, or ANVISA), setting out the basic norms for the operation of TCs.[12] Over the last twenty years, its representatives have become institutionally organized. Following the "Crack Plan" in particular,[13] which provides a clear possibility of federal funding for these institutions, greater coordination emerged between these actors seeking to position these institutions both to function within existing legal frameworks and also to propose the inclusion of the TC model within broader public policy initiatives.[14] This mobilization has resulted in significant gains for TCs as whole in legislative and economic terms.

The political organization of the representatives of TCs in Brazil has occurred through meetings, events, congresses, and also in more institutionalized form through participation in public policy councils, the work of national TC federations, and even through parliamentary interest groups that include members of diverse political parties.[15] This articulation allows them to reorganize their existing conflicts, to unify the demands of TC directors and professional workers, to collaborate in the establishment of alliances

[8] Priscila Farfan Barroso, "Comunidades terapêuticas como política de Estado: uma análise sobre a inclusão deste modelo de cuidado nas políticas sobre drogas no Rio Grande do Sul" (PhD diss., Universidade Federal do Rio Grande do Sul, Porto Alegre, 2020).

[9] Nathalí Di Martino Sabino and Sílvia de Oliveira Santos Cazenave, "Comunidades terapêuticas como forma de tratamento para a dependência de substâncias psicoativas," *Estud. psicol. (Campinas)* 22, no. 2 (2005): 167–74.

[10] Renata Cristina Marques Bolonheis-Ramos and Maria Lucia Boarini, "Comunidades terapêuticas: 'novas oportunidades' e propostas higienistas," *História, Ciências, Saúde-Manguinhos* 22, no. 4 (2005): 1231–48.

[11] Fernanda Mendes Lages Ribeiro and Maria Cecília de Souza Minayo, "As Comunidades Terapêuticas religiosas na recuperação de dependentes de drogas: o caso de Manguinhos, RJ, Brasil," *Interface (Botucatu)* 19, no. 54 (2015): 515–26.

[12] Ana Regina Machado, "Uso prejudicial e dependência de álcool e outras drogas na agenda da saúde pública: um estudo sobre o processo de constituição da política pública de saúde do Brasil para usuários de álcool e outras drogas" (MSc thesis, Universidade Federal de Minas Gerais, Belo Horizonte, 2006).

[13] Decree 7,179/2010: "Establishes the integrated plan for combatting crack and other drugs, creates its Management Committee, and makes other provisions."

[14] Barroso, "Comunidades terapêuticas como política de Estado."

[15] Marcello Doudement and Vínnie Nasser Mesquita da Conceição, "Frente Parlamentar em defesa das Comunidades Terapêuticas," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 167–86.

with representatives of government bodies, and to redirect their political mobilization in defense of the institutions at national level.

The TC federations are representative entities that certify the work done by these institutions, offer advice and training to their professional staff, and mobilize politically to obtain gains for the proposed model. In Brazil, thirty-four federations are estimated to exist,[16] founded along regional and/or religious lines. They may also be interconnected, such as when the same federation is represented in different regions. These federations can be perceived as one more of the institutional actors making up the organizational field of TCs in Brazil, working in processes of public policy construction in the country.[17]

The author's doctoral dissertation provided an ethnography of the TC federations in the state of Rio Grande do Sul between 2016 and 2019, with in person participation at diverse events connected to the theme where it was possible to observe how the policy's legitimacy is constructed in the public sphere.[18] The speakers, participants, and organizers are key actors in terms of understanding the composition and dynamics of this political field. Their active discourses, established positions, and evident moralities help us understand the new directions inducing the policies in question. Accompanying events in Rio Grande do Sul revealed the importance of the relationship between the social actors linked to the TCs and the government actors for the growth of the TC model in the public policy area.

In the subsequent research for this article, the analysis was broadened to include the mobilization of TC federations at the national level. However, in response to the Covid-19 pandemic, this activity also itself had to be reorganized. The events ceased to be held in person and instead took place virtually through social media and networks, principally through live broadcasts on the internet to which anyone has access. In these live streams, the debate's proponents and audiences can participate in synchronous fashion, interacting through chats. When recorded, these livestreaming sessions can also be watched later. Hence, the TC federations, which had already been growing substantially in Brazil, have maintained their political articulations to ensure the functioning and financing of these institutions,[19] as well as continuing to press the state concerning the agendas relevant to the sector. In this way, national mobilization has expanded and has proposed actions to government bodies intended to benefit the TCs, thus allowing these social actors to collaborate in the process of "state making."[20]

The live streams raise issues relevant to the TCs but also function as part of political strengthening strategies in competition with other proposals for treating drug users. During the pandemic, both the demands and the disputes raised by the federations became more publicly visible. Reflecting this fact, the research sought to attend and analyze the live streams hosted by Brazilian TC federations between

[16] IPEA— Instituto de Pesquisa Econômica Aplicada, *Nota técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017).

[17] Roberto Rocha Coelho Pires, "Um campo organizacional de Comunidades Terapêuticas no Brasil? Dos processos de convergência e suas implicações às clivagens emergentes," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 133–66.

[18] John Cunha Comerford and Marco Otavio Bezerra, "Etnografias da política: uma apresentação da Coleção Antropologia da Política," *Anál. Social,* no. 207 (April 2013): 465–89.

[19] Directive 340/2020 of the Ministry of Citizenship: "Establishes measures for responding to the Public Health Emergency of National Importance resulting from human infection with the new coronavirus (Covid-19) within the scope of Therapeutic Communities."

[20] Antonio Carlos Souza Lima, "O estudo antropológico das ações governamentais como parte dos processos de formação estatal," *Revista de Antropologia* 55, no. 2 (2012): 559–64.

April and August 2020—ranging from the first live events broadcast to the end of the period necessary for analysis of the data needed to write this article—with the objective of understanding the political mobilization constructed by these representatives. It is worth mentioning that after the research period, some federations continued to host live streams until the end of 2020, albeit at a lesser frequency.

The article is structured in three parts: an explanation of the methodology used, including the process of recording the data through ethnographic study of the TC live streams; a presentation of the social actors linked to TCs that host and watch these live events; and a description of the controversies among the TC federations in the public debate. In the process, the text develops its argument by revealing the convergences and divergences between the federations participating in the discussions advocating for the inclusion of this model in the public policy sphere.

ETHNOGRAPHIC RESEARCH METHODOLOGY USED FOR THE TC LIVE STREAMS

Studying the theme for her doctorate,[21] the author was able to uncover and learn about the issues relevant to the "world of the TCs," as well as establish contacts with key interlocutors linked to the federations. With the limitations posed by the Covid-19 pandemic and given the public nature of these activities, the decision was thus taken to follow the political mobilization of these social actors in the social networks and livestreaming, solely as an observer, without informing them about this new research project and without interactions during the live sessions. It should be emphasized, however, that without the prior ethnographic research, it would have been exceedingly difficult to access and comprehend what was in play for these actors in the public debate.

At the same time, this study was based on the theoretical framework of "digital anthropology," which takes ethnographic research in the field of cyberculture as a viable methodology. Cyberculture is not a particular object but a privileged way of ethnographically documenting relations between humans and non-humans.[22] The materiality of digital worlds constitutes part of what makes us human, allowing us to study, incorporate, and analyze this materiality as research data.[23] In this sense, we must also "take the virtual seriously," recognizing that individuals invest considerably in the relations established through this medium.[24]

Data was collected on the topics discussed in each live stream, along with the main arguments and recommendations, based on the dialogues among the debate's mediators and guests, as well as some of the interactions with the public on the platform being used. Next, the material was categorized and analyzed using NVivo analysis software, version 11. This processing was important to visualize the relevant categories in the current political panorama that involves correlate social actors, the most relevant subjects, and the political articulations delineated by the representatives of the TCs.

[21] Barroso, "Comunidades terapêuticas como política de Estado."
[22] Jean Segata, "Dos Cibernautas às Redes," in *Políticas etnográficas no campo da cibercultura*, eds. Jean Segata and Theophilos Rifiotis (Brasília: ABA Publicações, 2016; Joinville: Letradágua, 2016), 91–114.
[23] Daniel Miller and Heather A. Horst, "O Digital e o Humano: prospecto para uma Antropologia Digital," *Parágrafo* 2, no. 3 (2015): 91–111.
[24] Carolina Parreiras, "'Não leve o virtual tão a sério'? – uma breve reflexão sobre métodos e convenções na realização de uma etnografia do e no on-line," in *Etnografia, etnografias: ensaios sobre a diversidade do fazer etnográfico antropológico*, eds. Daniela Moren Feriani, Flávia Melo da Cunha and Iracema Dulley (São Paulo: Annablume/Fapesp, 2011), 48–58.

The study accompanied four national-level TC federations that have more frequent interactions with the federal government and that were producing livestreaming sessions during the pandemic. Thirty-six live chats hosted by these federations were analyzed, an average of three live sessions per week with an average duration of approximately two hours, broadcast on virtual communication channels like Facebook and YouTube, all divulged on social networks. It is estimated that these live chats had received around 100,000 views by the end of the fieldwork period.

The federations monitored were the Brazilian Federation of Therapeutic Communities (Federação Brasileira de Comunidades Terapêuticas, or FEBRACT) with weekly live streams; the National Spirituality and Science Therapeutic Community Federation (Federação Nacional de Comunidade Terapêutica Espiritualidade e Ciência, or FENACT), also with weekly live streams; Brazilian Blue Cross (Cruz Azul no Brasil, or Cruz Azul) with monthly live streams; and the Federation of Evangelical Therapeutic Communities of Brazil (Federação das Comunidades Terapêuticas Evangélicas do Brasil, or FETEB), which held just one livestreaming session. The table below displays the number of live streams hosted by each federation and the main themes discussed in them during the period under analysis.

Table 1. Ethnographic mapping of the live streams

Federation	Number of live streams	Main themes of the live streams
FEBRACT	20	Public policies, public funding, specific legislation, everyday activity of the TCs, practices of professional workers in TCs, theoretical and practical knowledge, definition of TCs, questions about chemical dependence and spirituality.
FENACT	10	Public policies, public funding, everyday activity of the TCs, practical knowledge, definition of TCs, and spirituality.
Cruz Azul	5	Public policies, legislation, public funding, and chemical dependence.
FETEB	1	Public policies and legislation.

Source: Author's elaboration.

SOCIAL ACTORS, THEIR TRADITIONAL FORMS OF POLITICAL ARTICULATION, AND THE CONTEMPORARY ROLE OF LIVE STREAMS

FEBRACT was created in 1990 by the priest Haroldo Rahm, who founded the Fazenda do Senhor Jesus (Farm of the Lord Jesus) in Campinas, São Paulo, in 1978, along with teacher and psychologist Saulo Montserrat. Its institutional website shows that the federation is represented in almost all Brazil's states,[25] comprising two hundred and sixteen affiliated TCs across Brazil, the majority Catholic and

[25] FEBRACT's institutional website is available at https://febract.org.br/. To obtain the number of affiliates, the site was accessed February 13, 2021.

located in the Southeast and South regions. According to the live stream on State Funding Programs for Therapeutic Communities,[26] which has been hosted by the federation since 2013, FEBRACT receives state funds to monitor fifty-six TCs, all of them affiliates linked to the New Start Program (*Programa Recomeço*) run by the Drug Policy Coordination Office of the state of São Paulo's Department of Social Development. Its work on the state program has thus enabled the federation to develop expertise in this area, which the entity attempts to disseminate to its affiliates in the rest of the country, including in other states wishing to adopt an equivalent program.

FENACT was previously called the Federation of Therapeutic Communities of the North and Northeast (Federação do Norte e Nordeste de Comunidades Terapêuticas, or FENNOCT) and naturally is more strongly articulated in these regions of Brazil, where it has one hundred and thirty-three affiliates, as informed on its institutional website.[27] This federation was begun in 2007 by Célio Barbosa, who presents himself as a recovering substance dependent who received treatment in a TC.[28] He also founded the Fazenda da Paz (Peace Farm) in Teresina, Piauí, in 1995 (a nonprofit institution, Christian in inspiration, which receives chemical dependents wishing to abstain from use). Recently, as the founder explained on one of the live streams,[29] the name of the federation was changed to allow more national institutions to join and also to emphasize how "faith" and "science" should walk hand-in-hand in the TC model. The federation has regional partners and includes managers from other TCs who collaborate to disseminate its work.

Cruz Azul is a Christian organization brought to Brazil from Germany in 1995. It was founded in Brazil by a member of the International Blue Cross directorate, Hermann Hägerbäumer, and representatives of the TCs Cruz Azul de Panambi (Panambi Blue Cross), in Rio Grande do Sul, the Centro de Recuperação Nova Esperança CERENE (CERENE New Hope Recovery Center) in Blumenau and Palhoça in Santa Catarina, and RENASCER in Ituporanga, Santa Catarina. One of its activities is acting as a national federation of TCs, seeking to advise institutions providing care for drug users. Its office is located in Blumenau, Santa Catarina, and it has nineteen affiliated institutions, concentrated in the South region of Brazil, with some affiliates in the Northeast, as detailed on its institutional website.[30] As a federation it has relatively few affiliates, its members being carefully screened. The representatives heading this federation work in the area of law, which helps in the explication of legal issues and the proposal of new regulations that support TCs at national level.

FETEB was founded in 1995 by the pastor Galdino Filho of Desafio Jovem (Youth Challenge) from Brasilia, Federal District, and by the pastor Edmundo Chaves, linked to the institution Esquadrão da Vida

[26] This live stream was broadcast on May 28, 2020, accessed May 28, 2020, https://www.youtube.com/watch?v=u6SXT9Zu_Xw&t=18s.

[27] FENACT's institutional website is available at https://www.fenact.com/. To obtain the number of affiliates, the site was accessed February 13, 2021.

[28] On this live stream, the work of the TCs was presented and the importance of spirituality was discussed, along with the challenges of the state contexts with new regulations, the advances of the policy, and social reinsertion. In addition, Célio sets out from his life history to speak about how institutions should organize to assist new users. This live stream was broadcast on July 29, 2020, accessed July 29, 2020, https://www.youtube.com/watch?v=TY_niyVqtag.

[29] This discussion appeared in FENACT's live stream on August 5, 2020. The stream is available at https://www.youtube.com/watch?v=j7VFkb8zx58. Accessed August 5, 2020.

[30] The institutional website of Cruz Azul is available at http://www.cruzazul.org.br/. To obtain the number of affiliates, the site was accessed February 13, 2020.

(Life Squad) from Bauru, São Paulo. This federation has representations in all of Brazil's five regions and its affiliated institutions are spread across the country. Nonetheless, unlike the other federations, FETEB does not provide a clear indication of the number of affiliates on its institutional website.[31] As explained in one of the live streams,[32] the affiliated TCs are smaller and have severe difficulties meeting the criteria for public funding applications, since they lack the financial resources to expand their infrastructure, hire more professional staff, or regularize their institutions. The federation's slogan is "faith and unity to serve" and evidently maintains close connections with the work of Evangelical churches, some of the affiliated TCs having begun their work on the actual grounds of churches, usually in their backyards.

To become affiliated, the TCs generally receive a visit from the federation's team, who learn about the institution's work and provide advice. In return, the institutions pay an annual fee to maintain their affiliation. All the federations provide support to the institutions affiliated to them, run training courses for the managerial and professional staff from the area, and participate in the construction of public policies in the national, state, and local spheres. In addition, it is worth emphasizing that the choice of which federation a TC should join involves a mixture of social relationships, regional issues, and religious beliefs, with one of these motivations often tending to be more dominant. So, for instance, although FEBRACT was founded by a Catholic leader, it has Evangelical TCs among its affiliates; Cruz Azul, more widely disseminated in the South of the country, also has affiliated TCs in the Northeast. These examples demonstrate that there is no homogeneity when it comes to understanding their political and institutional relations. In the Covid-19 pandemic, each federation has broadcast its own live streams. Some representatives of these federations make appearances on the live streams of others, like those of Cruz Azul, who take part in the debate during live events hosted by FEBRACT, providing clarifications on legislative issues, or even participating as listeners, congratulating the streams via the chats. Highlighting the particularities of each federation is relevant in terms of comprehending their different stances concerning the TC model, but it is also important to observe that they work together to broaden their national political mobilization.

The federations had already engaged in articulations at state and municipal levels, having met in 2011, in Teresina, Piauí, to formulate the Letter of Piauí,[33] which set out demands, arguments, and agreements for the political articulation at national level. In 2012, the National Confederation of Therapeutic Communities (Confederação Nacional de Comunidades Terapêuticas, or CONFENACT) was formally created with the already cited federations and another two—the Fazenda da Esperança (Farm of Hope)[34] and the National Federation of Catholic Therapeutic Communities (Federação Nacional de

[31] FETEB's institutional website is https://feteb.org.br/, accessed February 13, 2020.

[32] This was the only live stream broadcast by FETEB in the period under analysis, during which drugs and the pandemic were discussed. It was held on June 22, 2020, accessed June 22, 2021, https://www.facebook.com/watch/
live/?v=608352809795035&ref=watch_permalink.

[33] This document is available on the sixth slide of a CONFENACT PowerPoint presentation, accessed February 13, 2021, http://www.confenact.org.br/wp-content/uploads/2016/08/Apresenta%C3%A7%C3%A3o-CONFENACT-Constru
%C3%A7%C3%A3o-do-Marco.pdf.

[34] The Fazenda da Esperança (Farm of Hope) was founded by Brother Hans Stapel, a Franciscan of the Order of Friars Minor, in Guaratinguetá, São Paulo, in 1979, and also functions as a federation with seventy-eight affiliates. Its institutional website is found at https://www.portalfazenda.org/, accessed February 13, 2021.

Comunidades Terapêuticas Católicas, or FNCTC)[35]—with the aim of obtaining social recognition and federal funding for the TC modality of treatment. The slogan of this articulation stresses that "none of us alone is as good as all of us together." It is worth emphasizing that, in Brazil, despite the existence of numerous federations, there is only one confederation.

This union, through the processes of institutionalization, strengthened the organizational field of the TCs vis-à-vis the state and stimulated convergences between the federations.[36] In his work, Pires employs DiMaggio and Powell's concept of organizational field,[37] a construct of neo-institutionalist theory, to reflect on organizations that share common elements and become homogenized. He also draws from Fligstein and McAdam to add the idea of strategic field,[38] in which "fields" are understood as socially constructed arenas, composed by individual and collective actors that seek advantages for their area of interest. In this sense, the federations are collective actors with shared understandings of the field, ready to promote their agendas vis-à-vis the state, at the same time as they are subject to conflicts between their members, leading to changes in the directions taken by the field.

Generally speaking, the work at the federal level has brought together the representatives of the federations, unified the demands of the TCs and their political forces, built bridges with government actors who know and/or support the work of institutions, sought out federal public funds, and questioned existing legislation. These social actors have thus constituted an organizational field of TCs, working to strengthen their modality of treatment as part of the services offered to drug users by the public health system. Indeed, the union of these entities, based on the national confederation, has enabled significant national gains for TCs over the decade: social recognition, adaptation of the legislative framework to their interests,[39] and access to financial resources.[40]

The convergences among federations became concrete in the establishment of minimum standards concerning the characteristics and principles of the TCs, allowing them to dialogue more closely with the state. These convergences occurred through a shared therapeutic standard in the organizational field, seeking a more secure and socially acceptable path.[41] At the same time, the alignment between members in the organizational fields, as in the case of the creation of standardized parameters, may arise from isomorphic pressures. These also relate to the approximation with the state, which connects organizations through their similarities for the purpose of establishing a unity.[42] In the minimum standards set out in CONFENACT's statute, therefore, the existence of a degree of unity between the federations is made explicit. In this document, it is agreed that TC work involves: 1) spirituality, 2) voluntary admission, 3) day-to-day interactions between peers, 4) a residential character, 5) therapeutic

[35] This federation was created by the Pastoral da Sobriedade (Sobriety Pastoral) in 1997 by Dom Irineu Danelon, in Lins, São Paulo, initially under the name of the National Association of Therapeutic Communities and Related Institutions (Associação Nacional de Comunidades Terapêuticas e Instituições Afins, or ANCTC). It has ninety-three affiliates, according to the institutional website, accessed February 13, 2021, http://www.sobriedade.org.br/.
[36] Pires, "Campo organizacional de Comunidades Terapêuticas," 133–66.
[37] Paul DiMaggio and Walter Powell, "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields," *American Sociological Review* 48 (1983), 147–60.
[38] Neil Fligstein and Doug McAdam, *A Theory of Fields* (New York: Oxford University Press, 2012).
[39] For a more in-depth study of the regulatory framework for TCs, see the article by Noelle Resende in this series.
[40] The article by Renata Weber in this series presents a panorama of TC funding in Brazil.
[41] Pires, "Campo organizacional de Comunidades Terapêuticas," 133–66.
[42] DiMaggio and Powell, "Institutional Isomorphism," 147–60.

work, 6) criteria for admission defined by the Therapeutic Project, 7) knowledge of the institution's program, and 8) non-discrimination.

This definition is important—and strategic—in terms of these TCs distinguishing themselves from non-regularized institutions,[43] which carry out compulsory admissions and impose more authoritarian rules on their residents, often leading to accusations of human rights violations.[44,45,46] As one of FENACT's representatives remarked in a live event, these minimum standards allow separation of "the wheat from the chaff," highlighting which are the true TCs, in opposition to the false ones, based on criteria agreed between the federations.[47] This separation is not automatic and arises from an endeavor by representatives of TCs for the institutions, affiliated or otherwise, to adapt to the new norms and also meet the criteria stipulated by government entities. Later, these documented agreements would form the basis for the creation of CONAD Resolution 1/2015, which regulated the functioning of TCs vis-à-vis public bodies.[48] Even so, the operationalization of certain characteristics of the TCs is questioned by some representatives of federations and would have the potential to generate arbitrariness in practice, which puts these actors in conflict, as we will see below.

The representatives of the federations formulate the agendas of the live streams and mediate the debates. Invited to participate in these live events are the "dinosaurs," the TC managers or professionals with wide experience working in the area, most of them "recovering addicts"[49] who were treated in TCs; specialists, professionals in the treatment of drug users, seen as experts by the actors linked to the TCs (such as medical doctors, psychiatrists, social workers, and others); and administrators of government bodies (at federal and state levels) and of public policy councils. It should be stressed that the invited specialists and managers are sympathetic to the model promoted by the TCs, with the public display of this partnership between them conferring even more credibility to the TC model.

The online platforms on which the live streams are broadcast allow only limited interaction with the public, but have some impact on the live discussion, whether through the questions selected by the mediators or in the diverse comments accompanying the event, some of which may indeed be critical of

[43] No estimate exists for the number of non-regularized TCs in Brazil since these regularizations must be made annually by the municipalities where the institutions are found. However, those that receive public funding and the large majority of the TCs affiliated in the national TC federations are regularized.

[44] Conselho Regional de Psicologia de São Paulo, *Relatório de inspeção de comunidades terapêuticas para usuárias(os) de drogas no estado de São Paulo: Mapeamento das violações de direitos humanos* (São Paulo: Conselho Regional de Psicologia de São Paulo, 2016).

[45] Conselho Federal de Psicologia; Mecanismo Nacional de Prevenção e Combate à Tortura; Procuradoria Federal dos Direitos do Cidadão; Ministério Público Federal, *Relatório da Inspeção Nacional em Comunidades Terapêuticas* (Brasília: CFP, 2018).

[46] The article by Jardel Fischer Loeck, also published in this series, analyzes the regulatory question from ANVISA's perspective.

[47] Barroso, "Comunidades terapêuticas como política de Estado."

[48] CONAD Resolution 1/2015: "Regulates, within the scope of the National System of Public Policies on Drugs (SISNAD), the entities that provide shelter for people, on a voluntary basis, with problems associated with the harmful use of or dependence on psychoactive substances, characterized as therapeutic communities."

[49] "Recovering addict" is the term used by the interlocutors to express their understanding that drug users always remain under treatment, even when they have completed their stay in TCs, evincing their comprehension of drug use as a "disease without a cure." The expression is utilized in this article to faithfully reflect its use by the interlocutors in the live streams.

the model. Through participation in the live chats, it was possible to observe that those watching are usually managers, professionals, and supporters of TCs, as well as "recovering addicts" and their families, who see these debates as a way of keeping themselves informed and learning more about the topic of TCs as a whole. In the FEBRACT live streams, some representatives of institutions used the chat feature to say that they were watching along with residents as part of the activities developed in the TC. However, the live streams are also watched by social actors opposed to the treatment of drug users in TCs, who express themselves in the same chats, repudiating the model.

The live streams expose the public debate relating to the TCs and the live broadcast is normally recorded on the platform. Most of the live streams viewed during this research are still available on the online platforms. It thus comprises a public setting, constructed to present the work developed by the TCs, update TC professionals on new information in the area, and boost political mobilization in defense of the TC model. During the live streams, institutions are invited to affiliate with the federations, training courses are offered for TC professionals, and other products distributed by the federations are also presented, such as books, magazines, and manuals.

The very dissemination of the federations throughout the various regions of the country facilitates closer connections among those interested during the public events. On one hand, then, physical events, mobilized locally, facilitate the establishment of informal connections between actors through face-to-face contact, encouraging commitment to the cause. The live streams, on the other hand, amplify the range of participation of TC managers and workers throughout Brazil, with the participation even of people in other countries in Latin America and Europe. This political mobilization adds new individual and collective actors to the organizational field of the TCs, increasing the visibility of the campaign in favor of the model proposed by these institutions.

The public arenas and the controversies established among TC federations

The live streams involving the participation of government administrators were friendly and functioned as a form of political pressure in defense of the TCs. Some questions revolved around the criteria for participation in the public bidding competitions, the need to increase the monthly sums paid to fund places in TCs, and the importance of new regulations that could guarantee and expand the work in these institutions. In response, the government administrators justified their efforts through the public policies implemented under their administration, such as the public bidding issued to fund places on TCs and the directives regulating and giving legal certainty to the institutions. In addition, the officials explained that they understood the viewpoint of the TC managers and showed themselves willing to engage in debate. Thus, the alliance between the federations and these administrators strengthens the organizational field of the TCs, making it possible to generate new public policy proposals.

Some of the interventions in the live streams turned the debate more heated, revealing the dispute between CAPS and TCs over their divergent proposals for the treatment of drug users. In the live stream on regulating care for adolescents in TCs, hosted by Cruz Azul,[50] some viewers in the chat questioned a

[50] This live stream was broadcast on July 29, 2020, with the participation of Damares Alves, Minister of Women, Family, and Human Rights, Dr. Quirino Cordeiro, representative of SENAPRED, and the National Director of SENAPRED, accessed July 29, 2020, https://www.youtube.com/watch?v=47q8_DFbZcM.

recently published resolution:[51] "Isn't it a question of investing in the CAPS?" "Where's the signature of CONANDA [National Council of the Rights of the Child and the Adolescent]?" "They want to lock away young people!" "This is a step backwards!" and so on. To delegitimize these comments and support the work carried out by the TCs, the representative from the Ministry of Citizenship's National Secretariat for Drug Care and Prevention (Secretaria Nacional de Cuidados e Prevenção às Drogas, or SENAPRED), who participated in the elaboration of the resolution, inflamed the debate by emphasizing that these criticisms came from representatives of "ideological political groups" who had previously benefitted from public investment in the CAPS.[52] To justify the growth of the TCs, he also emphasized that there would no longer be "monothematic solutions" in the treatment of drug users, as he claimed took place before his administration, stressing the increase in the number of public bidding processes and directives benefitting the TC model. In emphasizing the investment in TCs as part of the range of different services provided by the public system in the treatment of drug use, and entrenching the contrast between the CAPS and TC treatment models, the government actor's position aligned with the stance adopted by the representatives of the federations, effectively making him part of the organizational field of the TCs too.

Despite the effort to articulate a circumstantial and political unity between the TC federations, which establish convergences and agreements in defense of the model, there are also public disagreements among the representatives themselves, similarly made explicit in the analyzed live streams. The more the TC model approximates the state and becomes part of public policies, the more the debate intensifies between the federations, revealing the heterogeneity of the field. In this sense, the organizational field of the TCs presents isomorphisms, but it is also a place of contestation, conflict, and competition, in which relations of force and internal struggles emerge in a continuous historical movement.[53,54] The actors and their positions may vary, causing them to occupy new positions and orientations within the field. In this way, some disagreements between the federations have become clearer in public arenas during the pandemic.

Religion, spirituality, and devotional moments

The first of these disagreements concerns the exercise of spirituality in the TCs. Some studies have already emphasized the importance of spirituality in the treatment of drug users, especially to maintain abstinence.[55] The federations agree that this is one of the most important tools in the TC model's mode of treatment. In the FENACT live stream,[56] people typically emphasize that "chemical dependence is a

[51] CONAD Resolution 3/2020: "Regulates, within the scope of the National System of Public Policies on Drugs (SISNAD), the sheltered care of adolescents with problems arising from the use, abuse or dependence on alcohol and other drugs in therapeutic communities."

[52] This label has been used in contemporary society in an accusatory tone to delegitimize opponents, suggesting that public policies have been directed for their own benefit. The accusers also try to distance themselves from this label, as though their own position were more neutral; however, every accusing social actor is just as enmeshed in their own beliefs, motivations, and interests as the group being accused.

[53] Pierre Bourdieu and Loïc Wacquant, *An Invitation to Reflexive Sociology* (Chicago: University of Chicago Press, 1992).

[54] Pires, "Campo organizacional de Comunidades Terapêuticas," 133–66.

[55] Renata Barreto Fernandes de Almeida et al., "O tratamento da dependência na perspectiva das pessoas que fazem uso de crack," *Interface (Botucatu)* 22, no. 66 (2018): 745–56.

[56] Broadcast on June 24, 2020, this live stream features TC managers speaking about science and spirituality. Accessed June 24, 2020, https://www.youtube.com/watch?v=3yr2FcmoQGU.

disease of the body but also of the soul, which becomes emptied with the use of drugs." Consequently, spirituality aims to fill the individual's soul, giving the person the strength to continue their life sober. Despite this shared understanding among the TC federations, there are divergences on how spirituality should be practiced within the institutions.

In Brazil, religions play an important role in charitable work with stigmatized groups such as drug users. Not by chance, the first Brazilian TCs emerged through religious leaders with financial aid from the organizations to which they were connected, sometimes comprising an extension of the constructed religious apparatus. Religion promotes abstinence but also offers social resources to individuals,[57] which have been highlighted by actors linked to the TCs when they point to the lack of adequate public policies. However, in a secular state, as established under Brazil's Federal Constitution, public funding of non-governmental institutions is possible so long as the respective beneficiaries are not compelled to practice a religion.[58]

According to a survey by IPEA,[59] more than 80 percent of TCs have some religious orientation and even those that claim to be non-religious declare that they practice "spirituality." Many of these institutions have moments of worship, either involving everyday practices such as prayer before meals, or specific activities as part of their schedule. The heated debate in the live streams centered on the compulsory participation of the *acolhidos* (residents) in these moments provided by the institutions, given that the agreements between TCs and public bodies are premised on an absence of religious imposition.

The preference of these social actors for the term "spirituality" rather than "religiosity" seeks to highlight people's inner world but also to distance themselves from any clear and direct identification with institutional dogmas related to religion.[60] This is also a strategy pursued by the TCs for the public bodies to accept their inclusion in the network of public services. For this reason, the federations highlight the term "spirituality" in the documents agreed among themselves, such as the Letter of Piauí and legal documents like CONAD Resolution 1/2015. Nonetheless, in the implementation of this element of the TC model, it becomes clear how the "religious" is posed as part of the treatment of drug users.

A portion of FEBRACT's representatives view positively the fact that some institutions offer alternative activities if the *acolhido* (resident) does not wish to participate in a moment of worship.[61] The TCs linked to the New Start Program themselves began to act in this form as a result of their negotiations with state government actors for public funding. In the live stream, managers of affiliated TCs who instituted this initiative said that they are challenged to make devotional activities more attractive to the residents and that, when invited, the vast majority end up choosing to participate in them.

Another professional from an affiliated TC argued that spirituality is related to valuing life and possessing optimism and need not to be limited to a specific moment of the TC's day-to-day activities.

[57] Zila van der Meer Sanchez and Solange Aparecida Nappo, "Intervenção religiosa na recuperação de dependentes de drogas," *Rev. Saúde Pública* 42, no. 2 (2008), 265–72.
[58] Constitution of the Federal Republic of Brazil, 1988.
[59] IPEA, *Nota técnica nº 21.*
[60] Rosa Virgínia Melo, "Crack: doença e família na lógica da ajuda mútua," in *Crack e exclusão social,* ed. Jessé Souza (Brasilia: Ministério da Justiça e Cidadania, Secretaria Nacional de Política sobre Drogas, 2016).
[61] This discussion took place on the live stream broadcast on May 28, 2020, accessed May 28, 2020, https://www.youtube.com/watch?v=u6SXT9Zu_Xw&t=18s.

He also stressed that people use the term "spirituality" in some TCs to disguise religion given that it can no longer be all about "work and prayer."[62] Thus, the proposal of an alternative activity seems to represent one of the changes that TCs must effect to forge closer links with the state.

In one of the live events, however, the FENACT representative manifested his disagreement with this concession.[63] Allowing an alternative activity would mean *acolhidos* not taking part in moments of worship, thus interfering in—and hindering—the treatment of their "disease" within the institution. He explained his view by referring to his own treatment in a TC: "the last place that the chemical dependent wants to be is in the encounter with God." This point is explicitly declared to be non-negotiable with the state, since any alternative activity would "remove God from the TC" in effect, disfiguring the proposed model.

To defend themselves from accusations of religious imposition, FENACT's representative claimed that at the time of the *acolhido*'s admission, the entire program should be presented, leaving it up to the person to decide whether to accept it or not, at the time of their entrance, as set out in ANVISA Board of Directors' Resolution (Resolução da Direção Colegiada, or RDC) 29/2011.[64] Furthermore, proposing alternative activities requires hiring more professionals in the institution and the restructuring of physical spaces, increasing costs. Finally, he publicly emphasized that "it is not the TC that has to adapt, it is the person," marking his stance as opposite to the position advocated by other federations.

In the various live streams broadcast by this federation, the same actor questioned the guests: "what does God mean to you? Would you take spirituality away from the TCs to receive public funding?" The TC professionals emphasize the importance of God in their lives, sometimes testifying to their own "spiritual awakening," sometimes recognizing the benefits of the "encounter with God" in the lives of their residents. In terms of public funding, they said that they would never relinquish spirituality to receive this money. One of them declared: "I have already faced many problems without funding, so I would not accept funding if this needed to be changed at the TC." Another argument revolves around their own testimony: "God renewed this vessel to help the TCs.[65] We need to be brave and not remove the spirituality!"

The FETEB live stream also emphasized that: "One should not forgo God to receive any amount of money!"[66] Discussing the broader question of spirituality, its representatives explained to the managers of non-affiliated TCs that the latter "need to organize and remove this taboo since today they can maintain a religious position and simultaneously meet the requirements of the government bodies."

[62] These remarks were made during the live stream on chemical dependence in the female universe held by FEBRACT on May 7, 2020, accessed May 7, 2020, https://www.youtube.com/watch?v=2yfL48EFsM4.
[63] This live stream was broadcast by FENACT on August 5, 2020, to discuss the theme of spirituality in the TCs. Accessed August 5, 2020, https://www.youtube.com/watch?v=j7VFkb8zx58.
[64] ANVISA RDC 29/2011: "Provides for the health and safety requirements for the operation of institutions that provide care services for people with disorders arising from the use, abuse, or dependence on psychoactive substances."
[65] The reference is to a Bible passage in which the potter molds a broken vessel, making it new again. The parable suggests that God does the same with the potter, molding people to make them anew. In the case of the argument made here, God renews people too by collaborating in the work of the TC model.
[66] This live stream was the only one broadcast by this federation, held on June 22, 2020. Accessed June 22, 2020, https://www.facebook.com/watch/live/?v=608352809795035&ref=watch_permalink.

This dispute over how to operationalize spirituality in those institutions that have contracts with the state can be traced back to the problem of secularization in modernity,[67] in which it is necessary to question what is secular and what is religious. The Brazilian state itself, although officially committed to the principles of secularity, includes the presence of religion in its structure,[68] meaning that the imbrications and porosities in the relationship between these two domains have become increasingly evident. When God is called to the public debate, in the process of institutionalizing the TCs, religion is revealed to occupy an ambiguous zone between the secular and the religious. Therefore, in the discourse surrounding the operationalization of spirituality, these boundaries also come under pressure, and the federations position themselves as rivals in their negotiations with the state on this point. Hence, the discourses in the public events expose the struggles of the actors linked to the TCs in their relations with the state, pushing these boundaries to obtain public funding without losing what they deem to be the essence of the TCs.

Tension between faith and technical-scientific logic

Another controversial issue among the federations is the incorporation of the technical-scientific logic into the day-to-day activities of the TCs. This logic pervades the restructuring and training of their teams, the review of the practices for treating residents, and the technical-scientific grounding for the TC model. Traditionally, Brazilian TCs have relied on "recovering chemical dependents" as their main workforce, who conduct the treatment of the residents through their own experience of remaining sober as learned in the TCs. However, as the TCs developed closer relations with the bureaucracy of the state through public contracts, the model needed to be modernized to adapt to the regulatory standards imposed by the public authorities to ensure legal support for the operation of the institutions. Hence, ANVISA RDC 29/2011 requires a technical administrator with a college degree, along with a substitute with the same level of qualification, but does not establish specific requirements for any of the other workers at the TCs.[69]

In any event, the TC federations have encouraged their affiliates to compose their institutional teams from professionals with college degrees, aiming to improve the quality of treatment given to drug users. The experience of the "recovering chemical dependents"—called "monitors" in the TCs—is taken into consideration but the technical knowledge of health professionals is also applied, generally doctors, psychologists, and social workers, who collaborate in directing various aspects of the treatment. In addition, training courses are offered to the TC monitors, managers, and professionals by the federations themselves, which present the more technical language to be incorporated by the TC model.[70] This contributes to a better understanding of the scientific knowledge available on drug use, enabling a standardization of the work of the TCs and a reconciliation between institutional practices and state requirements, as well as promoting dialogue with other professionals from the public services network. Thus, the federations concur about the importance of approximating "faith and science," aware that this modernization entails additional costs and modifications to the therapeutic program used in the TCs. These entities diverge, however, when it comes to the speed of implementing this step.

[67] Talal Asad, "Genealogies of Religion," in *Discipline and Reasons of Power in Christianity and Islam* (Baltimore: The Johns Hopkins University Press, 1993).
[68] Emerson Giumbelli, "A presença do religioso no espaço público: modalidades no Brasil," *Relig. soc.* 28, no. 2, 2008, 80–101.
[69] ANVISA Board Resolution 29/2011.
[70] Barroso, "Comunidades terapêuticas como política de Estado."

FEBRACT emphasizes the importance of the professionals with higher education, suggesting the need to abandon "guess work," concentrating on technical and scientific information for the treatment of drug users in the TCs.[71] The argument repeated by its representatives was that "we have to study, based on science, to be able to take decisions within the TC with more tranquility."

More than half of FEBRACT's live streams focused on modernizing the practices of the professionals working in the TCs. The themes discussed were preventing abandonment of treatment; chemical dependence among women; preventing and managing relapses; training "social skills";[72] updating the "Twelve-Step" program; questions about sexuality and sexually transmitted infections (STIs); and institutional gatherings and treatment during the Covid-19 pandemic. New practices were proposed by the federation's representatives, including: permission for the residents to use mobile phones; preventing abandonment of treatment in the TCs; more flexible management of relapses; more horizontal relations between residents and professional staff in the TCs; stricter health criteria within the institutions; careful treatment of transsexual and cross-dresser residents; technical adaptations of the care given to residents; focus on registering information on residents; more flexible family visits; different possibilities for *acolhidos* (residents) to leave the institutions; increased intolerance in relation to tobacco smoking; referral of residents by the Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS), among others.

Some discussions seemed to be too advanced for the TC model and still shocked the public linked to the institutions. In the chats, people asked how all these changes could be implemented without losing control of the TC, how to discipline residents without punishing them, and so on. Traditionally, the TC model was based on the punishment of individuals so that they would adjust to the institutional rules,[73] but these premises were under review by the federations since there were numerous cases of excesses practiced in these institutions denounced to the public authorities. This change in the way in which the TCs related with the *acolhido* also favored the adaptation proposed for the institution to receive public funding.

During the FEBRACT live streams, theorists from psychology and psychoanalysis were cited,[74] and even renowned institutions like the World Health Organization (WHO) and the National Institute on Drug Abuse (NIDA), to legitimize aspects of the treatment of drug users in TCs. Research by IPEA showed that, among professionals with higher education,[75] it is those from the psychology field who are most prominent among the staff, with an average of one professional per researched institution, which explain the references made in some live events. The experience of one of the federation's own representatives was also valorized in the live stream held by FEBRACT, since he received treatment in a

[71] This discussion occurred during the live event promoted by FEBRACT on conceptualization, management, and prevention of relapses, held on May 14, 2020. Accessed May 14, 2020, https://www.youtube.com/watch?v=nC5DcdLxz6s.

[72] Almir Del Prette and Zilda Del Prette, *Psicologia das relações interpessoais: vivências para o trabalho em grupo* (Petrópolis: Vozes, 2001). According to Del Prette and Del Prette, these social skills include possible behavioral responses to social stimuli or situations in diverse everyday contexts.

[73] George De Leon, *A Comunidade Terapêutica: teoria, modelo e método* (São Paulo: Loyola, 2014).

[74] Among them were cited works like those of Sigmund Freud, Carl Jung, Donald Winnicott, Carl Rogers, and Gordon Alan Marlatt. Carl Rogers, for example, was used to discuss empathy; Gordon Alan Marlatt, for cognitive-behavioral therapy; Jung, as a supporter of participation in self-help groups, etc.

[75] IPEA, *Nota técnica nº 21.*

TC, founded his own TC, trained as a psychologist, dedicated his postgraduate studies to "proving the effectiveness of TCs," and held the post of general coordinator in the federation. However, when he adopted a heterodox posture in relation to use of ibogaine to treat drug dependence,[76] resorting to a more technical language to make his argument, the federation severed ties with him. This situation also demonstrates the limits imposed by FEBRACT itself in terms of the incorporation of technical-scientific knowledge into TC practices, with the federation favoring some authors, like Ronaldo Laranjeira,[77] in detriment to others, demonstrating that controversy also exists in the scientific field.

The other federations (FENACT, Cruz Azul, and FETEB) used the live streams to present summaries of the work of the TCs affiliated to them, to divulge the new criteria for care in TCs during the Covid-19 pandemic, and to discuss political and legislative questions relating to the TCs. In so doing, they made more use of the "dinosaurs" of the TCs,[78] like TC managers and professionals, and administrators from the public bodies and the public policy councils, and less use of specialists with no direct relation to the work in TCs. The practices of professionals in the TCs were mentioned in the accounts of the participants but were not subject to any great reflection and questioning.

The FENACT representative held diverse live events with TC managers and, when presenting the participants, stressed to the public: "This TC is top! They work to recover people!" But he did not go into detail about what, exactly, this criterion referred to. He only mentioned that many institutions had been through a process of modernization to compete in public bidding processes. While he recognized this effort, he seemed to push the technical questions into the background, such as when he claimed that "technique is very good, but it is fundamental to have love!" And he added: "In our view, science is there to serve man, not man to serve science and lose the essence of relationships."[79] In this way, a contrast was highlighted between the "coldness" of technique—knowledge—and the "warmth" of human relations—lived experience—as if, for him, these were difficult to reconcile within the context of the TC model.

At other moments of the FENACT live streams, the work of the professionals with college degrees was discussed, both by the federation representative and by the TC managers. Indeed, it was emphasized that many "recovering chemical dependents" have pursued higher education training and will go on to

[76] This is the active principle of a plant root that has been utilized in clinical studies for treating drug users. SENAPRED is opposed to the utilization of this substance for the treatment of the chemical dependence, since it is not licensed in Brazil, it interacts with various systems of neurotransmitters on the brain in uncertain form, and there are indications of complications arising from its use. Concerning this theme, see Technical Note 64/2020 of the Ministry of Citizenship's Special Secretariat of Social Development.

[77] Psychiatrist from the Alcohol and Drugs Research Unit (Unidade de Pesquisa em Álcool e Droga, or UNIAD), who has the support of the Department of Psychiatry of the Universidade Federal de São Paulo (UNIFESP). Although considered a controversial figure by many specialists and activists from the field of drugs policy, he has numerous publications on the topic of chemical dependence, is recognized as an international scientific reference, supports the work of the TCs, and is opposed to the use of ibogaine in the treatment of drug users.

[78] These are more long-term "recovering addicts" who, after treatment in a TC, continue to be abstinent and have specialized in the treatment adopted in this model, as a professional with higher education and/or a TC manager, the founder of a self-help group, and so on, disseminating the principles of the TCs.

[79] This discussion took place in the live stream broadcast by FENACT on June 24, 2020. Accessed June 24, 2020, https://www.youtube.com/watch?v=3yr2FcmoQGU.

work in TCs.[80] When the TC model came under question from professional councils like the Federal Psychology Council (Conselho Federal de Psicologia, or CFP), however, the aforementioned FENACT representative pointed to the professionals from the area already working in TCs, saying he was "hurt," since although the TCs are not obliged to hire that many higher education professionals, they nonetheless employ many psychologists. He also stated that these professionals need to work to improve how the TCs are perceived by their councils. This circumstance also causes discomfort among the psychologists who work in TCs and their respective professional associations, also creating divisions there. One of the psychologists who work in a TC said that the regional councils are not always in agreement with the federal councils, and that "it is complicated to say something. We know that the CAPS obtain results, but it is in the TCs that I see more evolution of the resident." In this sense, despite the federation recognizing the importance of the therapeutic project as a technical instrument used by the TC to accompany the *acolhidos* (residents), as agreed in the CONFENACT statute, questions still perceptibly exist for this federation concerning the use of the technical-scientific logic compared to traditional and religious practices based on "vocation," "charity," and "love."

In any case, it becomes clear that in the work of the organizational field of the TCs with the state, pressures exist for the professionalization of the practices of actors and institutions. As Bourdieu stressed,[81] "the more the political field is constituted, the more autonomous it becomes, the more professional it becomes." Hence, disagreements between the federations are cited by actors in terms of the techniques and instruments introduced by professionals with college degrees to the practices of the workers of TCs; those who are more resistant to this process, defending the preponderance of experiential knowledge allied to the religious vocation, are perceived by others as more traditional or, from a more conflictual perspective, more backward.

Resident-professional relationships: between custody and autonomy

Finally, we can highlight the way in which the user is perceived by the federations as someone more or less in the custody of the professionals at the TCs. This is a subtle question, but also reveals diverse conceptions. The very discussion on the practices of the professionals in the TCs provides clues as to how the representatives of the federations perceive the residents. Despite CONAD Resolution 1/2015 emphasizing voluntary admission and prohibiting actions of containment, punishment, and discrimination,[82] there are perceptible differences in the way in which the federations promote the autonomy of the residents within the TCs.

FEBRACT has questioned the morality traditionally linked to the TC model, at the same time as it seeks to promote greater autonomy for residents. In the live streams of this federation, precisely because of their questioning of the practices of professionals, this vision of resident autonomy became more evident. The new therapeutic proposals in the TCs enable a closer approximation of the model with the state and even with principles of the Unified Health System (Sistema Único de Saúde, or SUS). One of these principles is the "preservation of people's autonomy in defense of their physical and moral

[80] This point was raised in the live stream on the partner federations and affiliates of FENACT, hosted by the latter federation on July 8, 2020. Accessed July 8, 2020, https://www.youtube.com/watch?v=AWT1KtXhaDk.
[81] Pierre Bourdieu, "O campo político," in *Revista Brasileira de Ciência Política,* no. 5 (July 2011): 193–216.
[82] CONAD Resolution 1/2015.

integrity."[83] It is explained, however, that this is a discourse expressed in the live streams but does not necessarily reflect the everyday situation in the affiliated TCs. FEBRACT also seeks to exempt itself from agreeing to practices different from those it defends.

In a live stream on assemblies in TCs,[84] held to discuss important points of the everyday life of these institutions, a more horizontal relationship between residents and professionals was encouraged so that everyone can suggest, assess, and decide what happens in the institution. Generally, the guidelines come from top-down. However, one of the FEBRACT representatives stated that "if the resident learns autonomy, he will manage to leave there better!" Another TC manager added: "We must give credit to the addict's thought and not presume that he doesn't think!" On the other hand, this aspect was seen with some apprehension by other TC managers and professionals, who sent numerous questions in chat messages about the operationalization of this process. The mediator of the FEBRACT live stream, in turn, pushed back on such questions saying: "It won't transform the TC into an anarchy since the roles are well-defined; they will make it more functional and adequate to the institution's needs."

In various live streams run by this federation, the conclusion presented by its own representatives and by the specialists who worked in TCs was that the biggest difficulty resides in the professionals rather than the residents. Worried about "losing control," the professionals believe that they need to subjugate residents using authoritarian measures. FEBRACT, however, has encouraged its affiliates to break with this pattern, trusting in their residents more. The TC managers who took part in the live streams reported that they had been surprised by the potential for implementing this principle. One of them related that not making it compulsory to shave did not mean that the residents became "relaxed" about their hygiene; on the contrary, they began to groom their beards diligently.

Based on the analyzed live streams, it cannot be affirmed that the other federations do not promote the autonomy of the residents, at least at a discursive level. But this was a point seldom emphasized in the debates hosted by the other federations. For this reason, the emphasis given by FEBRACT stands out from the other federations, revealing the differences concerning this question. Thus, while FEBRACT seems more disposed to accept the recommendations that entail a review of the TC model, the other federations are more reserved on this topic.

What was more frequently observed was the defense of the custody of the residents, expressed in paternalistic, welfarist, and salvationist relationships on the part of some representatives of federations and managers of TC affiliated to them—both between them and in relation to the residents. In the FENACT live streams, some guests were presented as "children" who now worked in their own TCs. This relation involved the strong figure of FENACT's founder, perceived by many as a "father," recognized for pioneering the participation of TCs in public policies, mobilizing legislative debates, activating networks to enable public contracts, and promoting training courses, stimulating TC managers and professionals to adapt to the legislation.

[83] Law 8,080/1990: "Sets out the conditions for the promotion, protection and recovery of health, the organization and functioning of the corresponding services, and makes other provisions."
[84] The live stream was broadcast on July 30, 2020. Accessed July 30, 2020, https://www.youtube.com/watch?v=xrnsXeiUoZE.

Many of the TC managers who participated in the live streams of this federation emphasized that the work in the TCs "is a project of the heart that comes from God to save lives."[85] This argument, based on the "salvation" of drug users, suggests a more passive perception of the residents, who needed the institutions to remain alive.

CONCLUSION

Inspired by digital ethnography, utilizing the live streams hosted by TC federations as empirical material, it is clear that the representatives, managers, and professionals of these entities have become increasingly institutionalized through these activities; they meet, make demands, compete for space in public policies, and acquire significant financial resources. The live streams held during the pandemic in the research period discussed topics and themes relevant to those who work and are active in the area from the viewpoint of their practices; but they are also part of the political mobilization in search of legitimacy and public funding for these institutions, based on closer relations with the state.

The organizational field of the TCs involves a political articulation of the actors connected to them,[86] as well as close relationships with the representatives of government bodies, thus allowing these institutions to act more directly in the public arena. Therefore, the unity of the TC federations is revealed as an organizational field, showing centripetal forces that evince shared agreements,[87] with the aim of including the participation of the TCs in public policies for the treatment of drug users. As Fligstein and McAdam show,[88] this field can be perceived as a field of strategic action in which actors reach common agreements, even if there is no consensus. At the same time, the differences, divergences, and disagreements elucidate centrifugal forces,[89,90] presenting heated discussions on the operationalization of the principles and characteristics of TCs, which can result in changes in the directions taken by the field. The exposition of the differences between the federations in the public debate forms part of the strategies of the social actors in their quest to achieve hegemony of their model in the organizational field of the TCs vis-à-vis the state.

Three points stand out that expose disagreements between the TC federations. The first is the proposal for an alternative activity for exercising spirituality during the moment set aside for worship, about which diverging opinions are presented. The second relates to the incorporation of the technical-scientific logic in the day-to-day life of the TCs, which is revealed by the importance attached to professionals with college degrees, by the acceptance of new therapeutic proposals, and by the science-based discourse. And finally, by the way in which residents are perceived in the TC, considering actions that enhance, or diminish, their autonomy.

The divisions observed in the field are directly associated with a degree of proximity to the state. Thus, these point to a movement of revision of the TC method, which has looked to absorb some of the scientific innovations in the field of care for drug users and the regulations of the public sector, possibly

[85] This claim was made by a TC manager on the live stream broadcast by FENACT on June 24, 2020. Accessed June 24, 2020, https://www.youtube.com/watch?v=3yr2FcmoQGU.
[86] Pires, "Campo organizacional de Comunidades Terapêuticas."
[87] DiMaggio and Powell, "Institutional Isomorphism."
[88] Fligstein and McAdam, *A Theory of Fields.*
[89] Bourdieu and Wacquant, *Reflexive Sociology*.
[90] Pires, "Campo organizacional de Comunidades Terapêuticas."

to make it easier to obtain funding for these institutions, among other possible aims. It is in this sense that the social actors linked to the organizational field of the TCs also pressurize, construct and "make the State,"[91] amid other individual and collective actors. According to the presented data and analyzed discussions, therefore, conflicts between the TC federations can be identified insofar as they become stronger and develop closer relations with the state. They unite to challenge the critics of the TC model but also publicly express the fissures between them.

Consequently, despite the TC federations showing convergences, established by isomorphic pressures in the approximation with the state, in establishing minimum standards for the functioning of the institutions other differences and divergences come to the surface, especially in the debates between them, pointing to potential institutional changes in their organizational field. This suggests important reflections concerning their complexity and heterogeneity, enabling us to perceive the differentiations and hierarchies established in this organizational field.

FEBRACT went as far as to request disaffiliation from CONFENACT in 2017.[92] The fieldwork conducted for the author's doctoral thesis showed that FETEB's affiliation was also heavily questioned by members of CONFENACT in 2018. Whatever the case, though, these federations currently remain united and active in the confederation. During the pandemic, the emphasis on FEBRACT and FENACT was due precisely to the larger number of live streams hosted by these federations at this time, meaning that the mediators of the live events themselves end up elucidating the differences between the federations in the public debate.

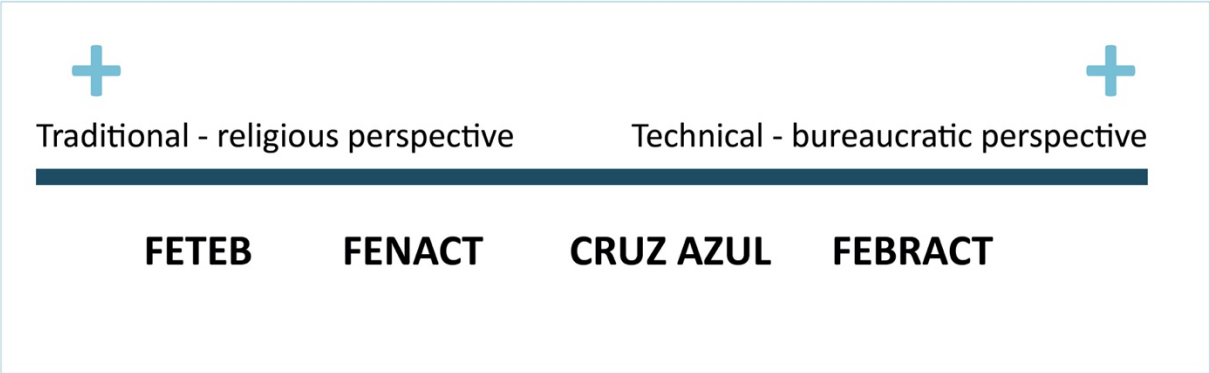
The FENACT representative emphasized being shocked by the competitiveness between the TC federations and sought to persuade them that they should not see each other as rivals but rather it was more advantageous for them to be united. Meanwhile the FEBRACT representative, looking to assuage the explicit conflicts, gave the assurance in one of the live events that: [93]

> FEBRACT is not the possessor of absolute truth but presents possible proposals. Let's collect experiences! The TCs presented here are not necessarily models to be followed. We are not inventing rules or dictating norms. We are only sharing testimonials experiences!

Consequently, the federations assume discourses in the public arena that traverse diverse viewpoints that are not mutually exclusive but place them in different positions relative to the state. The first is the more traditional-religious viewpoint; the second, the technical-bureaucratic viewpoint. Hence, proposing a scale of proximity to the state, which spans from the greater to lesser proximity obtained by the four institutions responsible for producing the live streams during the pandemic, an interpretation can be ventured like the one presented graphically in Figure 1:

[91] Souza Lima, "Ações governamentais."
[92] Pires, "Campo organizacional de Comunidades Terapêuticas."
[93] The theme of this live stream was "Community Assembly—The Essence of the TC" and the quoted remark is a literal reproduction of what was said. The live stream was broadcast on July 30, 2020. Accessed July 30, 2020, https://www.youtube.com/
watch?v=xrnsXeiUoZE.

Figure 1. Scale of proximity of the TC federations with the state.



Source: Author's elaboration.

Although the federations analyzed here do not represent all the existing TCs in Brazil, their political mobilization is significant and increases the visibility of the work performed by the institutions. The degree of proximity or distance between the federations reveals challenges and conflicts in the organizational field of the TCs by including the TC model in public policies. Despite the unity of the federations in defending the TCs, the disputes between them are still shown to permeate the actual adaptation of the institutions to the parameters established by the state. While some federations perceive themselves as better prepared for the modernization process, given that they are adapting to state requirements, others prefer to maintain their canons, as though flexibility could alter the essence of the model.

At the same time, it remains important to analyze in the future the movements within this organizational field, highlighting the historical and political circumstances in which one federation moves closer to another, or becomes more intransigent in this confluence. Comprehending the specificities of these processes allows the objectives of this article to be advanced, discerning moral, religious, political, and economic nuances that play out between the federations to understand the complexity surrounding the discussion on TCs and public policies.

INTERFACES BETWEEN RELIGION, PROBLEMATIC DRUG USE, MORALITIES, AND GENDER IN THERAPEUTIC COMMUNITIES

JANINE TARGINO[1]

This article analyzes the interfaces between religion, problematic drug use, moralities, and gender in three therapeutic communities (TCs) in Brazil that provide care exclusively to the female population. The aim of this research is to understand some of the elements that define the particular trajectories of women staying in religiously affiliated TCs. The material studied here originates from a series of semi-structured interviews conducted in selected institutions with a Catholic or Evangelical affiliation.[2] This choice is based on data from the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, or IPEA), which shows that the majority of TCs in Brazil have an Evangelical (47 percent) or Catholic (27 percent) religious orientation.[3] Five female residents and one institutional leader were interviewed in each of the three selected TCs, for a total of eighteen interviews in all.[4]

TC1 is the institutional headquarters of a network of TCs with various units located in Brazil and other countries. The center is run by members of a religious community that emerged from the Catholic Charismatic Renewal (CCR)[5] and is located in the interior of the state of São Paulo. Among the features of this TC is its infrastructure, which includes a school and a nursery to cater to the children of the resident women.[6] For this reason, when the interviews were conducted, there were approximately twenty children at TC1 in the company of their mothers.[7]

Of the three TCs studied, TC1 is the only one to accept the children of the residents (*acolhidas*).[8] The children accompany their mothers on practically all occasions and share all the spaces with the other

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[2] The research was conducted following approval from the Research Ethics Committee of the Center of Philosophy and Human Sciences of the Universidade Federal do Rio de Janeiro (UFRJ). The approved research project was registered as CAAE 35363920.9.0000.5582.

[3] IPEA – Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017), 20, http://repositorio.ipea.gov.br/bitstream/11058/8025/1/NT_Perfil_2017.pdf.

[4] The interviews and other interactions with the TC residents and support team members followed all the health precautions necessary to carry out research during the Covid-19 pandemic.

[5] For more details on the CCR, see Marcelo Camurça, ed., *Novas Comunidades Católicas: em busca do espaço pós-moderno* (Aparecida: Ideias & Letras, 2009).

[6] The school and nursery are also open to the children of families living in the area around the TC.

[7] Some women were accompanied by more than one child. Approximately eighty women were staying at TC1 when the interviews were conducted.

[8] Over the course of the text in Portuguese, the term *acolhida* is used to refer to the women in the TCs. This term (Translator's Note: from the verb *acolher*, meaning "to welcome, receive, host, take in, protect, shelter, offer refuge") expresses the condition in which these women find themselves and how they are recognized, since they stay in the institutions voluntarily and may leave at any time. It is essential to emphasize, however, that *acolhida* is an emic term used within the universe of the TCs and does not necessarily reflect a definition accepted in the field of drug and healthcare policy more widely, and its utilization by the TCs is controversial (TN: Since there is no real equivalent in English, the term has been translated here simply as "resident.").

residents. There are no separate rooms for mothers and children, meaning that they use the same bed in the collective accommodations. Likewise, all meals are cooked together and the mothers are responsible for preparing food for their offspring.[9]

TC2 is situated in the north of Rio de Janeiro state and is a venture run by an Evangelical church, a denomination within the tradition of so-called Historical Protestantism,[10] offering care to female drug users. This TC is part of a broader network that includes other units providing care to women, as well as units that exclusively receive men, run by members of the church responsible for conceiving the project. Meanwhile, TC3, located in a neighborhood in the West Zone of Rio de Janeiro city, is linked to a Pentecostal Evangelical denomination.[11] Like TC1 and TC2, it receives women only. But unlike the other two institutions, TC3 is a small-scale initiative without any affiliated units, run exclusively by the pastor responsible for founding the project.

According to a study by Villar and Santos,[12] these three institutions form part of a very small group. Analyzing data from a 2015 survey of five hundred TCs located across all regions of Brazil, the authors discovered that 80 percent of the TCs operating in the country provided refuge for men, while 15 percent catered to both the male and female populations, and just 5 percent of institutions provided care exclusively for women. The much higher number of TCs for men indicates that male drug users are perceived as a group that requires more efforts and resources to confront their dependence.

In terms of how TC1, TC2, and TC3 operate, several common aspects stand out. The first is the requirement that the women abstain completely from drugs (in contrast to the more prevalent logic of harm reduction). Although not exclusive to these TCs,[13] this factor should be emphasized for a clearer characterization of their work. Another important aspect of these TCs is that isolation from social life is an unnegotiable precondition, a demand intended to encourage closer interactions between peers, who develop a community life within the institution. Similarly, these TCs set the period for which the residents can stay at somewhere between nine and ten months. Nevertheless, there were some women whose stays had exceeded the maximum time of twelve months. The women remained voluntarily in these TCs and could leave the institution whenever they wished. In terms of routine, the three institutions run according to well-defined and fairly inflexible schedules, soliciting the involvement of the women throughout the day to perform religious activities, cleaning tasks, and organizational duties. Finally, it should be emphasized that the institutions do not charge for the services they provide and,

[9] Although the particular scenario of TC1 raises questions about the impact that the stay in the institution may have on the children who accompany their mothers during their stay, analysis of this aspect lies outside the scope of this article.

[10] On the category of "Historical Protestants," see Leonildo Campos Silveira, "'Evangélicos de missão' em declínio no Brasil," in *Religiões em movimento: o censo de 2010*, ed. Faustino Teixeira and Renata Menezes (Rio de Janeiro: Editora Vozes, 2013), 311–27.

[11] For a more detailed categorization of Pentecostal Evangelicals, see Antônio Gouvêa Mendonça, "Evangélicos e pentecostais: um campo religioso em ebulição," in *As religiões no Brasil*, ed. Faustino Teixeira and Renata Menezes (Rio de Janeiro: Editora Vozes, 2011), 89–110.

[12] Nayara Villar and Maria Paula Santos, "Sexualidade e relações de gênero nas comunidades terapêuticas: notas a partir de dados empíricos," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Santos (Rio de Janeiro: IPEA, 2018), 101–119, https://www.ipea.gov.br/portal/images/stories/PDFs/livros/livros/190103_comunidades_terapeuticas.pdf.

[13] IPEA, *Nota Técnica nº 21*, 20.

given this philanthropic profile, may be more likely to take in women from the lower classes with insufficient resources to pay for the services offered elsewhere by private institutions.

The purpose of this article is to present information that helps build our knowledge about the set of meanings shared by female drug users receiving care in religiously affiliated institutions. In this respect, the insights of Clifford Geertz,[14] an anthropologist who carried forward the extremely important work of Max Weber, are especially useful, since they tell us about the complex semiotic web formed by the meanings that actors themselves attribute to their actions in every sphere of social life. In other words, through the meanings that the actors attribute to the methods employed by the TCs, this article sets out to reconstruct and interpret a set of concepts and meanings not limited to the religious universe, insofar as they connect religion, gender, morality, and drug dependence.

The research data was also explored through the prism of concepts relating to both religious and nonreligious morality and conversion. Hence, the narratives of the residents and the leaders of the TCs were closely examined to understand how, within the TCs, the proselytizing discourses and moralities present in the religious cosmology are mobilized.

THE INTERVIEWS

In general terms, Christian religious narratives can be said to consider both men and women susceptible to the "temptations and pleasures of the flesh," since they possess "weaknesses" perceived as inherent to the human condition.[15] However, the efforts employed to exercise control over women's lives have always been significantly greater, meaning that religious morality has a stronger impact on female bodies.[16] Among the moral prohibitions stemming from religious discourse, undoubtedly the most relevant are those pertaining to female sexuality. Seen as bearers of human lasciviousness and responsible for the original sin, women have been historically subject to religious strategies to control their bodies and their subjectivities.

Among the individuals in need of being rescued from their "cursed lives," women figure through a series of emblematic stereotypes like the "prostitute," the "drug addict," and the "deviant." By way of comparison, the stigmatizing labels most used for men are "criminal," "beggar," "idiot," and "junkie."[17] Hence, the stigmas associated with women and men coincide only in relation to drug dependence. While the other stigmas projected onto women center around sexual activity, men are more frequently labeled with terms connected to crime. In other words, if on the one hand there is the "prostitute," on the other there is the "criminal," and neither figure corresponds adequately to socially constructed expectations for their gender. And even though much more than prostitution and crime are involved, these are the key categories that need to be considered.[18]

[14] Clifford Geertz, *A interpretação das culturas* (Rio de Janeiro: LTC, 2019), 3–21.
[15] Kelma Lima Cardoso Leite, "Implicações da moral religiosa e dos pressupostos científicos na construção das representações do corpo e da sexualidade femininos no Brasil," *Cadernos Pagu*, no. 49 (2017): 7, https://www.scielo.br/pdf/cpa/n49/1809-4449-cpa-18094449201700490022.pdf.
[16] Michel Bozon, *Sociologia da sexualidade* (Rio de Janeiro: FGV, 2004), 27.
[17] Cesar Pinheiro Teixeira, "O testemunho e a produção de valor moral: observações etnográficas sobre um centro de recuperação evangélico," *Religião e Sociedade* 36, no. 2 (2016): 110–12, https://www.scielo.br/pdf/rs/v36n2/0100-8587-rs-36-2-00107.pdf.
[18] The author thanks Cesar Pinheiro Teixeira for his comments on this point.

Indeed, researchers have notably devoted themselves to analyzing specific Christian religious currents that strive to reach individuals with "broken lives" with the intention of giving new meaning to their life histories through the process of conversion.[19,20,21] In this context, it is unsurprising that diverse resources have been mobilized by religious groups to "recover" those living outside God's designs.

When reached by these proselytizing discourses, the woman previously classified as "errant" and "perverted" becomes conceived as a raw material capable of being transformed into the ideal of the Christian woman. For this transformation to occur, it is essential that she adapt to the religious group to which she intends to belong. Obviously, the moral reform that the Christian religions seek to instill in the lives of female drug users prioritizes elements very different to those employed in their endeavors to rescue male drug users. The "failures" attributed to female users are distinct from those attributed to men under the same conditions, since women are much more frequently blamed for any failure in relation to motherhood, while there tends to be little or no discussion about fathers' responsibility to their children. Consequently, the religious discourses focusing on the reconstruction of the life histories of male and female drug users address distinct elements and mobilize specific meanings according to the social roles assigned based on gender by wider society.

Previous research has shown that Catholic and Evangelical TCs share religious and nonreligious moralities that sustain an ideal model of the Christian woman.[22] This model is founded on the triple identity of "good mother + good wife + good Christian," which, according to the rhetoric widespread in the three TCs analyzed here, refers to attributes absent from female drug users. There is a broad understanding in these institutions, therefore, that performing the functions associated with motherhood, marriage, and the church is the most reliable strategy for these women to successfully abandon their use of drugs. At the same time, those women identified as inadequate mothers and wives are, in this setting, taken as morally weak and insufficiently devoted to religion.

Still on the subject of the triple identity of "good mother + good wife + good Christian" and the failures commonly attributed to female drug users, the analysis of the interviews will be presented from the viewpoint of reconstructing the moral careers of the residents,[23] through the repositioning of these women vis-à-vis their families and the church/religion. To this end, this triple identity is separated here into two parts, one relating to the family (good mother and wife) and the other to the church and to the experience of religion and/or spirituality (good Christian). This will hopefully provide clearer insight into the meanings that these women impute to their own lived experiences in the TCs, as well as into how

[19] Carly Barboza Machado, "Pentecostalismo e o Sofrimento do (Ex-)Bandido: testemunhos, mediações, modos de subjetivação e projetos de cidadania nas periferias," *Horizontes Antropológicos*, no. 42 (2014): 160–66, https://www.scielo.br/pdf/ha/v20n42/07.pdf;

[20] Cesar Pinheiro Teixeira, "De Corações de Pedra a Coração de Carne: algumas considerações sobre a conversão de bandidos a igrejas evangélicas pentecostais," *Dados* 54, no. 3 (2011): 462–73, https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0011-52582011000300007.

[21] Natânia Lopes, "'Prostituição Sagrada' e a Prostituta como Objeto Preferencial de Conversão dos 'Crentes,'" *Religião e Sociedade* 37, no. 1 (2017): 37–42, https://www.scielo.br/pdf/rs/v37n1/0100-8587-rs-37-1-00034.pdf.

[22] Janine Targino, "Religião contra as 'drogas': estudos de caso em duas comunidades terapêuticas religiosas para dependentes químicos no Rio de Janeiro" (PhD dissertation, Universidade do Estado do Rio de Janeiro, 2014), 174–86.

[23] Erving Goffman, *Estigma* (Rio de Janeiro: LTC, 2019), 41–50.

the roles of mother, wife, and Christian are shepherded by the institutions as part of their offer of assistance to the women in their care.

Being a good mother and wife: Motherhood and marriage as part of the method of the TCs

Reconstructing the panorama of the place occupied by women in colonial Brazil, Del Priore points out that motherhood was coopted as a tool to discipline female life.[24] As Del Priore explains, "being a mother" in the colony was founded specifically on "instructing and educating children in Christian fashion" and "taking diligent care of domestic affairs."[25] It is worth stressing just how strongly the elaboration of this model of saint-mother, in which women were to sacrifice themselves and assume a submissive posture for the sake of the family's preservation, was connected to the precepts of the Catholic church, functioning as one of the most critical mainstays of society during this era. Long after, in the twenty-first century, motherhood remains a phenomenon capable of attributing status to a woman and channeling attention and care toward her, very often removing the woman from a situation of invisibility and raising her condition to one of hypervisibility.

As mentioned previously, a singular feature of TC1 is its infrastructure dedicated to accommodating women accompanied by their children. For this reason, a considerable part of the methodology employed by TC1 revolves around motherhood and how the team believes it should be experienced by the residents. Another important point is that the women who stay at TC1 with their children, as well as pregnant women, are seen as individuals who demand more attention from the institution. This view is based not just on the idea that pregnant women and/or women with children need more practical assistance, but also on the notion that this group of residents requires specific learning to handle the responsibilities given to them by motherhood. In this sense, the declaration[26] by Ester,[27] leader of TC1, provided a good illustration of the institution's position vis-à-vis these women.

> Many of them come here to learn about maternity, learn the trade. Many of them have children but leave them with her parents, with someone, with the grandfather, with the grandmother. *But they are not mothers*. Because the drug addiction robs them of this a lot. That responsibility, judgment, perspective, that fine thing that is motherhood, being a mother, they don't have it. Many of them have never properly performed the function, much less in the literal sense of the word. So when they need treatment and have nobody else with whom they can leave the children, the option in many cases is the [TC1]. […] And the mothers are mothers, as you saw here, who need intensive treatment for their drug addiction, teaching, teaching them everything, how to speak, how to sit, how to walk, how to converse. They must be taught everything. (Ester, leader of TC1, author's emphasis)

Interestingly, Ester attributed the supposed lack of success of these women in the exercise of motherhood to the fact they are drug dependents. In her view, the problematic use of substances (*drogadição*, drug addiction, in her words) "robs" the residents of their maternal responsibilities and

[24] Mary Del Priore, *Ao sul do corpo: condição feminina, maternidades e mentalidades no Brasil colônia* (São Paulo: Editora Unesp, 2009), 41.
[25] Ibid., 41.
[26] All the quotations from the TC residents and leaders cited over the course of the article are literal transcriptions, including any errors, taken from the interviews.
[27] All names appearing in this article are fictitious.

prevents them from being "true mothers." Here, the figure of the "abandoning mother," as explored by Fernandes,[28] serves as an excellent analytic key for us to comprehend Ester's viewpoint. As Fernandes points out, the mother who "abandons" her child tends to be employed as a generic category encompassing almost any case in which a child comes to live under the care of other people. This modality of deviant motherhood, in which the woman, to paraphrase Ester, leaves her children with "her parents, with someone, with the grandfather, with the grandmother," is cited as a negative example to be avoided. In this context, the "abandoning mother" is depicted as the antithesis of the "true mother," one who possesses the moral characteristics socially classified as positive.[29]

As becomes clear in the narratives of the residents, the expectation of "learning to be a mother" not only applies to those women whose children stay in the TC with them; it also strongly affects those who have left their offspring in the care of their own parents, grandparents, or others. Furthermore, as various interview dialogues that touch on motherhood make clear, these women often tended to agree with the accusations made by the TCs regarding their poor performance as mothers.[30] Such was the case of Sara, thirty-three years old, separated, dependent on alcohol, and the mother of three children who, during her stay at the TC1, remained under the care of her own mother.

> Researcher: What was the situation that led you to seek help?
>
> Sara: My children.
>
> Researcher: What happened?
>
> Sara: My daughter called me a slut [vagabunda]. That's what… She didn't want to see me anymore; she didn't want me at home a day longer. She didn't want anything to do with me. Even so, for a few days I kept saying, "I'm not bothered." But gradually the reality struck me. My children are growing up and are already discarding me. The reality struck home. I said to myself, "Hey, hang on." […] My daughter said she didn't want to speak to me until I left here recovered, she said she wasn't going to speak to me. […] Then last Sunday I'd been here three months [staying in TC1], so I called home to my children,[31] and my daughter asked to speak to me. Wow! Floods of tears. So now I'm really not leaving, I'm going to stay here to complete a full year. […] What else could I want then? Just for me to leave here a *true mother*. […] The one thought in my mind is to take care of my children and my parents. […] Because I wasn't bothered before, I wasn't being a mother. But today [TC1] is teaching me.
>
> Researcher: At one point you said you wanted to be a true mother. What is a true mother?
>
> Sara: Caring for them, being by their side, supporting them, right? It means seeing their tears, their smiles, everything, everything. […] I literally abandoned them; I withdrew from my children. I'm an excellent mother when I'm with them, everyone says so. I'm very loving with

[28] Camila Fernandes, "Figuras da causação: sexualidade feminina, reprodução e acusações no discurso popular e nas políticas de Estado" (PhD dissertation, Universidade Federal do Rio de Janeiro, 2017), 183, https://sucupira.capes.gov.br/sucupira/public/consultas/coleta/trabalhoConclusao/viewTrabalhoConclusao.jsf?popup=true&id_trabalho=5425227.
[29] Ibid., 183.
[30] The author thanks Maria Paula Gomes dos Santos for her comments concerning this point.
[31] In TC1, as in TC2, the women are not permitted to make contact with family members during the first three months of their stay in the institution.

> them. But I left that place, "Sara" was no more, their mother was no more. (Sara, TC1 resident, author's emphasis added)

Sara, who would be readily categorized as an "abandoning mother," said that her stay at TC1 enabled her to learn the meaning of being a "true mother." As she explained, this entails involving herself in every detail of her children's lives, being present at every moment and supporting them. Moreover, in Sara's narrative, the insults and rejection from her daughter appeared as the nadir of her painful life as an alcohol-dependent mother. The feeling of sadness generated by these events can be understood as what drug users here call the *fundo do poço*, rock bottom:[32] the moment when the suffering becomes unbearable, leading the individual to seek ways to rewrite their own trajectory. Given the adversities generated by Sara's troubled relationship with her children, she decided, among many other possibilities, to seek admission to TC1. Inside the institution, she began to review her performance as a mother—"I wasn't being a mother. And today [TC1] is teaching me"—and set her goal for motherhood in conformity with the model that she began to accept as ideal.[33]

Among the mothers interviewed in the research (two in TC1, five in TC2, and two in TC3), all cited children as a motivation for seeking help. Even in those accounts in which children were not the only reason given for ceasing to use drugs, they still occupied a central place in the women's decision, even outweighing health problems and other disorders caused by the problematic substance use.

Going back to the specific setting of TC1, among the interviewees was Rebeca, thirty-five years old, dependent on crack, married, and the mother of four children. She arrived at the institution accompanied by her youngest daughter, just five months old at the time. According to Rebeca, the main condition she set for accepting any kind of care was for her baby to be with her throughout the process. After searching on the internet, a female friend came across TC1 and recommended the institution for Rebeca to seek help. At the time of the interview, Rebeca was just a few days away from concluding a twelve-month stay at the institution, the maximum period that a resident may remain at TC1.[34] When asked about her experience during this period in the company of her baby, she said:

> For me it's special, very special, because I don't know how I would be here with a baby there outside. I don't know how so many women manage to leave a baby behind. Because she's a baby, she depends on me, I want to be part of this moment. So, thanks to God, I was able to bring her, because I recovered *my sense of being a mother* here with her. [...] But it's much more difficult to think about me, very difficult. […] It's more difficult, it's more pressure, but it has a deep significance for me, because I tried to abort the pregnancy, I used drugs while pregnant, I lived on the street pregnant, she became weak inside my womb, and I abandoned her at my sister's home. Even if was just one night, so to speak, but it's an abandonment. She felt all of

[32] Zila van der Meer Sanchez, "As práticas religiosas atuando na recuperação de dependentes de drogas: a experiência de grupos católicos, evangélicos e espíritas" (PhD dissertation, Universidade Federal de São Paulo, 2006), 253–303, http://www.repositorio.unifesp.br/bitstream/handle/11600/21281/2006%20SANCHEZ%2c%20ZILA%20VAN%20DER%20MEER%20Doutorado.pdf?sequence=1&isAllowed=y.

[33] The author thanks Mauricio Fiore and Taniele Rui for their comments relating to this point.

[34] However, according to the leader of TC1, there are specific cases in which a stay beyond the twelve-month limit is allowed, such as when the resident experiences difficulties finding somewhere else to live outside the institution.

> that. Afterward she traveled with my husband and was suddenly far away from me. She felt everything but now she is getting a *new meaning in her life* with her time spent with me, showing her another side. Taking care of her all the time as best as possible. This love that the girls give to her, this love that the leader [of the TC1] gives to her, you know? This care that she and I have received. We haven't wanted for anything, anything at all, even without any visitors [due to the quarantine established by the Covid-19 pandemic]. Everything I needed; she has always had the very best. (Rebeca, TC1 resident, author's emphasis)

Rebeca's experience demonstrates another element of extreme importance found at TC1: namely, the recuperation of the "sense of being a mother" through the new meaning given to maternity within the institution. It is interesting to note that, in her view, the child also has the chance to find a new "meaning to life" after all the events during pregnancy and her first months as a newborn when Rebeca was still using crack. The emotional reconnection of mother and daughter occurs in parallel with the resident's experience of life at the TC.

The possibility of assigning a new meaning to motherhood through the woman's experience at the TC can also be discerned from interviews obtained at TC2 and TC3. Unlike TC1, however, which allows a woman's children to stay with her, at TC2 and TC3 this process occurs in the children's absence. Such was the case of Judite, thirty-nine years old, who connected important events in her life trajectory with her experience at TC3, where she had been living for a year and seven months. According to Judite, when her daughter was nineteen years old and herself a mother of a five-year-old girl, she began a problematic relationship with a young man who assaulted her constantly. She tried to separate from him almost a dozen times. As the couple broke up and reconciled, the aggressions became increasingly serious and culminated in the murder of the young woman, killed by her partner in the house where they both lived. Her daughter's sudden and violent death and the suffering caused by the traumatic event led Judite to seek to alleviate her emotional pain through excessive consumption of alcohol. As the months passed, her dependence worsened, along with a series of other consequences, which eventually led her to ask for help at TC3. On arriving at the institution, she related that she had been better able to understand why her daughter had become the victim of such a brutal act. According to Judite, as she gradually overcame her dependence on alcohol and learned more about the work carried out at the TC, she reached the conclusion that God's purpose for her life was for her to become a "mother" to other women who needed help overcoming drug dependence. In her view, God had preordained the time when he would remove her daughter from her life, leaving her five-year-old granddaughter in her place. Moreover, the young woman's death was the starting point of a journey that would lead Judite along various paths until finally reaching TC3, where she would discover many other "daughters" who needed her.[35] In this account, we can perceive how a traumatic event can be invested with new meaning and contemplated within a context in which the problematic use of substances and the time spent at the TC are transformed into self-knowledge, spiritual improvement, and the discovery of a new modality of exercising motherhood. Likewise, the new meaning and renewed sense of purpose in motherhood allowed Judite to recover a "raison d'être" that had been lost following her daughter's death.

The new meaning attributed to motherhood and the desire to exercise it in full very often coexist with expectations concerning a (re)construction of amorous relationships. Among the residents interviewed

[35] As one of the residents who had been at TC3 the longest, Judite had been given various responsibilities by the pastor who runs the TC, which involved looking after the other women living at the institution.

were some who identified the experience of staying at the TC as a form of reapproaching their partners or even proving to them how committed they were to the decision to stop using drugs. As a good example of those women who attribute the collapse of their relationships to their use of substances, we can turn to Madalena's story. A young woman of twenty-eight, with no children and dependent on cocaine, she was in a relationship with a young man who, according to the interviewee, was the biggest encourager for her to stay at TC3, the institution where she had been living for approximately two months. According to Madalena:

> He [her partner] would frequently be in tears at home. "Look, I just want my woman with me here, I just want her here lying beside me, watching a film together." And, for me, staying at home, was the last thing imaginable. But now what I want most is to be at home with him, you know? Everything I most want now is to be at home with him. But even so, he didn't abandon me. […] He said that when he comes, he should be coming to visit tomorrow, he said he'll bring the engagement rings, he plans to marry me. […] So now *God is going to restore my life, because I have someone who loves me, someone who supports me, who wants to marry me, so this is where I will rise again*. Like I told you, I was deeply humiliated so I could be exalted later. I believe my time has come, you know? *I'm going to leave here married, in Jesus's name* […] And then I'm going to work, as I told you, wake up early, have a job, *arrive home and care for the family, it's what I really want.* Feel the baby grow, kicking inside me, it must be magical. (Madalena, TC3 resident, author's emphasis)

An analysis of Madalena's interview reveals that her stance regarding the relationship with her partner shifted. Conjugal life came to be viewed differently, with what was once undesirable—staying at home with her partner—becoming a goal in the post-TC phase—"arrive home, care for the family"—along with the prospect of being a mother in the near future. The restoration of her life, in her expectation, necessarily involved realizing the promise of marriage and the possibility of having children with her future husband.

Among those residents who declared having no amorous relationships outside the institution (two in TC1, two in TC2, and three in TC3), we can also glean an expectation of constituting a family alongside a partner who matches the criteria established by religious doctrine. The wait for the "man of God" or for the "rod/male [*varão*] of God"—a term widely present in the conversation of the women interviewed at TC3— a man who will appear in His time and who will be prepared by Him, becomes one of the objectives to be achieved after their period living at the TC. On this point, comments by Eva, thirty-seven years old, a dependent on restricted-use drugs and the mother of two children, is especially illustrative:

> I don't know when I will leave here because I am living God's time. But I can tell you that if I'm to care for my children, I want God to set a true man of God on my path. Because that's what we learn here, life in a family with everything correct, married, sanctifies the woman. (Eva, TC2 resident)

Marrying a "true man of God" and leading a "correct" life in a family, as religious teaching dictates, are, for Eva, the path for her sanctification as a woman. In Christian semantics, being a "saint" means to be "separate from the rest," to be on a higher level than non-saints. In this conception, the antithesis of the sanctified woman is the female drug user, represented in the narratives of the residents and leaders alike as a woman who symbolizes the sinful and wayward life. Equally notable is just how much Eva's wait for "the true man of God" seems like a religious version of "meeting a prince charming." Even if the hope of finding happiness through marriage is not exclusive to women in TCs, this fact reveals just how

narrow may be the paths and perspectives for self-realization offered by these institutions to their female public.

Indeed, the representations of motherhood and marriage among leaders and residents in TC1, TC2, and TC3 coincided substantially in terms of how they idealized the roles of "good mother" and "good wife." In all three institutions, the research came across both the accusatory category of "abandoning mother" and the belief that marriage constitutes one of the most secure ways for women to stop using drugs. This observation shows that the doctrinal differences between Pentecostals, Charismatic Catholics, and Historical Protestants do not entail any perceptible differences in the way in which these religious variants position themselves in relation to gendered social roles.

Being a good Christian: Conversation and agency in the TCs

Concomitantly with the adherence to religious morality, there is the experience of conversion lived—or not—by the female residents over their period of stay at these institutions. Conversion, observed as a structural element in the composition of a new ethos for individuals receiving care in religious TCs, has been explored in research by Teixeira,[36] Ribeiro and Minayo,[37] and Targino,[38] who describe it as a phenomenon made up of two distinct elements: belief and engagement. In other words, for an individual to be considered fully converted by her peers, she needs to be engaged in religious practices and express/feel that she believes in their efficacy. Belief and practice are thus the two pillars of conversion.

Although TC leaders commonly declare that residents are not compelled to adopt the religious practices performed in these institutions, their discourses continually repeat the claim that, without conversion, abandoning problematic drug use becomes unfeasible given how the institutional routine tends to be based around activities of a religious nature.[39]

Marta, the leader of TC2, was asked about the role of religious activities and conversion in structuring the methodology used by her institution. In response, she highlighted the following points:

> Extremely important. And religious activity for us *is not religiosity*. It's knowing precisely that Christ is the agent who began everything. And this conversion through Jesus Christ is the most noteworthy way, and I tell you, the only way […] The tool that we hand them [the women resident at TC2] does not come from the human being. Something that was disturbed by the plague of drugs, you can give with some kind of allopathic medicine or whatever. But our vision, the vision of [TC2], is *Christocentric*. […] If she allows herself to be treated, *she will be treated in the light of the Bible, and who will effect this transformation is God.* We believe. Speaking for myself, I have seen "n" number of people being transformed here from the moment that they allow themselves to be cared for by the power of God. We show them the path. We guide them, yes. We lead them and have been through this. But we understand that, socially speaking, it is

[36] Teixeira, "O testemunho e a produção de valor moral," 113–19.
[37] Fernanda Mendes Lages Ribeiro and Maria Cecília de Souza Minayo, "As Comunidades Terapêuticas religiosas na recuperação de dependentes de drogas: o caso de Manguinhos, RJ, Brasil," *Interface* 19, no. 54 (2015): 515–22, https://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832015000300515**.**
[38] Targino, "Religião contra as 'drogas,'" 174–86.
[39] Ibid., 174–86.

> also possible for various people to say "no" and, without converting, pass through [TC2], knowing the word, yes, but without it generating that piety in her. That's not what we are talking about. *We're talking about a change in mindset, a change in attitude, a change in behavior*. And to remake all of this in the context of a person's character, only He can do it, because He built it. He is the builder. So, He knows exactly what and where He's going to make changes, when we allow Him to take care of us. So that is undoubtedly the weightiest condition, or tool, perhaps, or perhaps not, that we will apply. (Marta, TC2 leader, author's emphasis)

Marta, who represents the institution, revealed TC2's commitment to reinforcing the understanding among residents that conversion to Jesus Christ is the most effective strategy to fight drug dependence. Although she recognized that various women who have passed through TC2 obtained a successful outcome without experiencing conversion, her account highlights the need for the resident "to allow herself to be treated" in order for God to effect the necessary transformation. "Treatment in the light of the Bible," as she mentioned, represents the shortest path to a change in the mindset, attitude, and behavior of these women. Marta also indicated how drug dependence is institutionally conceived: as an individual problem that requires religious adherence to be resolved.

In response to the question, "What role do religious activities and conversion play in the structuring of the methodology offered by the institution?" the leaders of TC1 and TC3 shared Marta's view about conversion, but also highlighted other elements valued by these institutions. According to Ester from TC1, communal living, dedication to learning the lessons about self-care—as well as care of the children accompanying their mothers—, and commitment to performing domestic activities are just as important as conversion and participation in religious practices. Meanwhile, Joel, the pastor responsible for TC3, added that although conversion is a driving force allowing the resident to achieve a cure for her dependence, compliance with institutional rules and assigned tasks are non-negotiable conditions for them to stay at TC3. This became very clear in how the pastor narrated the reception given to women who do not wish to convert to the religion professed at TC3:

> [What] they cannot do is bring their own religion inside here. Now, we won't mess with their religion at any point, or offend them, or hurt their feelings. […] We've already had situations where the women don't want to take part [in religious activities]. The only thing we ask of them is that they sit there, right? During prayers, she can pray to whoever she wants, but silently, just like the girls who are Christian will pray in silence too. […] Now, they must also understand that they are coming here to respect the place, right? Because respect is essential. That doesn't mean that when she's here, she also has to be who she is. We don't permit that. She can come here, that's fine. But she must respect the institution, the institution's rules, and if she respects them, she will be respected in turn. (Joel, pastor responsible for TC3)

But although the leaders made clear their expectation that residents would convert, "the other side of the coin" also needs to be included in our analysis; namely, the way in which these women adopt religious practices and beliefs. Although conversion is promoted by the leaders, it cannot be seen as a process that unfolds beyond the wishes of the women themselves. Very often bringing the imprint of earlier religious experiences and affiliations with them, these women may experience conversion in various forms, adopting those beliefs and practices with which they feel more affinity. Moreover, a huge gulf may exist between practice and belief: even active participation in religious activities may coexist

with diverse levels of beliefs and engagements.[40] Many nuances exist when it comes to conversion. Although the individual is asked to convert, the woman, learning that her stay at the institution depends on her express behavior, may well assume specific performances to meet the institutional demands.

Posed with the challenge of differentiating between belief and engagement among the residents, the study analyzed their answers to the questions "What is your religion?" and "Is your current religion the same one you professed before entering the TC?" Although the research focuses only on a limited part of the universe of these female residents, this data can provide some clues to the degree of belief that these women manifest in the doctrinal line adopted by the institution.

At TC1, there were no conversions to Catholicism, while at TC3, Judite, Eunice and Elisa became Evangelicals after entering, and Madalena declared herself Evangelical before arriving at TC3. Furthermore, it is fairly significant that at TC2, where conversion is advocated as the maximum resource of its applied methodology, recorded responses included, "I am a daughter of God," "I have my God," and "I live with the Holy Spirit," given by Raquel, Talita, and Abigail, respectively. Additionally, the biggest gaps between the institution's religion and the religion of the female residents themselves occurred at TC1 and TC2, which perhaps suggests a certain level of resistance among them to following the explicit guidance on converting to the institution's professed religion. Meanwhile, the highest conversion rate was observed at TC3, which preaches Pentecostalism. This may indicate that the proselytizing rhetoric of this religious denomination is more effective in winning over followers among drug users who seek help at TCs with Pentecostal affiliation.

Table 1. Responses of residents to the questions "What is your religion?" and "Is your current religion the same one you professed before entering the TC?".

TC1 Catholic	Sara	Evangelical before entering the TC.
	Rebeca	Evangelical before entering the TC.
	Débora	Already identified as Catholic before entering the TC.
	Isabel	Already identified as Catholic before entering the TC.
	Ana	Already identified as Catholic before entering the TC.
TC2 Missionary Evangelical	Raquel	Was Evangelical, now calls herself a "daughter of God" with no religion.
	Talita	Had/has no religion. "I have my own God."
	Abigail	Says she "is living with the Holy Spirit" and had/has no religion.
	Hosana	Was Catholic, became Evangelical after entering the TC.
	Eva	Had no religion, became Evangelical after entering the TC.
TC3 Pentecostal	Madalena	Already identified as Evangelical before entering the TC.
	Judite	Became Evangelical after entering the TC.
	Geni	Had/has no religion. "I believe in God."
	Eunice	Became Evangelical after entering the TC.
	Elisa	Became Evangelical after entering the TC.

Source: Author's interviews and summarization.

[40] Clara Jost Mafra, *Na Posse da Palavra: religião, conversão e liberdade pessoal em dois contextos nacionais* (Lisbon: Imprensa de Ciências Sociais, 2002), 136–40.

Also relevant in terms of understanding the scale of resident involvement with belief and practical engagement are their narratives concerning what they considered the "true encounter with God." Here Raquel, thirty-two years old, the mother of four children, dependent on cocaine and alcohol, and a resident at TC2 for one year and four months, spoke about her experience:

> I spent some time here inside thinking that you just had to follow the rules and be a good woman. Generally say that you accept the rules and do your bit. So I did my bit, for example, but I wasn't actually doing anything because I was hiding behind a *cloak of religiosity*. I attended all the church services, I knew where passages were in the Bible, but I didn't live the words I read. Lots of times I memorized them for status reasons, I wanted to know because I wanted the pastor to turn up and I could answer well, be the woman who answers questions, speaks well, knows very well where all the citations are. So, that's what happened… I hid behind a *cloak of religiosity*. But in reality, *I didn't let Jesus enter my heart and work what needed to be worked* […] So, here inside the [TC2] it was really good for me to discover who I am. Because I didn't know who I was. I didn't know myself. I didn't know the things I was capable of and what I can do for God and in God. That God was able to truly change that hideous old creature into the woman I am today, a woman who prays, a woman with the determination to have a structured family relationship. Who today wants to be a good mother. (Raquel, TC2 resident, author's emphasis added)

Raquel's trajectory is common among the women staying at TCs. Before entering TC2, she had spent a brief period at TC3.[41] She recounted that her main goals had been to rid herself of dependence on cocaine and alcohol and to regain custody of her children. However, her first try at TC3 did not produce the desired results, leading her to abandon the institution and go back to using drugs. Sometime later, her family suggested TC2, and Raquel decided to try once again. On entering TC2, she adopted the stance of a "good woman" who learns Bible verses by heart and follows all the institution's rules to the letter. However, this engagement did not seem enough to her, since, in her own mind, what she was doing was merely hiding behind a "cloak of religiosity." Everything changed when Raquel "discovered who she is" and learned that God can truly change the "old creature" who she used to be. It was at this moment, after attaining a level of belief that she considered genuine, that Raquel finally pictured herself as a woman capable of having a family and being a good mother. Even so, our interviewee said she has no religion and classified herself simply as "a daughter of God," which can perhaps be taken as a sign of the exercise of her own agency in response to the faith preached in TC2. Her belief seemed to have maintained a degree of independence from the institution.

Narratives like Raquel's were found among other residents who spent time at more than one TC and/or who came and went from the same TC at various times, as in the cases of Madalena, Geni, Rebeca, Abigail, and Talita. Attributing the failure of their previous attempts to their refusal to "let Jesus enter their heart," the women also converged in terms of how they interpreted their current experiences. They emphasized that "it is different now"; this time there was an "encounter with God," and so they knew that this time they would successfully complete their stay at the TC.

[41] Raquel recalled meeting two women at TC2 who she later met at TC3, which may indicate the existence of a "circulation" of drug-dependent women among religious TCs.

It is interesting to note that these women felt more authorized to exert their agency in relation to the religious and spiritual teachings of the TCs than to relativize the institutional guidance on motherhood and marriage. This suggests that the morality surrounding the role of women is even stronger than religious morality itself, in part because this morality transcends the space of the TCs in question, diffused throughout wider society. Given these observations, it becomes clear that the paths along which belief and engagement develop are neither linear nor consistent. Although the institution tries to present itself as all-powerful, there is a sphere of personal will that pulsates and vibrates with a creative force capable of giving life to new moralities of connection with the sacred and to diverse experiences with religious practices.

CONCLUSION

Analysis of the material collected for this research leads to the observation that the "new" ethos cultivated in the TCs does not entail a rupture with the ideal model of women dominant in wider society. Founded on Christian morality, this feminine ethos remains consistent with prevailing views in which women are frequently evaluated in terms of whether they meet expectations for them to avoid living a "wrong sexuality" and to perform the role of "good mothers" diligently.[42] In this sense, the ultimate aim of the TCs would be a return to patriarchy, which has been somewhat deconstructed in the experience of contemporary urban women. Nonetheless, for this dynamic to function, it is essential to mobilize the accusation and stigma of the "abandoning mother." While contemporary society can accept female autonomy from men to some extent, there are no concessions for the mother who supposedly abandons her children. Thus, the introjection of this stigma by the women discussed here may have been the key that "opened their hearts to Jesus"—or, in other words, that catalyzed them to make changes to their own behavior.[43]

Likewise, the data suggests that the assistance provided by the TCs appeals to various aspects of Christian morality and other moral issues deeply rooted in patriarchal society. Motherhood, marriage, and conversion, associated with abstinence and self-discipline, together compose the moral approach employed by these TCs, with the aim of reformulating the moral careers of their female residents.[44]

The attempt to comply with the categories forming the triple identity of "good mother + good wife + good Christian," as has been shown, is not experienced in a standardized and simultaneous form by all the residents. Given the particularities of their trajectories and their power of agency, these women may prioritize just one of the three performances, leaving the other two momentarily in the background.

Finally, the phenomenological concept of embodiment developed by Csordas helps us comprehend the experience of the sacred narrated by the women receiving care. According to Csordas, "the body is not an object to be studied in relation to culture, but is to be considered as the subject of culture."[45] By adopting this perspective, we can move away from the mechanistic observation of the (in)effectiveness of therapeutic processes and concentrate on exploring the meanings constructed through the experience of the sacred and on the transformations experienced by the woman during her stay at the

[42] Fernandes, "Figuras da causação," 5–7.
[43] The author thanks Maria Paula Gomes dos Santos for her comments on this point.
[44] Goffman, *Estigma*, 41–50.
[45] Thomas Csordas, *Corpo significado cura* (Porto Alegre: Editora UFRGS, 2008), 102.

TC. Adherence to the creed, marked by the phrase “Let Jesus enter your heart,” so often repeated by the interviewees, points to a watershed in the trajectories of these women. The moment when engagement in the institution’s religious practices combines with belief in the action of the sacred is comprehended by all the actors involved as the first waypoint in the woman’s transformation and cure. Indeed, in the case of interviewees who spent periods in various TCs and/or abandoned and returned to the same TC multiple times, the interpretation of the leaders concerning these TC residents is that the “cloak of religiosity” is insufficient to attain the potential benefits promised by the institution. Religiosity by itself, understood here as a mechanical process of ritualistic repetition, does not lead to the substantive transformation desired by the TC’s actors, since here practice without belief is empty of meaning.

Nevertheless, as we know, the effectiveness of behavioral change can only be really tested when these women return to the contingencies of life outside. Repeated admissions, as well as the construction of religious or therapeutic careers after periods of stay in TCs, indicate that this encounter with the sacred requires certain environmental conditions, such as the distance from everyday pressures of survival offered by the TCs but not always attainable by these women when they are in the outside world again.

THERAPEUTIC COMMUNITIES: A STUDY OF ACCESS AND BARRIERS TO HEALTHCARE

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This research sets out from the experience of the first author with a care network for people with problems relating to the use of alcohol and other drugs. Working between 2014 and the first months of 2020 at a Psychosocial Care Center for Alcohol and other Drugs (Centro de Atenção Psicossocial de Álcool e outras Drogas, or CAPSad) that adopted a teaching-healthcare approach,[3] located in the municipality of Salvador, Bahia, he noted a significant presence of therapeutic communities (TCs) in the care trajectories of various users of the service.[4] Also inspiring this study was the same author's involvement in the formulation of public policies as a member of the Bahia State Council for Drug Policies from 2016 to 2018. He participated in the council's efforts to construct criteria and mechanisms for the supervision and certification of TCs at the state level,[5] carrying out inspections of these institutions and following up on the results, as well as drafting proposals for training the professional staff of TCs in the state.

The denomination "therapeutic community" emerged in England in the 1940s through care services for people undergoing psychiatric treatment. It comprised an attempt to reform the traditional hospital system and introduce more democratic treatment, encouraging a closer relationship between therapists and inpatients. The United States in the 1960s saw a growth in therapeutic community programs exclusively for people with problematic usage of alcohol and other drugs, popularizing TCs as a specialized service for the treatment of this public.[6] In Brazil, the first TCs also emerged in the 1960s, with a significant expansion at the end of the 1990s and the beginning of the 2000s. According to research by the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, or IPEA), 78 percent of the 1,950 TCs surveyed in 2016 were founded after 1996, and 38.2 percent of these after 2006.[7] In 2011, the launch of the "Crack, you can beat it" program by the federal government

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[3] Service linked to the Universidade Federal da Bahia, integrated in the local health system. CAPSad provides care to the public as well as teaching activities for undergraduate and graduate students from different courses in healthcare. It also offers training activities for the intersectoral care network for people with problematic use of alcohol and other drugs in the state, through a partnership with the Health Department of the state of Bahia. (Translator's Note: CAPS, defined further along in the text, and CAPSad are similar facilities, but the latter focuses solely on problems related to alcohol and other drugs)
[4] The term service "user" is utilized, as a citizen with rights, for people who seek assistance in the healthcare networks. Brazilian Ministry of Health, *Carta dos direitos dos usuários da saúde*, 2nd ed. (Brasília: Ministério da Saúde, 2007), 1–9.
[5] Resolution CEPAD 003/2018 of the *Justice, Human Rights, and Social Development Secretariat of the* state of Bahia.
[6] George De Leon, *A Comunidade Terapêutica: teoria, modelo e método*, 5th ed. (São Paulo: Loyola, 2014), 13–36.
[7] IPEA – Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017), 17.

enabled the transfer of federal resources to these organizations via the Ministry of Justice.[8] Also in 2011, TCs were formally included in the Psychosocial Care Network (Rede de Atenção Psicossocial, or RAPS) "for people with mental health issues or mental disorders and with needs arising from the use of crack, alcohol, and other drugs, as part of the Unified Health System."[9]

Brazilian TCs have been the subject of various reports of disrespect and mistreatment of users of their services, registered either in official inspections or in the press.[10,11,12] In the work of the Bahia State Council for Drug Policy (Conselho Estadual de Políticas sobre Drogas, or CEPAD/BA), similar occurrences have also been recorded in some of Bahia's TCs. In the day-to-day work of CAPSad, there was a tension between the demand for the services offered by the TCs and the difficulty many users experienced in staying in these institutions when forced to deal with situations described by them as abusive or disrespectful. As well as reports of physical violence in some establishments,[13] a strict disciplinary regime was implemented oppressively, including the obligation to follow the daily routine, participate in religious activities, and/or perform manual work, with the application of a range of punishments in cases of refusal. Restrictions on the freedom to contact family members and receive visitors were also reported. Faced with these circumstances, many users were unable to remain admitted, abandoning the TC after a few days or weeks and thus returning to a vulnerable situation. On the other hand, among those who managed to continue their care in the TCs, it was not rare for users to distance themselves from other health services and their own affective relationships. Such situations are considered barriers to the care of these individuals, since they both limit their access to services sought in the TC itself—with users dropping out—and restrict the users' connections to their personal networks of relationships.

Adopted here is the concept of access points—or barriers—to care beyond the physical-geographic sense of the terms,[14] seeking to investigate the quality of the care that is being accessed. Our understanding is that qualified access implies care centered on users and their needs, capable of alleviating their suffering, but also of broadening their networks of connections and increasing their capacity to deal with life's adversities.[15] Care is understood to involve a commitment to the individuals

[8] Maria Paula Gomes dos Santos, "Comunidades Terapêuticas e a disputa sobre modelos de atenção a usuários de drogas no Brasil," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 28.

[9] Ministry of Health's Ordinance 3,088/2011.

[10] Conselho Federal de Psicologia, Mecanismo Nacional de Prevenção e Combate à Tortura, and Procuradoria Federal dos Direitos do Cidadão/Ministério Público Federal, *Relatório da Inspeção Nacional em Comunidades Terapêuticas 2017* (Brasília: CFP, 2018).

[11] Conselho Federal de Psicologia, *Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas* (Brasília: CFP, 2011).

[12] Clarissa Levy, "Adolescentes denunciam tortura e mostram marcas de violência em comunidade terapêutica evangélica," *Pública*, October 30, 2020, Accessed November 20, 2020, https://apublica.org/2020/10/adolescentes-denunciam-tortura-e-mostram-marcas-de-violencia-em-comunidade-terapeutica-evangelica/?mc_cid=50f17a2991&mc_eid=60e0cddd8d.

[13] The term is used here in accordance with the nomenclature of the Ministry of Health's National Register of Healthcare Establishments (Cadastro Nacional de Estabelecimentos de Saúde, or CNES).

[14] Emerson Elias Merhy, Laura M. C. Feuerwerker, and Erminia Silva, "Contribuciones metodológicas para estudiar La producción del cuidado en salud: aprendizajes a partir de una investigación sobre barreras y acceso en salud mental," *Salud Colectiva* 8, no. 1 (January–April 2012): 25–34.

[15] Emerson Elias Merhy et al., "Redes vivas: multiplicidades girando as existências, sinais da rua. Implicações para a produção do cuidado e a produção do conhecimento em saúde," in *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes*, vol. 1, ed. Emerson Elias Merhy et al. (Rio de Janeiro: Hexis, 2016), 31–42.

and their singularities, which involves actions of assistance/support for the different ways of being in the world, constructing connections that increase each person's potentialities far beyond diseases or diagnoses.[16] It entails access to care constructed with the other and through the other, guided by the living encounter between worker and user.[17] However, many care practices subordinate the desires and projects of users to standards and protocols, limiting, to a greater or lesser extent, their participation, their worldviews, and their therapeutic choices. This in turn becomes the "cause of innumerable failures in the relationship between health workers and the population."[18] They thus produce barriers to users wishing to access care centered on their real needs.

Therefore, taking the TCs to be part of the same care network offered to people assisted by the CAPSad, various questions were formulated concerning the inclusion of these services in the users' distinct therapeutic projects: which health services did these users try to access in the TCs as part of their care network? Were the barriers to care identified by the research perceived in the same way by users themselves? Were there other barriers that had not been identified? To answer these questions, a study was carried out based on the care trajectories of female and male users assisted by the CAPSad and TCs from the network in question, seeking to analyze the production of the care offered by these TCs and the existence of potential barrier mechanisms to this care.[19]

PATHS TAKEN IN THE RESEARCH[20]

In the development of this research, the concept-tool "user-as-guide" (*usuário-guia*) was adopted as a methodological recourse, used in other studies on access and barriers to healthcare.[21] In addition to being considered a "highly complex case for the care network, and consequently being a major user of the available networks,"[22] the user-as-guide is an ethical-methodological approach that seeks to shift the researcher's gaze to the user's perspective,[23] with the latter's perspective providing a guide to navigate through the networks and experiences that expand or limit his or her life projects. In search of these life trajectories and forms of care, the researcher becomes a cartographer of "psychosocial

[16] Laura Camargo Macruz Feuerwerker, "Cuidar em saúde," in *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes*, vol. 2, ed. Laura Camargo Macruz Feuerwerker, Débora Cristina Bertussi, and Emerson Elias Merhy (Rio de Janeiro: Hexis, 2016), 35.
[17] Emerson Elias Merhy, *Saúde: a cartografia do Trabalho Vivo* (São Paulo: Hucitec, 2002).
[18] Aluisio G. da Silva Jr., Emerson E. Merhy, and Luis C. de Carvalho, "Refletindo sobre o Ato de Cuidar da Saúde," in *Construção da Integralidade: cotidiano, saberes e práticas em saúde,* ed. Roseni Pinheiro and Ruben Mattos (Rio de Janeiro: IMS-UERJ/Abrasco, 2003), 124.
[19] The research was developed within the scope of the Psychosociology of Communities and Social Ecology graduate program (EICOS Program) of the Institute of Psychology of the Universidade Federal do Rio de Janeiro, subsequently awarded funding by the Social Science Research Council's Drugs, Security and Democracy Program.
[20] The authors thank Professor Kathleen Tereza da Cruz and the members of the course Advanced Studies in Community Networks in Health – 2020.2, of the EICOS/UFRJ Program, for their relevant contributions in the development of this article.
[21] Maria Paula Cerqueira Gomes and Emerson Elias Merhy, *Pesquisadores IN-MUNDO: um estudo da produção do acesso e barreira em saúde mental,* ed. Maria Paula Cerqueira Gomes and Emerson Elias Merhy (Porto Alegre: Rede UNIDA 2014), 1-176.
[22] Ibid., 13.
[23] Clarissa Terenzi Seixas et al., "O vínculo como potência para a produção do cuidado," *Interface - Comunicação, Saúde, Educação* 23, no. e170627 (2019): 1–14.

landscapes,"[24] gathering data not only on events, but also their subjective effects, internal mobilizations, and affections, "everything that serves to produce an expressive body of material and create meaning" for the investigation.[25]

The decision was made to identify the users-as-guides from the CAPSad at the Universidade Federal da Bahia (UFBA) where the authors' research questions originally surfaced. Among the functions of the broader Psychosocial Care Center (Centro de Atenção Psicossocial, or CAPS) is the "organization of the demand for and network of mental healthcare within their territory,"[26] making it a key space for observing the care network in which it is embedded. Additionally, the first author's prior work at this CAPSad allowed for the accumulation of other experiences alongside the users-as-guides,[27] and, in adopting this cartographic perspective, this accumulated experience became another source of information to be recorded in a cartographic diary.[28]

Between July and August 2020, therefore, five users-as-guides were selected in conjunction with the CAPSad team. Criteria were a history of at least one admission to a TC during the period of accompaniment at CAPSad and being over eighteen years old. The Covid-19 pandemic interfered in the selection process since it excluded several possible candidates due to contact and travel problems during the period. Collecting narratives from distinct sources such as medical records and interviews with professionals and users-as-guides, not only their therapeutic itineraries were mapped[29] but also the diverse affective connections that these users have been producing in their lives, which also construct them as individuals.

As well as the five users-as-guides, five professionals from the CAPSad were individually interviewed, each involved in the care trajectories of the selected users. Another six professionals joined the collective interview, focused on the relationship between CAPSad and TCs. No professionals from other network services were interviewed. The interviews were conducted in the physical space of CAPSad or on home visits to users, respecting the local health protocols for protection during the pandemic. The collective interview with professionals from the CAPSad was conducted virtually using a digital platform. As well as the narrative of each participant about the care trajectory and the care and life histories of the users-as-guides, the interviews encouraged people to talk about the relationship established with TCs during their stays.[30]

[24] Suely Rolnik, *Cartografia Sentimental: Transformações Contemporâneas do Desejo* (Porto Alegre: Sulina/Editora da UFRGS, 2007), 65.
[25] Ibid., 65.
[26] Ministry of Health's Ordinance 336/200, which establishes the modalities of the services: CAPS I, CAPS II and CAPS III.
[27] Jorge Larrosa Bondía, "Notas sobre a experiência e o saber de experiência," *Revista Brasileira de Educação* 1, no. 19 (2002): 1–15.
[28] Helvo Slomp Junior et al., "Contribuições Para Uma Política De Escritura Em Saúde: O Diário Cartográfico Como Ferramenta De Pesquisa," *Athenea Digital* 20, no. 3 (2020): 1–21.
[29] Paulo César B. Alves and Iara Maria A. Souza, "Escolha e avaliação de tratamento para problemas de saúde: considerações sobre o itinerário terapêutico," in *Experiência de doença e narrativa*, eds. Míriam Cristina M. Rabelo, Paulo César B. Alves, and Iara Maria A. Souza (Rio de Janeiro: Fiocruz, 1999), 125–38.
[30] The research was approved by the Research Ethics Committee (FMB/UFBA) in May 2020, CAAE: 31511720.8.0000.5577.

In the exploratory phase,[31] the available literature on TCs was consulted to guide the investigation and the analysis of the collected material, seeking to correlate the findings in the field with evidence already described. In the analysis of the itineraries, the "Analyzer Flowchart" tool was used,[32] enhancing the visualization of the network, the decision-making processes, and the interruptions to the flows. Based on the literature and on encounters in the field research, analyzers were chosen that foregrounded elements related to healthcare and their respective access and barrier situations,[33] looking to produce an analytic map of these elements. After a brief description of the users-as-guides, the findings are presented and discussed according to the following set of analyzers: motives for admission; conversion treatment; "I felt mistreated"; existential connections; and the CAPSad-TC relationship.

Users-as-guides

Using fictitious names, short profiles and histories of the users-as-guides are presented.

Aruana is a Black woman native to Salvador, Bahia,[34,35] aged between thirty and forty years old. She recalled first being sexually abused by her stepfather when she was around nine years old. She said that her mother did not believe her accusations, which prompted her to leave home for good at the age of twelve and live on the streets, where she began to use alcohol and crack and engage in prostitution. She frequented various care services, such as the Axé Project[36]—where she learned to dance—and the Universidade Federal da Bahia's Center of Drug Abuse Studies and Therapies (Centro de Estudos e Terapias do Abuso de Drogas, or CETAD-UFBA),[37] where she began clinical care at fourteen years old. She became involved in drug trafficking and, once again, suffered from abusive relationships with men. "The female [drug] user is the man's slave," she said, speaking of the situation of women on the streets. She recounted that her only protection was her knife, which she needed to "assert herself" to gain respect and not suffer abuses. For some years, she established a relationship with an older woman with whom she lived, which brings back happy memories. Over time, she re-established closer ties with her mother, keeping in contact with her and sometimes asking for help. She frequented other services related to problematic drug use: the Run for a Hug Program (*Programa Corra para o Abraço*),[38] two

[31] Maria Cecília de Souza Minayo, *O Desafio do Conhecimento: Pesquisa Qualitativa em Saúde*, 8th ed. (São Paulo. Hucitec, 2004), 89–104.

[32] Emerson Elias Merhy, "Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde," in *Agir Em Saúde: um desafio para o público*, ed. Emerson Elias Merhy and Rosana Onocko, 2nd ed. (São Paulo: Hucitec, 2002), 71–112.

[33] Gregório F. Baremblitt, *Compêndio de Análise Institucional e outras correntes: teoria e prática* (Rio de Janeiro: Rosa dos Tempos, 1992), 69–72.

[34] Aruana is a Brazilian indigenous name associated with the female gender, signifying "sentinel," https://www.dicionariodenomesproprios.com.br/.

[35] At Aruana's own suggestion, information on her life history was also collected from another study in which she had participated: Patrícia Maia Von Flach, "*Experiências de sofrimento social e movimentos de resistência entre trabalhadores e gente de rua (usuários de álcool e outras drogas), na Praça das Duas Mãos – Salvador-Bahia*" (PhD dissertation, Universidade Federal da Bahia, Salvador, 2019), 177–83.

[36] The Axé Project is a non-profit non-governmental organization, founded in 1990, for the "defense and protection of children and adolescents." Accessed November 30, 2020, http://www.projetoaxe.org/brasil/.

[37] More information at http://www.cetadobserva.ufba.br.

[38] Initiative of the state of Bahia's Justice, Human Rights, and Social Development Secretariat. "Its objective is to promote citizenship and guarantee the rights of people who make abusive use of drugs in contexts of vulnerability, or are affected by problems related to the criminalization of drugs, based on strategies for physical and social harm

admissions to TCs, and the CAPSad at UFBA. In 2016, she became involved with social movements—she said that she became aware of her rights and how to fight for them "without using violence." She began to affirm her identity as a *maloqueira* (street woman) and defend her colleagues in the street and life. Over recent years, she has been hit by the death of three loved ones—the most recent at the start of the pandemic—propelling her into new periods of high drug consumption and general disarray in her life, culminating in a new admission to a TC. At the time of the interview, Aruana was residing at a shelter, but met the authors at the CAPSad to talk.

Piatã is a Black man,[39] aged between thirty and forty years old, who grew up in a poor community in the city. As a teenager, he began to steal and later engaged in armed robberies. As time passed, he grew apart from his family, eventually living on the streets, finding it difficult to control his consumption of crack and cocaine. He was admitted to three different TCs, abandoning treatment in all of them. He says, somewhat bitterly, that friends and family "turned their backs" due to the choices he made in life, leaving him to "battle alone" to overcome his "dependence." Today, however, he has a good relationship with his family, living close to various relatives in the neighborhood where he grew up. He is described by the healthcare professionals as a calm person. In 2014, while carrying out a robbery, he was shot in the arm and arrested. After this incident, he received legal aid from the Run for a Hug Program with which he was associated. The injury to his arm transformed into osteomyelitis, which left him in constant need of assistance. He revived his relationship with a former female partner, stating that he "was really well" during this period. In 2018, the relationship ended traumatically. "It derailed me totally...," he recalled, once again taking him back to the streets and to an intense consumption of drugs. On leaving the TC, he found work doing "odd jobs" as a barber and builder in his neighborhood, where he also met his current companion. He welcomed us to his home for the interview, which he showed us proudly as beautifully well-kept.

Potira is a Black woman,[40] aged between fifty and sixty years old. She grew up in considerable poverty, with a history of much violence in childhood. She began to use alcohol while still a child, working in the bar owned by her family. Over her lifetime, she had relationships with various men, with whom she had six children. Motherhood was always exceedingly difficult for Potira, leading her to leave all her children to other people's care. Her youngest daughter is the only one with whom she lived for some time, eight years, but Potira ended up handing her over to the State Custody Service during one of her crises (the girl was subsequently adopted). Despite these adoptions, Potira always maintained some contact with all her children over the course of her life, since she knew the people who raised them. In addition to the consumption of alcohol—and sometimes crack—Potira experienced frequent episodes of mental disturbance and talked about killing herself, which led to admission to psychiatric hospitals, where she received various diagnoses. She suffered greatly from the death of her last companion when he was run over. She also lost two of her older children, both murdered. She arrived at the UFBA's CAPSad in 2012. She was admitted to various TCs, located in Aracaju, Sergipe, and towns and cities in Bahia (Conceição do Coité, Salvador, Itaparica, and Feira de Santana), generally during crisis situations. During one stay, one of her sons sold her house and vanished with the money, provoking a lengthy period of mourning.

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reduction, enabling its beneficiaries to access existing public policies." Accessed November 28, 2020, http://www.corraproabraco.wordpress.com/.

[39] Piatã is a Brazilian indigenous name associated with the male gender, signifying "hard rock" or "strong man," https://www.dicionariodenomesproprios.com.br/.

[40] Potira is a Brazilian indigenous name associated with the female gender, signifying "flower," https://www.dicionariodenomesproprios.com.br/.

In 2018, she joined the Care Intensification Program (Programa de Intensificação de Cuidados, or PIC),[41] which helped her to reconcile with those of her children who were still alive. The interview was held in the shelter where she currently resides.

Taiguara is a Black man,[42] aged between forty and fifty years old, who grew up in Salvador's historical center, moving away in the 1990s, after his family received compensation from the state government to leave the townhouse where they lived. However, Taiguara remained connected to the central region, living on the streets and sometimes returning to the neighborhood. "I was born and raised in the Pelourinho. I'll never leave here, nobody can remove me," he asserted. On the streets, he became increasingly involved in drug use, financed by small thefts and trafficking. Over time, he was banned from entering the neighborhood where his mother lives at the orders of the local drug gang, linked to a rival faction. He arrived at the CAPSad in 2013 when he was still living on the streets of the historical center. During his history of being assisted at the service, he experienced various episodes of imprisonment for thefts or drug trafficking, as well as many records of medical care following traumas and episodes of violence. In 2016, he suffered an attempted homicide. He was admitted to the general hospital and later to a TC, eventually being discharged without complications. His love of music led him to become involved in a percussion band, though that involvement had ended. He also continued to receive help from the Run for a Hug Program, participating in a harm reduction training course. He continues to live on the streets of the city center, involved in small crimes and frequenting the care and welfare services for occasional demands, usually health clinics, social services, and legal aid for issues relating to the court proceedings in which he was involved. While this research was being conducted, he was residing at a shelter where the interview took place.

Iberê is a Black man,[43] aged between thirty and forty years old. He began to be assisted at the CAPSad at the end of 2019. He lives with his mother, who accompanies him on various appointments. Iberê recalls that he began to use drugs "quite some time ago," but only in recent years has he "lost control," using mainly crack and cocaine. The high level of consumption led Iberê to get into frequent debt, leading to physical attacks and death threats. Recently, he and his mother moved neighborhoods due to threats from the drug gang and to move away from "bad influences," but Iberê went back to using crack in the new location. His mother said that Iberê is a "calm boy" who does not involve himself in thefts or drug trafficking, nor acts aggressively. As well as using crack, in the last few years he has presented symptoms of mental disturbance and persecutory deliria, spending time in a psychiatric hospital before arriving at the CAPSad. Two months before the start of this research, already amid the pandemic, he asked to be admitted since he was feeling "very distressed." He managed to access a TC, but only stayed at the establishment for thirty days. He continues to live in his mother's home—where the interview took place—and receives outpatient care.

[41] In Portuguese, *Programa de Intensificação de Cuidados*: a university extension program with a team composed of healthcare professionals and students, working in conjunction with the CAPSad team to offer daily listening and assistance to users connected to the program.

[42] Taiguara is a Brazilian indigenous name associated with the male gender, signifying "the freed slave" or "free man," https://www.dicionariodenomesproprios.com.br/.

[43] Iberê is a Brazilian indigenous name associated with the male gender, signifying "shallow river" or "river that flows slowly," https://www.dicionariodenomesproprios.com.br/.

Motives for admission

This was one of the first analyzers to emerge in the field, pointing to distinct interests of the users in seeking out the TCs.

Aruana recounted that her first admissions to TCs occurred following approaches in the streets made by teams from the service itself. "I was in a really bad way, not taking care of myself, not bathing, using a lot [of drugs] … so I agreed," she said. In subsequent stays, the initiative came from Aruana herself. "It was like the other times. I was crazy… So my TR [*técnica de referência* or contact professional] succeeded in finding a place for me, for me to have a time out." In less than a year, she returned to the same TC for the same reason, "for a time out" from a critical situation in her life, when she was using excessively, and her self-care was compromised. Her last admission to a TC, in 2020, occurred after her brother's death, which led to intense suffering and uncontrolled consumption of alcohol and crack. Concerning the admissions, she speaks clearly of the interest in general care during moments of fragility.

Taiguara's second admission to a TC occurred after he suffered a serious attempted homicide with a firearm. After being hospitalized, in an ICU and then a general ward, he was discharged and sent by the CAPSad team to a TC on the same day. The primary objective was to avoid Taiguara returning to the streets by providing shelter and meals to a convalescent person, recovering from surgery. The team was also trying to protect him from another attempted murder by removing him from the territory for longer, until the situation "cooled." Taiguara left the TC after "five months and fifteen days" on his own account. "When I thought I was well again, I left. I could have put up with staying longer, but I thought it unnecessary," he explained. "But they didn't want me to leave, you know?! 'I fought' to leave!" he said about the insistence he had needed to show to be discharged.

Potira also said that she sought to be admitted during moments when "life was very difficult," associated with feelings of "pain and despair," leading to high alcohol consumption and suicide risk. Staying at a TC was a relief during these moments.

These accounts show that people seek to be admitted to TCs for care at moments when their lives are threatened, whether from violence or from a precarious state of self-care, related or not to an acute and excessive increase in drug use. "Temporary shelter" or "temporary refuge" was how the CAPSad professionals framed the motives for admission to the TCs—a place for people to "reestablish" themselves and maintain a temporary abstinence, a protected space with shelter and food. Other studies, conducted directly with TCs, also contain accounts of admissions with the objective of protection, refuge, or exile.[44,45,46]

Professionals from the CAPSad related experiences of users who prefer TCs to shelters—or to nighttime accommodation at 24-hour Psychosocial Care Centers for Alcohol and other Drugs (Centro de Atenção Psicossocial de Álcool e outras Drogas 24h, or CAPSad III)—since they are seeking a period of abstinence,

[44] Cesar Pinheiro Teixeira, "O testemunho e a produção de valor moral: observações etnográficas sobre um centro de recuperação evangélico," *Religião & Sociedade* 36, no. 2 (2016): 111, https://doi.org/10.1590/0100-85872016v36n2cap06.
[45] Taniele Rui, "A inconstância do tratamento: No interior de uma comunidade terapêutica," *DILEMAS: Revista de Estudos de Controle e Conflito Social* 3, no. 8 (2010): 55.
[46] On this subject, see also Carly Machado's article published in this series.

believing it easier to achieve in a closed institution. The professionals also reported that the TCs are alternatives to the shelters and to CAPSad III when the latter have no vacancies, which is frequent. Data from 2015 on the offer of services to the street population in Salvador, Bahia,[47] indicates a precarious network of shelters, as well as just one CAPSad III with twenty-four-hour admission, serving a city with around three million inhabitants.

In the experiences cited here, users turned to TCs as a form of harm reduction—not only the harm caused by using alcohol and other drugs, but also those associated with life contexts of considerable vulnerability. Many of these people do not declare the wish to live without drugs, but ask for shelter and care in moments of difficulty. This access clearly helps save lives in many situations. However, it is a demand distinct from what is traditionally presented as the care proposal of the TCs, whose therapeutic goals are complete abstinence and change of behavior,[48] not accepting the continuing use of alcohol or other drugs under any circumstances.[49] Thus, two distinct care plans are configured: on the one hand, the user is seeking temporary relief and, on the other, the establishment is trying to enable a definitive change. This antagonism manifests as a dispute over care plans between professionals and users,[50] which may generate barriers that ultimately result in users desisting or terminating their stay, as discussed shortly.

Conversion treatment

When talking about his second period in a TC, Taiguara affirmed that the treatment would be "no use" to him. He said that "to really become free of drugs, only surrendering to Jesus will do. Living a Christian life, right?" since that is how he saw "recovered" people. He explained that surrendering yourself to Jesus required you to follow "a straight path," but he was not so disposed. He added: "I've got nothing against it. I respect it a lot. But for me, it's no use." He said that his real desire "was to manage to control the drug…" Saying this, he remembered the most recent loss of control he had experienced: after receiving the first installment of emergency aid for the pandemic, he bought some products that he needed and then decided to enjoy himself in the city center. "I spent everything I had in one night, a good stash of money, on women and drugs," he lamented. When this happens, he said that he feels like "shit, a *vacilão*," and that he even ends up using more, "just out of anger." He recounted, however, that during this period he was residing in a shelter, which helped him: "This time when the money ran out, I returned to the shelter and went to sleep, angry, but in my bed, right?! Imagine burning up all the money and afterwards having to sleep in the street?!"

Piatã recalled that in his four admissions to TCs, he sought "a change of life." However, he related conflicts with the process of change proposed in some services. In relation to one of his stays, he said that the treatment was "real brainwashing! Just like prison, when you must join a faction," speaking of the many daily pressures to adopt the community's standards. He related that his most recent admission, when he stayed for longer, helped him considerably, but he "also had problems." He said

[47] Nadja Conceição de Jesus Miranda, "População de Rua Em Salvador: Estudo dos Territórios e do Direito à Cidade (2005-2015)" (PhD dissertation, Universidade Federal da Bahia, 2016).
[48] Santos, "Comunidades Terapêuticas," 28.
[49] De Leon, *A Comunidade Terapêutica*.
[50] Luís Claudio Carvalho, Laura Camargo Macruz Feuerwerker, and Emerson Elias Merhy, "Disputas en Torno a los Planes de Cuidado en la Internación Domiciliaria: Una Reflexión Necesaria," *Salud Colectiva* 3, no. 3 (2007): 259–69, https://doi.org/10.18294/sc.2007.146.

that he felt under constant surveillance, as if the professionals and coordinators did not trust him. He related that he tried to act in line with the guidelines received, because he "wanted the treatment," but he thought there were too many demands. After completion, he was invited by the coordinator to remain at the TC, working as a monitor. Piatã thanked him but declined the offer. He told us that he did not want to be a snitch (*caguete*),[51] referring to the role of the service monitor, whose duties included "supervising" and reporting the irregular behaviors of other residents. During an interview at his home, he said that his stay in the TC was good, but he was happy to be able to act "in his own way" after being discharged, referring to the behavior demanded while staying there. He said that he has a few beers on weekends and sometimes uses small amounts of cocaine, but that he feels very well, managing to control his consumption. Today he has a home, work, and a new female companion in his life.

Taiguara and Piatã talked about treatments involving a life change beyond what users were disposed or wanted to undertake. In Taiguara's view, successful treatment entailed commitment to leading a "Christian life," following its teachings rigorously. Piatã, meanwhile, felt monitored and pressured to adopt behavior that the establishment comprehended as a therapeutic goal since, by demonstrating adherence to the expected conduct, his process of recuperation was recognized by the professional staff.

The literature indicates that behavioral change is, generally speaking, the main therapeutic goal of TCs. Abstinence is considered a consequence of treatment, but its principal objective is a complete change of the person's identity and lifestyle,[52] with the individual asked to submit fully to the treatment program.[53] Other studies also highlight the phenomenon of care practices focused on individual transformation, conceived as a conversion process,[54,55] with the birth of a new individual after the period of stay.[56] This literature also mentions that the new identity is based on moral standards, very often religious in orientation, with some research referring to this model as "moral treatment,"[57] "religious-moral treatment,"[58] or a "moral model."[59]

The experiences of Taiguara and Piatã suggest that treatment in these TCs was directed toward a change in behaviors and values. However, this change did not match what was sought by the users themselves,

[51] *Caguete*, or *alcagueta*, a pejorative term used for someone who informs on others, usually to a person in a position of authority.
[52] De Leon, *A Comunidade Terapêutica*, 71.
[53] Ibid., 348.
[54] Jardel Fischer Loeck, "Comunidades Terapêuticas e a transformação moral dos indivíduos: Entre o religioso-espiritual e o técnico-científico," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 77–101.
[55] Fernanda Mendes Lages Ribeiro and Maria Cecília de Souza Minayo, "As Comunidades Terapêuticas religiosas na recuperação de dependentes de drogas: O caso de Manguinhos, RJ, Brasil," *Interface: Communication, Health, Education* 19, no. 54 (2015): 519-520, https://doi.org/10.1590/1807-57622014.0571.
[56] Luciane Marques Raupp and Clary Milnitisky-Sapiro, "A 'reeducação' de adolescentes em uma comunidade Terapêutica: O tratamento da drogadição em uma instituição religiosa," *Psicologia: Teoria e Pesquisa* 24, no. 3 (2008): 361–68, https://doi.org/10.1590/s0102-37722008000300013.
[57] Renata Cristina Marques Bolonheis-Ramos and Maria Lucia Boarini, "Comunidades terapêuticas: 'Novas' perspectivas e propostas higienistas," *História, Ciências, Saúde - Manguinhos* 22, no. 4 (2015): 1231–48, https://doi.org/10.1590/S0104-59702015000400005.
[58] Ribeiro and Minayo, "As Comunidades Terapêuticas," 519.
[59] Raupp and Milnitisky-Sapiro, "A 'reeducação,'" 366.

who declared a desire to follow a different path. Even so, it was necessary to demonstrate compliance with the institutional goal in order to continue treatment, thus indicating a therapeutic imposition. This practice is also seen by Carvalho and Dimenstein as subverting the request of the user, who, in seeking help, must agree to "a modification of life that goes far beyond drug use."[60] Other studies point out that TCs tend to offer the same therapeutic proposal to all people seeking their services,[61] which denotes a prescriptive treatment that fails to consider the user's singular personality and desires. Care is not centered on the user but on the method and the goal, represented by the behavioral pattern of the "recovered" person, which may vary between TCs but is the same for all users of the same establishment. It imposes barriers to care for the needs, desires, or projects that users bring with them but which are incompatible with the moral model adopted by the institution, understanding morality as "a set of norms, freely and consciously accepted, that regulate individual and social behavior,"[62] historical in character and related to the existing social structure.

This article argues that increasing access to care requires that healthcare practice cease to be focused on itself and its techniques,[63] and open itself up to the user, guided by an ethics that "overthrows the system of judgment"[64] to valorize what potentializes each singular mode of life: an ethical approach that embraces life in its tragic dimension too; not to convert but to care for the person's suffering while they seek to affirm the potential of their life.

"I felt mistreated"

In the course of daily activities at the CAPSad, there were many reports of users feeling mistreated during their stays at TCs, varying according to the establishment. In the conversations with the users-as-guides, all had some account of abuse, mistreatment, or other forms of violence suffered during their stays.

Aruana recounted that during her first admission, physical punishments were inflicted for breaking the rules. "There was a cane called 'Tereza.' Anyone who stepped out of line had to 'talk' with Tereza," she said. She was also barred from wearing male clothes, which form part of her aesthetic and her self-image. She experienced similar abusive practices in the second TC where she stayed. In both episodes, she says, she remained in the institutions for only fifteen days because of the "punishments" and the daily routines, obligatory for everyone, stating that "praying while fasting isn't my thing." Concerning her most recent admission, in 2020, when she remained for a little over a week, she reported that "it was a good place, beautiful! There were lots of trees, plants… all looked after well. I wanted to stay there," but "I felt mistreated." She explained that she left because she could not stand the treatment. She added that she arrived at the TC during a moment when she was using crack heavily, following her brother's death. Her admission was paid for by people worried about her situation. Aruana said that when she arrived at the TC, "I was still in withdrawal, I just wanted to lie down, I didn't want to do

[60] Bruno Carvalho and Magda Dimenstein, "Análise Do Discurso Sobre Redução de Danos Num CAPSad III e Em Uma Comunidade Terapêutica," *Temas Em Psicologia* 25, no. 2 (2017): 656, https://doi.org/10.9788/TP2017.2-13.
[61] Santos, "Comunidades Terapêuticas," 28.
[62] Adolfo Sánchez Vázquez, *Ética*, 37th ed. (Rio de Janeiro: Civilização Brasileira, 2017), 63.
[63] Emerson Elias Merhy, "Fórum Social Mundial e a saúde: por uma ética global da vida," *Interface - Comunicação, Saúde, Educação* 6 (11): (2002) 133–36, https://doi.org/10.1590/s1414-32832002000200016.
[64] Gilles Deleuze, *Espinosa: Filosofia Prática* (São Paulo: Escuta, 2002), 29.

anything. So they began to treat me badly, saying I was lazy, I was taking advantage, I wasn't helping with anything, you know?! Saying I was a burden…"

Taiguara was also at the first TC attended by Aruana. He recalled that, at this place, he arrived "on a Monday, left on Friday." Asked about his reasons, he replied emphatically: "Are you crazy?! At five in the morning there were people waking you up to pray… It was a madhouse! And if you did 'something wrong'?! Just imagine: passing someone a note was 'something wrong,' can you believe it? Then there were the monitors who would beat you up! Ah, if they laid a hand on me…" He said that he left the TC so as not to do something "bad" there were they to hurt him. During his second admission, in another establishment, he recalled that the daily routine was "less rigid," but the main punishment for those who failed to follow the rules were food restrictions, a reduction in quantity or the removal of the "meat" from the meal. In a tone of indignation, he said that "messing with someone's food isn't right, is it?!"

Piatã's first admission was at the same TC cited by Aruana and Taiguara. He also referred to the "cane called 'Tereza'" used to physically punish the undisciplined. "I myself was never struck," he said, as he followed the rules, "but I saw a lot of people beaten." He related a day-to-day life of strict control and monitoring. He abandoned the treatment, saying that he was "disgusted to see those things." In the following two admissions, at different TCs, he recounted that there was no physical aggression. Instead, punishments involved the withdrawal of food or "kneeling down," when the transgressor had to stay kneeling for long periods. In one TC, he recalled, the coordinator would "yell and humiliate" when someone broke the rules. These circumstances led Piatã to abandon the treatments. He added that it was always a difficult decision since he also felt guilty about leaving the establishment. He left these admissions "feeling more down," with a desire to "end the world," and resumed the intensive use of drugs.

Iberê and his mother told us that the only experience they had with a TC was "very bad." Iberê was in a moment of uncontrolled drug use and asked to be admitted "out of fear of worse happening," as in other situations when he was attacked by drug traffickers. Iberê's mother obtained the contact information for a TC through another user undergoing treatment but reported that, soon after his admission, she had no more contact with her son. "They said that you can visit only after thirty days, it was part of the treatment," she said. Iberê also said that he was not permitted to phone home. After thirty days, when his mother was able to visit him, she recalled that Iberê had lost weight and was downcast, asking "for the love of God" to remove him from there. Iberê said that the routine was strict, with punishments for those who did not obey the rules. The main punishment, he reported, was restriction on food. After contact with his mother, Iberê returned home and resumed outpatient care.

All these experiences call attention to the frequency and variety of abuses suffered in situations that should be producing care, not oppression. In addition to the experiences described above, other accounts of mistreatment, rights violations, and abuses inflicted in TCs are widely registered.[65,66,67] It can

[65] Conselho Federal de Psicologia, *Relatório da 4ª Inspeção*.
[66] Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*.
[67] *Pública*, "Adolescentes denunciam tortura e mostram marcas de violência em comunidade terapêutica evangélica," accessed November 20, 2020, https://apublica.org/2020/10/adolescentes-denunciam-tortura-e-mostram-marcas-de-violencia-em-comunidade-terapeutica-evangelica/?mc_cid=50f17a2991&mc_eid=60e0cddd8d.

be inferred that the abuses are related to the disciplinary practices adopted by TCs. The accounts of the users-as-guides indicate that the TCs use disciplinary measures—called sanctions or punishments—as a quotidian practice in response to noncompliance with the establishments' rules. This practice is also recorded in other studies as part of the care dynamics of the TCs investigated.[68,69,70]

The inter-institutional inspection report produced by the Federal Psychology Council and other entities of twenty-eight TCs indicates that some of these services declared the use of disciplinary measures with a "pedagogical or therapeutic purpose."[71,72] The following types of punishments were identified: through work, with the "accomplishment of extra and demeaning tasks";[73] through restrictions, such as withdrawing food, limiting contacts, or "removing something that the transgressor likes";[74] through isolation or confinement; and through physical aggression. One of the fundamental texts for TCs in Brazil recommends, as a form of sanction, the use of practices that are in reality offensive and humiliating, such as hanging a sign from the neck with a "social label (for example, liar, thief, manipulator)"[75] referring to the infraction committed; being forced to conduct tasks considered inferior, such as cleaning bathrooms;[76] or even losing rights acquired with the progression of treatment, such as receiving family visits.

From the users' accounts, it is also noticed that the feeling of being mistreated led many people to leave the TC, and not just in extreme situations of physical aggression. During Arauna's most recent admission, although the TC did not inflict physical punishments, disrespect and humiliation were present in the form of accusatory labels and remarks. By leaving, users lose access to important care resources, as described earlier, configuring a barrier to access for these individuals. Furthermore, as Piatã recounts, quitting is very often comprehended as personal guilt, an incapacity to cope with the period of stay, which produces more suffering and itself constitutes a further barrier to care. Without space for their own protagonism, frequently the only way users can exercise their right to participate in their own therapeutic plan is by "not sticking to the proposals that cause them more discomfort or that do not produce the imagined/desired effect."[77] Resisting treatment is also an attempted protagonism of the users.

On the other hand, disciplinary practices have also been shown to be present in replacement mental health services like the CAPSads. These practices were the topic of an important debate in the care

[68] Alice Leonardi Pacheco and Andrea Scisleski, "Vivências em uma comunidade terapêutica", *Revista Psicologia e Saúde*, no. 2002 (2013): 165–73.
[69] Mariane Capellato Melo and Clarissa Mendonça Corradi-Webster, "Análise do funcionamento de comunidade terapêutica para usuários de drogas," *Athenea Digital* 16, no. 3 (2016): 379–99, https://doi.org/10.5565/rev/athenea.2012.
[70] Cesar Pinheiro Teixeira, "O testemunho e a produção de valor moral: observações etnográficas sobre um centro de recuperação evangélico," *Religião & Sociedade* 36, no. 2 (2016): 107–34, https://doi.org/10.1590/0100-85872016v36n2cap06.
[71] Conselho Federal de Psicologia et al., *Relatório da Inspeção Nacional*.
[72] Ibid., 111.
[73] Ibid., 113.
[74] Ibid., 114.
[75] De Leon, *A Comunidade Terapêutica*, 247.
[76] Ibid., 248.
[77] Feuerwerker, "Cuidar em saúde," 42.

network in which this research was conducted.[78] It was observed that disciplinary measures are frequently perceived by users as a form of institutional violence.[79] Despite the CAPS being conceived as a space of a clinical practice exercised without dominance, with respect for the other, and which should invest in creativity and inventiveness to confront challenges,[80] the work of the professionals involved does not always reflect these principles. It is not unusual for professionals to feel authorized, in the name of care, to "produce violent acts with looks, words, expulsions and criminalization."[81] Mendonça discusses how the use of discipline as a strategy for normalizing someone's life is a practice of domination involving the exercise of the force of the services/teams over users.[82] He argues that, for assistance to produce care, domination must be abandoned and a "weak force" exercised that does not impose but opens up to the other. Disciplining is a barrier to care.

Existential connections

Potira has a history of numerous admissions to TCs and psychiatric hospitals. Three professionals who have monitored her report that she usually asks to be hospitalized during moments of crisis, very often with the risk of suicide. These situations are related to episodes of enormous suffering, such as the loss of children or physical attacks. The professionals interpret Potira's requests as dependence on institutional admission. Generally, Potira leaves the stays in care abstemious and filled with ideas for many projects, but ends up having new decompensations, including heavy consumption of alcohol. Over time, Potira began to prefer admission to TCs, saying that in the hospital she would be "heavily doped" and would only be admitted for shorter periods. She has stayed in various TCs. At a particular moment of her therapeutic trajectory, Potira was included in a PIC, promoted as a university extension project. With the day-to-day support of the PIC team, Potira resumed her desire/project to reconnect with her children, especially her youngest daughter. The search for reconnection with people also meant connection to other services like the Public Defender's Office. In this process, the professionals report a reduction in Potira's requests for hospital and TC admission. She said that she asked to be admitted when "life was very difficult," associating these requests with moments of intense suffering. She said that she missed "the girls" from the PIC, who helped in moments of crisis, since "they talked a lot with her," complaining about the end of the program and the loss of contact with the interns. At the end of the conversation, when asked where she felt better, whether in the shelter—where she was at that moment—or in the TC, she replied: "In my own home!"

[78] "Impasses na RAPS: atos administrativos-disciplinares são aplicáveis aos usuários da Rede de Atenção Psicossocial? São legais? São legítimos? São necessários?," accessed November 20, 2020, https://cetadobserva.ufba.br/pt-br/seminarios-livres-qlinica-com-que-apresenta-impasses-na-raps-atos-administrativos-disciplinares-sao.

[79] João André Santos de Oliveira et al., "Desencontros entre a vista do ponto dos usuários e as formas de cuidar em saúde: reflexões sobre a produção do cuidado em uma região da cidade de Salvador-BA," in *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes*, vol. 1, ed. Emerson Elias Merhy et al. (Rio de Janeiro: Hexis, 2016), 277.

[80] Ricardo Luiz Narciso Moebus, *O Trágico Na Produção Do Cuidado: Uma Estética Da Saúde Mental* (Porto Alegre: Rede UNIDA, 2014).

[81] Emerson Elias Merhy, "Anormais do Desejo: os novos não humanos? Os sinais que vêm da vida cotidiana e da rua," in *Drogas e Cidadania: em debate* (Brasília: CFP, 2012), 13.

[82] Paulo Eduardo Xavier de Mendonça, "SEM SOBERANIA: Gestão Solidária e Força Fraca Para Cuidar de Vidas" (PhD dissertation, Universidade Federal do Rio de Janeiro, Rio de Janeiro, 2015).

In Potira's experience, the admissions provided relief from pain and enabled a disconnection from a context of suffering, becoming a resource that she used repeatedly. However, the long stays, in addition to distancing Potira from her problems, distanced her from her relationships and projects, such as reconciliation with her children, something she desired but had great difficulty in executing for different reasons. With the support of the intensification of care, Potira was able to reconnect more effectively with people and with her own desires, which contributed to reducing her requests for admission, despite continuing to experience moments of crisis.

Aruana also points to the importance of connections for her life and her care. She is a great mobilizer of networks around herself. As well as intensely consuming services from the formal care networks—CAPSad, harm reduction programs, shelters, TCs, the Public Defender's Office, and so on—she is active in social movements, spaces of representation, and diverse collectives, both demanding collective rights and arranging help for herself. When asked about the most important connections in her care trajectory, she did not refer to any network service. First, she cited her former partner, a woman who worked for many years as a harm reduction practitioner, also a user of psychoactive drugs. Next, she spoke about her performances in the show *Os Saltimbancos* organized by CETAD more than a decade ago. She says that it was after this show that she "found the enthusiasm to do rap, write, sing…"—her passions and tools for expressing joy and suffering.

It can be seen that individuals, seeking care, deliberately transit through distinct territories and services and produce connections to meet their needs, assuming a proactive role in this process.[83] These connections are not only with health services or other organizations, but also in the diverse relational ties in their lives.[84] Mobilized by users, these "living networks of existential connections"[85] are producers of care, but also produce individuals themselves, based on established relations. As Merhy et al. describe:

> The main objective in promoting the expansion of existential networks is to expand the resources that each person has available for … them to reinvent their existences to confront various moments of life. The lack of a network of encounters impoverishes the possibilities for change. When you include yourself in the other's network, you can contribute to new assemblages, as one more element in these networks, rather than being the only network that enables the other's potential.[86]

Potira's experience reveals a relationship between her repeated long-stay admissions and the impoverishment of her networks of existential connections, which diminished her resources to deal with adversities and increased her dependence on admissions. Her experience also emphasizes how barriers to the enrichment of individual networks are barriers to care. Other studies have identified the construction of an "institutional career"[87] as a possible consequence of the mode of operation adopted

[83] Antonio Lancetti, *Clínica Peripatética*, 4th ed. (São Paulo: HUCITEC, 2009), 19–37.
[84] Merhy, Feuerwerker, and Silva, "Contribuciones metodológicas," 25–34.
[85] Emerson Elias Merhy et al., "Redes vivas: multiplicidades girando as existências, sinais da rua. Implicações para a produção do cuidado e a produção do conhecimento em saúde," in *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes*, vol. 1, ed. Emerson Elias Merhy et al. (Rio de Janeiro: Hexis, 2016), 34.
[86] Ibid., 37.
[87] Marco Antônio Carvalho Natalino, "Isolamento, Disciplina e Destino Social Em Comunidades Terapêuticas," in *Comunidades terapêuticas: temas para reflexão*, ed. Maria Paula Gomes dos Santos (Rio de Janeiro: IPEA, 2018), 53.

by the TCs, which produces difficulty in adapting to life outside the organization, generating dependence on the internal dynamic to maintain everyday life.

Potira's and Aruana's experiences demonstrate the importance of care that invests in enriching users' networks of connections—connections that produce not only joy but also sadness, like almost everything in life, such that its significant moments and meanings can only be defined by each person's singular experience.

The CAPSad–TC relationship

Piatã's most recent admission lasted fourteen months, until he was deemed "recovered" and discharged by the TC. During this period, he invested considerably in his care, accessing diverse services within the network. He frequented the CAPSad each month for appointments with doctors, psychologists, and nurses. He also maintained regular contact with the legal aid team from the Run for a Hug Program. It was during this period that Piatã received care in a specialized orthopedic service, later followed by surgery to treat his osteomyelitis in a state hospital, a process mediated by the CAPSad. After release from the hospital, Piatã returned to the TC to conclude his stay with his arm healed.

This experience might seem a good example of the articulation of network care and the partnership between CAPSad and TCs. However, this entire process occurred under Piatã's own management. Through telephone calls from the TC, Piatã contacted his contact professionals at the CAPSad, requesting support to schedule appointments and exams, as well as asking about the progress of his requests. Whenever he visited the CAPSad, Piatã would reaffirm the requests for assistance, including asking the service coordination team for support. One of the requests made more than once was for the CAPSad to intermediate with the TC coordination team, which had imposed obstacles to Piatã leaving the institution to attend the medical appointments. Other residents and monitors asked, "Why does he have to leave so often?" he reported, observing that this was not routine at the establishment. A CAPSad professional visited the TC to talk with the coordinator and "show that Piatã was being treated by us and we assumed responsibility for his trips out." Even so, new intermediations were needed at other moments, even after this initial conversation. In a certain way, all the articulation of the networked care occurred despite the TC.

The CAPSad staff reaffirmed the difficulty of communicating with the TCs, demonstrating a low level of coordination between the services. The contacts of the CAPSad team with the TCs are generally via phone. Initially, the contact takes place with the coordination team to present the situation of the user soliciting a place. During the stay, the communication continues by telephone, directly with each user. There are no accounts of clinical discussion of the cases between professionals from the CAPSad and the diverse TCs with which they interact. Face-to-face contact between teams occurs occasionally, usually when users are being transported between services, the conversations focusing on administrative agreements and motivational issues.

Other studies also point to a low level of coordination between CAPSad and TCs.[88,89] There are reports of TC professionals who see the treatment provided at CAPSad as inadequate, as they consider any

[88] Lara Dias Cavalcante, Maria Eduarda Debiazzi Bombardelli and Rogério José de Almeida, "Condições sanitárias de comunidades terapêuticas para tratamento da dependência química," *Vigilância Sanitária em Debate* 4, nº 2 (2016): 44–50, https://doi.org/10.3395/2317-269x.00587.

alternative that does not require complete abstinence from alcohol and other drugs to be an incentive to maintaining drug use.[90] Meanwhile, the CAPSad staff also view the TCs with reservations, claiming that these institutions operate "in a completely different paradigm" to the one grounding the work of the CAPSads. They allege that the TCs "do not behave as health services," especially since they do not address issues that they consider to be fundamental in treating the problematic use of psychoactive substances, and in their view the "latent questions of the disorder, such as the role that drugs play in the individual's life, are 'swept under the rug.'" For some professionals, the therapeutic practices of the TCs are "prescriptive" and promote a "nullification of an individual's subjectivity." Regarding the articulation of care to users, these CAPSad professional workers attributed a "discontinuity of care" to the TCs, claiming that the therapeutic plan constructed prior to admission is placed "on hold," associating the relationship established between CAPSad and TCs with the relationship maintained between CAPSad and psychiatric hospitals.

Despite these reservations about the TCs, the CAPSad professionals request admission places for these services in various situations. Some reported that they feel "uncomfortable" but "meet the subject's demand," referring to the request of the user, who "knows which 'door' is accessible." Others say that they "do not usually recommend" admission to a TC but sometimes do so knowing that it is an important support when they cannot find other resources in the network. Some deal with this contradiction by asserting that "it's what's possible" given the care resources available for this population. As discussed earlier, the main motive for referral to TCs is the search for protection, shelter, or temporary abstinence, generally in situations where users are particularly vulnerable.

It appears that this low occurrence of partnerships between CAPSad and TC is related to differences in the models of care of these two types of establishments. The respective teams see themselves as operating different and sometimes antagonistic care paradigms, which results in the production of distinct therapeutic plans for the users, who are also disputed between health services. In Piatã's experience, while the TC tried to keep him tied to the daily routine shared by all the other users, the CAPSad supported Piatã's personal project, which tried to take advantage of the access to shelter, protection, and abstinence to "put his life in order," solving medical and legal questions, among others. The restrictions imposed to leave the establishment were barriers to organizing Piatã's care, which he was only able to overcome through his own protagonism. When the coordination depends solely on the service teams, the distance between them can entail new barriers.

FINAL CONSIDERATIONS

The findings described above should not be generalized. They depict the experiences of five users of health services in specific contexts, presented here for analysis and discussion. However, they point to important questions concerning the care offered by TCs to their users vis-à-vis other care settings.

This research shows Aruana, Piatã, Taiguara, Potira, and Iberê are people with their own desires, projects, values, and worldviews. At the same time, they present life histories full of suffering and

[89] Leila Gracieli da Silva, Luís Fernando Tófoli, and Paulo Renato Vitória Calheiros, "Tratamentos ofertados em Comunidades Terapêuticas: Desvelando práticas na Amazônia Ocidental," *Estudos de Psicologia* 23, no. 3 (2018): 325-33, https://doi.org/10.22491/1678-4669.20180031.
[90] Carvalho and Dimenstein, "Análise do Discurso," 654.

deprivations, demonstrating that to be alive is also an act of resistance. In their transit through care networks and services, they bring in their "baskets of needs"[91] all the dimensions of their lives, seeking care for their pains and wants, but above all a kind of care that supports the choices that make up part of their lives.

On accessing the TCs, these singular dimensions become subordinate to the collective project of the service. A path that is incompatible with the one defined by the service is considered invalid. Insistence on following a different path is interpreted as indiscipline, liable to result in punishments or even expulsion. Thus, as well as refusing to accommodate some of the singularities of the users, TCs dismiss or even criminalize users' personal desires and projects. The TC team is deemed to know what is best for the users, more so than the users themselves. As well as depotentializing their desires, the establishment reduces all the complexity of life and individual difficulties to the problematic use of drugs. The losses experienced by Potira over the course of her life, the abuses suffered by Aruana, or Taiguara's life of urban exile are ignored and attributed to the drugs, reaffirming a single therapeutic path. These are issues that must be addressed in care relationships but are ignored by the therapeutic project of the institutions, forming barriers to qualified access. Rather than producing singularity and recognizing differences, they produce serialization.[92]

Despite these restrictions, users continue to access these services at distinct points in their trajectories. They try out different TCs, seeking those where they feel more welcome or less restricted. They stick to the therapeutic projects—or care plans—that they have set up for themselves, fighting for them, in different ways, against those imposed by the services. Despite the treatment that tried to convert him, Taiguara remained at the TC until he felt safe to return to his territory. Notwithstanding the TC that tried to make him follow the service routine, Piatã went in search of outside connections to make his care plan viable. Whether negotiating, submitting temporarily, or quitting the TC, users pursue protagonism in their own care.

Finally, the perceived relationship between the disciplinary regime of these services and the practices of abuse and mistreatment should again be highlighted. As well as opening space for excesses, the use of disciplinary measures implies that a person—or team—is authorized to subjugate someone else in certain situations. Fear of punishment is assumed to contribute to individual change. Submission and change do not represent paths committed to care; rather, they produce barriers to such care.

Consequently, this article proposes that analyses of the care provided by TCs, as well as by other care facilities intended for this population, should adopt a form of care centered on users and their needs. It has also sought to show how users' distinct individual desires, projects, and conceptions are treated by teams and services, seeking to comprehend at what points the therapeutic relationship opens or closes to the singularities of the lives that seek care.

[91] Luiz Carlos de Oliveira Cecilio and Norma Fumie Matsumoto, "Uma taxonomia operacional de necessidades de saúde," in *Gestão em Redes: Tecendo Fios de Integralidade em Saúde*, ed. Roseni Pinheiro, Alcindo Antonio Ferla, and Ruben Araujo de Mattos (Rio de Janeiro: EDUCS – CEPESC – IMS/UERJ, 2006), 37–51.

[92] Emerson Elias Merhy, Laura Camargo Macruz Feuerwerker, and Maria Paula Cerqueira Gomes, "Da Repetição à Diferença: construindo sentidos com o outro no mundo do cuidado," in *Semiótica, Afecção e Cuidado em Saúde*, eds. Túlio Batista Franco and Valéria do Carmo Ramos (São Paulo: Hucitec, 2010), 60–75.

IMPRISONED ON THE OUTSIDE: THERAPEUTIC COMMUNITIES AS ZONES OF URBAN EXILE

CARLY MACHADO[1]

Therapeutic communities (TCs) are urban spaces frequently described as *that kind of place* where one can encounter *those kinds of people*. This formulation, generally presented as a critique of the indeterminacy surrounding the assistance offered by these institutions, is the starting point for this article. The aim is to reflect on the elements responsible for constituting the social and urban realities in which TCs become the destination for so many different people. It likewise explores the trajectories taken by these people's lives, the so many (un)certain lives of those who, at some moment in time, arrive at, stay in, and leave the TCs.

The religious recovery centers, or recovery and rehabilitation homes for people with a problematic use of drugs,[2] are spaces that over many decades have become part of a complex interplay of visibilities and invisibilities in Brazil. More recently, particularly since 2011 when some places in these institutions began to be funded by the federal government, these "therapeutic communities" (a category utilized in the process of formalizing these recovery centers) have started to be treated as a public problem for some fields of political and professional practices.[3] The majority of Brazilian TCs (82 percent) are linked to churches and religious organizations, notably those of Christian affiliation.[4] On account of the official secularity of the Brazilian state, the problematization of the *religious* character of these institutions centers especially on the following aspects: criticisms about the legitimacy of offering *religious treatment* for the drugs problem; the *public financing of these practices*; the *cost-benefit relation of the treatment* provided by religiously affiliated institutions; and denunciations of violations to the *religious freedom* of the people they take in. There also exist more general denunciations where the religious profile of these organizations functions as an aggravating factor, such as those relating to rights violations.[5]

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[2] Faced with the different terms referring to the *consumption* or *use* of psychoactive substances, the idea of a *problematic use* of drugs is consonant with the interests of this article since it affords an opening to meanings surrounding the "life problems" caused by drugs and their biological, political, economic, social, and cultural dimensions, as well as their potential solutions.

[3] For a panoramic view of the reality of TCs in Brazil, see Maria Paula Gomes dos Santos, ed., *Comunidades terapêuticas: temas para reflexão* (Rio de Janeiro: IPEA, 2018).

[4] IPEA – Instituto de Pesquisa Econômica Aplicada, *Nota Técnica nº 21 (Diest): Perfil das comunidades terapêuticas brasileiras* (Brasília: IPEA, 2017), accessed November 30, 2020, https://www.ipea.gov.br/portal/index.php?option=com_content&view=article&id=29865.

[5] For a more in-depth discussion of complaints related to TC activities, see the article by Carolina Gomes Duarte and Mathias Glens in this series.

Although religion is also an aspect of major interest to the discussions in this article, the intention here is not to focus specifically on the themes listed above, all of them highly relevant. The question guiding this work is different and concerns the relationship between religion and life in the city. Religious practices form part of urban daily life, comprising the life conditions of different populations, in structures more or less formally articulated with the state public authority. The interest here is to understand how TCs are situated in the structural arrangement between the "religious" and the "secular" that operates in the management of the mechanisms of violence,[6] difference, and suffering in the state of Rio de Janeiro,[7] forming part of the trajectories of urban subjects in search of a place to stay or escaping places where they cannot live.

Diverse studies have inspired a reflection on the circulation in the city of people considered as its surplus, those who "fail to fit" into urban life, individuals only placed in the city as circulating bodies, inconveniently inhabiting the frontiers of suffering, abandonment, violence, and even the freedom that this forced circulation implies.[8]

While drugs are part of this circuit, we know that they neither define all the terms of the problems experienced by these subjects nor all the destinations of their circulation.[9] A relationship with "drugs" implies possibilities for consumption, buying and selling, circuits of illegalities, violence, stigmas, problems, or solutions for life; in other words, speaking from the viewpoint of the question of "drugs" implies the mobilization of an extensive moral repertoire of *life problems of the urban surplus population* who circulate through prisons, police stations, shelters, streets, and TCs. Moreover, each moment of "stoppage" along these trajectories is delimited by a spatiotemporal relationship: where to stay and for how long.

Many of these trajectories, including those discussed in this article, are profoundly marked by moments of expulsion in which the individuals concerned are not allowed to "stay" or "reside." A process that imprisons them on the outside. Within the broader fabric of urban conflicts, therefore, what comes to the fore here are not the localities or institutions that force people to stay inside, like prisons, but situations and processes that prevent people from staying, not allowing them to remain inside or situate

[6] On the religious and the secular in the mechanism of violence, see Patrícia Birman, "Cruzadas pela paz: práticas religiosas e projetos seculares relacionados à questão da violência no Rio de Janeiro." *Religião & Sociedade* 32, no. 1 (2012): 209-226, https://doi.org/10.1590/S0100-85872012000100010.

[7] On Pentecostal practices and the management of suffering and violence, see Carly Machado, "Pentecostalismo e o sofrimento do (ex-)bandido: testemunhos, mediações, modos de subjetivação e projetos de cidadania nas periferias," *Horizontes Antropológicos* 20, no. 42 (July-December 2014): 153-180, https://doi.org/10.1590/S0104-71832014000200007; and Mariana Côrtes, *Diabo e Fluoxetina: Pentecostalismo e Psiquiatria na Gestão da Diferença* (Curitiba: Appris, 2017).

[8] One lives in circulation in the city, see Taniele Rui, *Nas tramas do crack: etnografia da abjeção* (Terceiro Nome: São Paulo, 2014); Fábio Mallart and Taniele Rui, "Cadeia ping-pong: entre o dentro e o fora das muralhas," *Ponto Urbe [Online]*, no. 21 (2017): 1-16, https://doi.org/10.4000/pontourbe.3620; Adriana Fernandes, "Quando os vulneráveis entram em cena: Estado, vínculos e precariedade em abrigos," in *Os limites da acumulação, movimentos e resistência nos territórios*, edited by Joana Barros, André Costa and Cibele Rizek (São Carlos: IAU/USP, 2018), 85-100; and Rafael Godoi, *Fluxos em cadeia: as prisões em São Paulo na virada dos tempos* (São Paulo: Boitempo, 2017).

[9] Mauricio Fiore, *Substâncias, sujeitos, eventos: uma autoetnografia sobre uso de drogas* (Rio de Janeiro: Telha, 2020).

themselves, but imposing instead the need for them to leave, as found in the experiences of exiles, refugees, and deportees.

At a general level, this research was undertaken with people who have spent time in religious TCs, or whose life trajectories included experiences in TCs, and who told their stories during the Covid-19 pandemic (July to September 2020). Their contacts were mostly obtained by actively searching among groups of friends, family members, and research interlocutors. In this broader universe, as well as people with experience of staying at TCs, conversations were conducted with pastors and the relatives of pastors responsible for TCs, workers from religious projects intended to address the problem of drugs in the streets, and mothers and sisters of men residing in TCs. Despite the diversity of this universe, the initial strategy was to talk to everyone who wanted to and could tell their stories.

In addition to the present author, the conversations were conducted by another five researchers, four women and one man: Nildamara Torres (PhD student—UERJ), Jamille Bezerra (MA course—UFRRJ), Aleixa Gomes (Undergraduate Researcher/UR—UFRRJ), Beatriz Corrêa (UR—UFRRJ) and Frederico de Assis (UR—UFRRJ).[10] Most conversations were conducted via WhatsApp. Some were conducted in person (one of them in a church, another in a shelter). The WhatsApp conversations unfolded over several days with audio messages being the channel of communication preferred by the interlocutors. The team talked to fifteen people in all. For the purposes of this article, the trajectories of six participants were selected, all men who had spent at least six months in TCs they had entered voluntarily. All were kept informed about the progress and results of the research. Here their names have been changed.[11]

The people with whom conversations were held over the course of the research were from Rio de Janeiro, and all of them had some contact with Pentecostal institutions as part of the trajectory of their relationship with drugs. The six men whose journeys were selected for this article had experiences with Pentecostal institutions and four of them had stayed in Pentecostal TCs. As indicated by the survey conducted by IPEA,[12] Pentecostal TCs are widespread in all regions of Brazil. In the Southeast, 15.3 percent of total TC vacancies are found in Pentecostal institutions, forming the largest contingent in the country when compared to other Brazilian regions.[13]

All the men with whom the team talked had been “away from drugs” for at least six months and most of them for some years. The temporality of their experiences was thus one of recovery and stability in

[10] This team was formed by students from the Distúrbio (UERJ-UFRRJ) and Observatório Fluminense (UFRRJ) research groups with whom the author develops her academic projects. The entire process of analyzing the data, constructing the arguments, and writing the article was discussed with this team, which met weekly from July to September 2020.

[11] The research was based on ethical principles shared with all the interlocutors throughout the entire process with their consent to participate and an assurance given that their personal information would remain anonymous. Conversations with the interlocutors were transcribed and analyzed and, after the first version of the text was drafted, all participants received the article and a 15-minute video presenting the text. The intention behind the video was to offer an audiovisual format for sharing the interim result of the work, increasing the collaboration with interviewees in its production. The approach adopted by the research was based on research methods in the anthropology of religion and urban anthropology.

[12] IPEA, *Nota Técnica nº 21*.

[13] The percentage of places in Pentecostal TCs in other regions of the country is as follows: North—3.5 percent; Northeast—9.8 percent; Center West—4.0 percent; South—8.4 percent. Ibid.

relation to the "drugs problem." Many of their remarks during the conversations employed a narrative formulated around being a "witness," which, as various authors have analyzed,[14] imprints specific discursive and performative characteristics on the person's trajectory when told as a religious or secular account of an experience of redemption and thus success. Nevertheless, as explained earlier, the focus of the conversation was not on "religious treatment" or on the experience of "conversion" per se.

The dialogues developed out of the team's interest in the urban trajectories of the interlocutors, in the urban boundaries that they traverse, in the directions of their lives that took them to the TCs, kept them there, and led them to leave. All the men had gone to the TCs voluntarily. It should be emphasized that the six trajectories analyzed here correspond to all the interviewees who lived for more than six months in these institutions. The only participants omitted here are those who, despite the amount of time spent in TCs, did not engage in the research conversations beyond the initial contacts. All the interlocutors who told their stories recounted violent episodes in their life courses, involving territorial tensions, severe conflicts, and the risk of death. Attention was paid to how their narratives provided an insight into the spatiotemporal dynamic of the life events that they presented, such as: *situations involving expulsion* (from home, from the neighborhood, from the district, and from the city); moments of *pausing* and *stopping* in places where they could stay in some form or other; and their formulations about where the process of recovery is territorially inscribed and about its unstable temporality.

IMPRISONED ON THE OUTSIDE: WHERE YOU CANNOT STAY

Dino spent several years of his life taking different types of drugs. But what he describes as a "kind of overdose" was a watershed moment in his transition to admission to a TC, combined with the birth of his daughter. "I couldn't stay at home in that state," leading that kind of life. As a potential solution, one of Dino's uncles suggested he talk to a pastor who, his uncle said, had once led a life like his own. And that was how Dino met a pastor who lectured him on the Brazilian Penal Code:[15]

> He told me his story and… and my phone didn't stop ringing. That was when he picked up the Penal Code and said to me: read this article here. He opened an article in it like an expert. He knew the Brazilian Penal Code as well as he knew the Bible… In this article that he told me to read, *it was written* that anyone who manufactures, transports, traffics, or simply facilitates [the drug trade] is indicted under the same article. So he said: with a lot of money invested by your father, with a lot of knowledge [of the system], you'll get eight to twelve years in prison. As you're a first-time offender, and with your father paying bail and so on, you'll stay inside for six months to two years, depending on the judge, and depending on where you're sent, if you don't try to escape. Even as a first-time offender, if they catch you, you'll be indicted for conspiracy (*formação de quadrilha*), facilitating trafficking, drug trafficking, all of that.

[14] On witnesses, see Côrtes, *Diabo e Fluoxetina*; Eduardo Dullo, "Testemunho: cristão e secular," *Religião & Sociedade* 36, *no.* 2 (2016): 85-106, http://dx.doi.org/10.1590/0100-85872016v36n2cap05; César Teixeira and Beatriz Brandão, "Sobre as Formas Sociais da Mudança Individual: o testemunho em centros de recuperação pentecostais," *Revista ANTHROPOLÓGICAS* 23, no. 30(1) (2019): 136-157.

[15] All the dialogues cited in this article are translations of the Portuguese version, which reflected literal transcriptions of audio recordings of conversations with the research interlocutors. Minor adjustments were made in the text only when the literal speech made it difficult to understand the content of the conversations. Other than the translation, no changes were made to the original terms and expressions used by the interlocutors.

> I said, *damn it, I've come to my senses!* And it's true, though I've never trafficked [drugs], I lent my motorbike, I lent money and we had a really large crew!... We would go to parties with a really large amount [of drugs], we wouldn't go intending to sell, but people knew we had a lot, they'd come and ask for some. So we sold it and… and shit would have hit the fan… it would have turned bad, as the saying goes. So I decided to accept his help.

As well as being unable to stay at home "in that state" with a small daughter, Dino learned from the pastor that by "living that way" he would eventually be forced to live somewhere else: in prison. The pastor's lecture was based on the Penal Code. And admission to a TC was the path for him to avoid jail.

Alexandre, a young resident of Baixada Fluminense, recounted that he had spent seventeen years "trapped in drugs." Before admission to a TC, he had reached rock bottom and was in a calamitous state. But a violent event marked the time of admission more definitively:

> So there was one day that I really fucked up, right? At the time there was no militia. Today it's militia, but in the past it was P2. They called them the *quebra*. The people who killed, the guys who killed. And so these guys were after me and I leapt over the wall at the back of the house and afterwards I returned and asked my brother: bro, take me to the recovery center, I want help. But I didn't really want help, I wanted out of that problem.
>
> I entered the home when I was already suffering some… you know, some disturbances. There was a cousin of mine… who had died… and I had always hung out with him. And he was shot ten times, nine times in the back and one in the leg… there outside, in the square… And, so, me, when I went away, they killed him then, you understand? So, I was already walking around like that, suspicious of everything. So I would take drugs, I was already, I was already somewhat like that, out of my head, I was really agitated. So I even thought about getting a gun, a gun, for payback, to go after those who had done it. Because that's what they do… it's what they do here. And they walk around just like that. And so after that, these things started happening to me. My mind started to become really disturbed. So that's why I asked for help.

Alexandre was "trapped in drugs" and could not, therefore, carry on walking around freely in his neighborhood. He was already on the radar of violent actors: the drug gangs and the police. Death brushed him, very closely, so closely that gunshots had already killed his cousin. The "problem" he wanted to escape and the "disturbances" from which he was suffering were inscribed on the border between drugs and the body, mind, crime, and the city.

Jailson, a resident of Rio de Janeiro's west zone, recounted that "he discovered drugs at 14." During his teens, he found support on the courses run by FEEM (Fundação Estadual de Educação do Menor),[16] which helped him to lead a straight life. After three months on the course, he found work at a company. "As a 'FEEM minor' I managed to achieve that," he told us. To stay at the firm, he went six months without using any kind of drugs, afraid of being caught in the entrance exams. After this period, he went back to taking drugs.

[16] Fundação para a Infância e Adolescência—FIA, "História," accessed November 30, 2020, http://www.fia.rj.gov.br/content/institucional/institucional_historia.asp.

For seven years Jailson used drugs along with his partner's mother. According to his account, they had a "kind of refuge," a "drug den," a space where drugs could be taken without the risk posed by the streets in the welcoming context of domestic life. After their separation, however, "as he was already addicted," he had to face the dangers of consuming cocaine in other places, now public. He described this situation as follows:

> One time a guy invited me to snort (*botar uma inteira)*, and so we entered an alley… and a short while later… loads of gunshots, loads of gunshots, and us running everywhere! We entered a house and came out on the roof. The owner of the house said: "*you can't stay here, man. You need to leave. Okay, you entered here, but now you have to leave. You can't stay in my house.*" And so everyone left via the roof, and I stayed a while there, trapped, scared to leave.
>
> To use [the drugs], you could only use them on the train tracks. So I showed up at the train tracks, because it's open there, and there were a lot of police. So, when we showed our faces there, people started to run. Me too. A load of shooting starts. I manage to escape, but the two people with me stayed behind, the police caught them both and I got away. So I said: I'm leaving this life behind! I've had it… if I manage to get out of this free, I'm leaving this life behind!

The "crisis" situations described by Jailson concerning his experience with drugs are presented through territorial conflicts. Crucial moments in which his search for places to take drugs placed him in danger: the danger of being caught or shot. Jailson experienced the collapse of his life as a whole, a social collapse. He thought about "leaving this life behind" each time he evaded death or prison. That was when he decided to be admitted to a TC.

Silvio, in our conversation held at the church where he has been a member since he left the TC, told his story through a family dilemma: a turbulent marriage, the loss of contact with his daughter, and the worsening of his "drink problem." He was homeless for four years. "I began with cachaça [rum]. If I drank one, two, three bottles of *buchudinha* a day… I got drunk… And then I became a beggar. The square really became my home. I began to live in the streets. I was desperate. I lived there for real, I slept there in the squares."

At that time, Silvio would stay in shelters:

> I stayed in shelters nearby, but you stayed five days imprisoned inside. After five days, though, you could go back into the street. It was the same as nothing. You could enter as late as 10 p.m. It was useless because you went out, drank and drank, and returned to sleep. I entered this shelter twice. When I was there, I was calm. Because I had a place to feed myself and sleep.
>
> But that short time passed and then you were back on the street again. And you had to wait another ninety days to be allowed to return. By then, you've turned into an alcoholic again. You're back drinking again. You know?

In the street, as a homeless person (*praça*), Silvio lived a life that was too free. In the shelter, he would be "imprisoned" for a few days but afterwards he "could go back into the street" and being in the street was synonymous with drinking. The shelter, on the other hand, was a place to eat and sleep. A place to stop but for a limited time only. Afterwards, he could only go back after ninety days. "By then, you've

turned into an alcoholic again." For four years, Silvio's life followed this intense dynamic of circulation among the streets, squares, shelters, and so on.

The trajectories of Dino, Alexandre, Jailson, and Silvio present a complicated economy involving experiences labelled by them as *imprisonment*, "feeling imprisoned" in different situations, and other experiences of perceiving themselves to be "too free." Too imprisoned in drugs, they became too free in the streets; too free to consume, they found themselves imprisoned in the dangerous conditions that this life imposed; free to circulate in the city and in the streets, living the adventure of *viração* (of being free, of managing to get by even if precariously), they lost the right to stay in their homes, in their neighborhoods, in their territories, which began to expel them as undesirables. Free to move through the urban boundaries of illegalities, they constantly ran the risk of being captured by agents of the state, who, to a large extent, act according to a logic of criminalizing the poor.

This was how Abdias, whose interview was conducted in a shelter, ended up in prison:

> I was heavily involved in drug addiction, which is why I'm here today, in this shelter now. That led to my relationship with my daughter's mother ending, to my being arrested many times for committing crimes to pay for drugs. Because the more you use, the more you want to use. It's complicated. And I went inside for these crimes. I spent ten and a half years in prison. I came out and, I won't lie, I went back to drug addiction again, as though nothing had happened…. When I wasn't in the shelter, I was in the street. From Christmas 2007 to 2008 on, my life was prison and street. Ten years of this was in jail, but the rest was in the street, until here [in the shelter].

The trajectory of intense circulation that Abdias relates also included a large turnover in TCs. In all, he spent seven periods in "recovery clinics." Abdias was thirty-three when we talked to him, and he had already lived ten years in "jail" and stayed in seven TCs, along with the many different shelters mentioned in his narrative. Even without being questioned on the matter, but clearly in some sense looking to justify his unsuccessful experiences in the TCs (after all he had stayed in seven), Abdias explained that the TCs sought to "rescue the person from the bad life," but his "thought wasn't centered" at the time and he had not wanted to stay in any of them.

It was also the *decentered thought* that brought Luciano close to death and saw him end up in a psychiatric clinic. Luciano told us that he became *aimless, disoriented*. From recreational use, he slipped into what he described as "a degrading life":

> One fine day, I was in the Morro de São Carlos favela with a friend of mine. We had gone there to get drugs, all that stuff… and then, a very degrading situation occurs. I walked back. I had a rash. Because I had gone to the bathroom, but there was no toilet paper. I'm telling you this so you understand the level of human degradation you reach. And so I walked all the way from São Carlos to Lapa. I arrived there with my buttocks covered in rashes. And that was the day I tried to kill myself. I said: hey, you know what? I'll take it. I had already been… I had already suffered two crises before. I ended up in a psychiatric clinic but was not hospitalized. But I was medicated with Diazepam. To calm me down, all that stuff. And soon after I was admitted. I asked to be admitted. Because that's really important, right? Because you have to humble yourself.

Luciano never faced problems with the world of crime and violence. His upbringing as a middle-class youth had set his life on other paths. However, cocaine was a risk factor in his story, possibly lethal, and the drug was his prison and his condition for expulsion from domestic life, marriage, and family. The

interplay between *feeling imprisoned or enjoying freedom* in this process that led him to "ask to be admitted" is subtly formulated in his narrative on the start of his period of admission:

> Of course, it took me two months to begin to understand this entire process. As I told you, initially I wanted to leave, my life was outside. But at the same time I couldn't leave. Not because I was barred from leaving, because there you're not forced to stay. Nobody held me back. But I knew that if I took this step, I would also traumatize my entire family, the people who were paying for my stay there, the people who love me, you know? So, this all weighed enormously. And then, after two months, I began to allow myself, to study myself. Man, I found it really interesting.
>
> What is difficult for you to understand is that this freedom thing… what we call freedom… was a tremendous prison. It's a complete inversion of values, I think. You think that using drugs is freedom, like, in abusive form.

Spaces and times where you can stop, when you cannot just stay wherever you want, cannot live at home, in your neighborhood, in your own territory; when your life is at risk in all kinds of ways, when life enters into collapse, can be conceived as spaces of exile and refuge. The idea of "urban refugees" is not new and indeed has already been used to reflect on the city's "surplus" population, those who inhabit the *cracolândias*, the streets, the shelters.[17] In this article, the intention is to contribute further to this reflection, thinking about TCs as zones of exile, religious inscriptions in the urban circuits produced by the mechanisms of violence.

ZONES OF URBAN EXILE: THE SPACE – TIME OF TCS

Pentecostal practices in Rio de Janeiro's urban environments have consolidated an important repertoire for mechanisms of managing violence and suffering in the city. In recent years, various leading studies have confirmed Pentecostal mediation in the experience of imprisonment,[18] as one element in the set of practices used by those operating the illegal trade in drugs,[19] as well as in the institutionalization of religious projects focused on confronting the field of violence.[20]

The hypothesis adopted here as an analytic axis, cognizant that this argument cannot be fully developed within the scope of the article, is that the Pentecostal recovery centers or homes, which have existed in Brazil for five decades, are central to and important precursors of this endeavor to provide political, religious, and territorial mediation in the urban peripheries, a topic researched more heavily in the 2000s. Revisiting these analyses and knowing more now about the realities of TCs, the hypothesis is that

[17] Raquel Carriconde, "Refugiados urbanos em trânsito permanente: efeitos menos visíveis da produção de uma cidade olímpica," *Hist.Soc.* 39 (July-December 2020): 82-104, http://dx.doi.org/10.15446/hys.n39.82883.

[18] Eva Scheliga, "E me visitastes quando estive preso: estudo antropológico sobre a conversão religiosa em unidades penais de segurança máxima" (MA thesis, Universidade Federal de Santa Catarina, Florianópolis, 2000). Repositório Institucional UFSC: https://repositorio.ufsc.br/handle/123456789/78979.

[19] Christina Vital da Cunha, *Oração de traficante: uma etnografia* (Rio de Janeiro: Garamond, 2015).

[20] Patrícia Birman and Carly Machado, "A violência dos justos: evangélicos, mídia e periferias da metrópole," *Revista Brasileira de Ciências Sociais* 27, no. 80 (October 2002): 55-69, https://doi.org/10.1590/S0102-69092012000300004.

these urban spaces—religious but not ecclesiastical—that "take in every kind of person" became mobilized as places where people could stay when *exile becomes the only possibility for life.* Despite voluntary link to TCs being a trait common to all the interlocutors in this research, severe circumstances in the trajectory of each led to the condition of exile on which the present text seeks to reflect.

The broader literature on exile discusses political banishment from national territories.[21] An attempt to transpose studies of national exiles to urban contexts entails many challenges, but also possibilities. Agamben argues that exile is situated between the *exercise of a right* and a *penal institution*, simultaneously freedom and condemnation.[22] This ambiguity inherent to exile occurs, according to Agamben, because exile is the figure that human life adopts in the state of exception, in its immediate and original relation with sovereign power. "The exception is, really, according to a possible etymology of the term (*ex-capere*), taken from outside, included by its own exclusion."[23] Said, in his own reflections on exile, elaborates the idea that *exile is sometimes better than staying behind or not getting out*.[24] This condition formulated by Said expresses many of the circumstances of expulsion that lead individuals to TCs: *better* there than staying behind or not getting out.

The questions posed here through the theme of exile reverberate directly with the literature on refugees. Agier, in his discussions of refugees in the new world order,[25] explores the dilemmas and violence embedded in the urban inscription of displaced individuals and populations, and the harsh conditions of their life as refugees. By analyzing the "humanitarian" management of war in all its contemporary forms, Agier centers the debate on the conditions of survival, guaranteed governmentally in refugee camps, through the triad of *care, cure,* and *control*. Refugee camps, he asserts, are composed by *police, alimentary and sanitary* mechanisms, characterized by their isolation, in which undesirables are left to wait, in survival mode, without rights.

The proposal here is not to reflect on *exiles or refugees in urban contexts*, minimizing the radicalism and violence of the experience of expulsion beyond national borders. On the contrary, the aim is to qualify other forced and violent displacements from territories of belonging—the home, the neighborhood, the city—through the *intensity of the banishment* that characterizes national exile, while seeking to preserve its radicality and its unique and insurmountable repercussions. In dialogue with Agier's proposals, it is interesting to think of TCs as spaces for *isolating undesirables* made to wait in violent urban contexts. In such circumstances, just as in the refugee camps, the condition of "survival" and "suspension of rights" evinces the tenuous line through which these mechanisms of *care*, *cure, and control* (in Agier's terms) operate in the process of taking in people, as well as control and abuse.

While one of the lessons of looking from the viewpoint of exile is the emphasis on the *circumstances of expulsion* that constitute it, as mentioned above, the drama of the exiled person is also constituted by processes of *reception* and *transit,* which lead to an approach focusing both on the political logics of

[21] Michel Böss, "Theorizing exile," in *Re-Mapping Exile Realities and Metaphors in Irish Literature and History*, ed. Michel Böss, Irene Gilsenan Nordin, and Britta Olinder (Denmark: Aarhus University Press, 2006), 15-46.
[22] Giorgio Agamben, "Política del exilio," *Revista de Estudios Sociales* 8 (2001): 119-124, https://doi.org/10.7440/res8.2001.13.
[23] Ibid., 122.
[24] Edward Said, "Reflexões sobre o exílio," in *Reflexões sobre o exílio e outros ensaios* (São Paulo: Companhia das Letras, 2003), 46-60.
[25] Michel Agier, Refugiados diante da nova ordem mundial, *Tempo soc.* 18, no. 2 (2006): 197-215. https://doi.org/10.1590/S0103-20702006000200010.

exclusion and the integration of the displaced.[26] Here we return to the specific debate on religious TCs in the context of Rio de Janeiro's urban peripheries.

Urban peripheral contexts are constituted by forms of state, criminal, and religious governances,[27] each with their institutions, practices, symbols, and discourses,[28] comprehension of which is indispensable to understanding the dynamics of urban exile. Urban conflicts thus take place on the boundary between these forms of governance, whether they constitute the *expulsive* dimension of the condition of exile, or its *receptive* dimension, or its *transitory* dimension. As Jensen stresses,[29] there is an important warning here for empirical research: the mutating phenomenon of exile can assume the form of institutionalized exclusions (that is, judicially sanctioned acts) or factual situations: escapes, flights by those afraid to become a victim of murder or imprisonment.

The intention here is to situate TCs as a potential space of *reception* in the trajectory of individuals who have experienced the situation of being expelled as an urban exile. The religious aspect of these TCs, in addition to being what defines them, is also what *indetermines* the profile of these initiatives and enables them to receive many different types of people.

After four years spent between the streets and shelters, reverting to alcoholism whenever he was not "imprisoned" in the shelter, Silvio asked for help at a church and, through it, admitted himself to two religious recovery centers. In the second, he spent eleven months:

> They admitted me there at the project… I stayed there eleven months. There I learnt to be a man of honor. Love one's neighbor like oneself. Because there… I'll be frank… a recovery center does not recover anyone. There you stay away. You stay away from drugs, alcohol, cocaine, marijuana. You only stay away. You can see that the wall is low. If you want to leave, you can.

TCs are, for many people, spaces where they can stay "away" from problems, keep a "distance" from the territories that pose a danger to them. In Silvio's case, the risk was from life on the street, death on the street, access to cachaça or *buchudinha*. The shelters gave him too much freedom: he could leave, enter, return. At the same time, they set time limits: he could spend a few days inside and then had to leave. He could not stay. "Not being able to stay" is a route that provides access to the TCs where the period of stay allowed is longer, or more precisely, more indefinite. In the TC where Silvio stayed, the maximum period was nine months, but he remained for eleven.

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[26] Silvina Jensen, "Sobre la política del destierro y el exilio en América Latina de Mario Sznadjer y Luis Roniger Hacia un enfoque sociopolítico, macrohistórico y teórico-analítico del problema," *Historia, Voces y Memoria* 8 (2015): 13-20; Mario Sznajder and Luis Roniger, *The Politics of Exile in Latin America* (Cambridge: Cambridge University Press, 2009).

[27] Patricia Birman, "Cruzadas pela paz: práticas religiosas e projetos seculares relacionados à questão da violência no Rio de Janeiro," *Religião & Sociedade* 32, no. 1 (2012): 209–226, https://doi.org/10.1590/S0100-85872012000100010; Martijn Oosterbaan and Carly Machado, "Postsecular Pacification: Pentecostalism and Military Urbanism in Rio de Janeiro," in *Cultures, Citizenship, and Human Rights*, ed. Rosemarie Buikema, Antoine Buyse, and Antonius C.G.M. Robben (London: Routledge, 2020), 104–120.

[28] Michel Foucault, *Segurança, território, população: curso dado no Collège de France, 1977-1978* (São Paulo, Martins Fontes, 2008).

[29] Silvina Jensen, "Sobre la política," 13–20.

In Dino's case, the danger was the criminalization of his leisure activities, which included selling small quantities of cocaine at parties. And while the pastor convinced him to go to a TC by using the Penal Code, the place where he ended up staying, outside Rio de Janeiro state, confirmed the use of TCs as facilities in the mechanism for managing not just urban violence but crime:

> This center is private. It accepts students who pay a monthly fee. But they also have an agreement with the city's judiciary and the judges, when… when the defendant is a first-time offender, and they caught him with a small amount of drugs, they send him there. Instead of sending him to jail, they send him there, to the recovery center, and decide the amount of time that the offender had to stay there.
>
> So then… it was a very complete experience, right? Because there weren't just people who the family took there, there were, so to speak, real criminals. Who in reality didn't want to be there.
>
> So then, I had to try even harder to find my way, to avoid becoming even more deeply involved with these people and end up facing an even worse outcome.

Silvio's story also evokes the dimension of violence and the presence of "criminals" in the TC, but not because they were completing sentences, as in Dino's account. In Silvio's narrative, criminals admitted themselves to the TCs so as to hide:

> There were many people there inside who had messed up here outside, killed someone here outside, they entered as a drug addict but weren't addicted. There were people who had never smoked a cigarette in their life. And they were there as addicts. Your limit is up to nine months. So they would go there to hide. *Being* there, you can chill out… stay calm. You have to know how you speak to others because you don't know who anyone really is. You're thinking that the guy is there… but the guy is a killer. You're sleeping next to a killer and don't know it.

Alexandre, who saw his cousin die and who told us that he had been persecuted and threatened in his neighborhood, says that he stayed in the TC for nine years. But it is necessary to hear a bit more about his story to understand the time spent there:

> So, in the first two months it was really difficult, but since it was here… so I agreed… And so, after that I carried on staying and staying and staying, and by the end of my recovery… I hadn't wanted to stay, but I started to like it, I liked it more and more and so stayed.
>
> But there's the fact that I didn't remain all those nine years there inside. After I had been there four years, and then when I saw it; I had begun to date someone and got engaged. So then I had to leave to work, because the recovery home had no government funds, from nobody, not the city council or anyone. So I spent a year or so working, afterwards I returned there again because the [home coordinator] called me, since I hadn't relapsed. Because he had suffered a stroke, he needed people there, committed people. He saw that in me. So I went back there to work. And so I spent more time there, again. That makes nine years now. But not all nine years inside. I spent a year and a bit working and a few more months here outside. Let's say, two years here outside, you understand?

Alexandre was too fixated on drugs, too free in the streets running risks. He began to feel imprisoned again. He didn't want to stay in the TC. But as time passed, he decided to stay. And so he remained

there. He lived in the TC, met his fiancée there, married, moved away, worked outside, and returned to work inside. And so nine years passed.

Jailson, who for some years consumed drugs with his mother-in-law in a domestic "refuge," brought about by living with her, and later experienced the dangers of taking drugs on the streets, after years decided to admit himself:

> And I praise God for that day because the desire had already been maturing in me to admit myself, to *find a refuge*, to search to improve my life.... I was already dead spiritually, but I actually wanted death, there was no way out. And in this [state], I slept and had a vision… And this voice spoke, God spoke: "Go, I'm going to take care of everything."

Jailson's description of the place where he was admitted emphasizes its "simplicity." "In 2002, the establishment was very simple. I mean, in the spiritual sense." The time of exile lived by Jailson was a time of discipline. He had to perform the scheduled activities with intervals set virtually every half-hour: get up, make the bed, take a shower, make the five meals offered at the set times, do a "therapy" ("tidy up the small farm, clean the lodgings, and some other things"), wash clothes, fast, study the Bible. All simple activities. "You're the one who keeps watch of your time, your dedication."

"Keeping busy" was one of the keys to Jailson's life at the TC: occupying body and mind with *work/self-care and care for others* and with *religion*. Occupation, obligation, reception, and care form a conglomerate of practices and moralities specific to the TCs and their projects for transforming behaviors with the aim of transforming lives. Jailson says that at the TC he discovered "consecration," the devout, monastic life. But his experience of conversion came later.

Dino said the same thing: he did not convert during his time at the TC. He emphasizes, though, that by staying at the TC he *discovered the power of God* and saw people being cured "of various different problems." In his words: "I saw hard men leave there transformed by the power of God":

> I saw God cure traffickers, killers, even killers. I saw that God had this power, you know? For those who really surrendered, for those who threw themselves into that treatment, I understood they would be cured, I saw they were cured, they left there cured.
>
> Medicine says that chemical dependence is incurable, but there I saw that through religiosity, through the power of God, people were cured. I saw various people being cured there. The time [at the TC] served greatly for this. For me to see that a cure exists, for me to see that there is a chance for me to be cured. So, there I decided then to follow Jesus. In fact… conversation in fact came later.

The people who participated in the conversations were not abandoned individuals but exiles from specific urban territories. Imprisoned on the outside of these places, they circulated through the city as its surplus. They were inscribed in diverse zones of space–time, including in TCs. Among other forms of mediations, these institutions offer more prolonged—or, at least, indeterminate—spaces and times. Their length of stay is not the long duration imposed by prison, or the short duration of the social care provided by shelters, or the ephemeral and instantaneous circulation of the street. Given the severe conditions experienced by certain populations in the entangled world of drugs in the city, their perceptions of TCs, far from being romanticized, show us a situated perspective. The TC is not a home,

but it provides bed, food, and clean clothes. It is not work, but there is occupation. It is not a family, but there is discipline, rules, morality, and habits, and acts have consequences. It is not a church, but there is a community life, ideas to occupy the mind, helping to produce meanings and explanations, and rituals to mobilize the body.

Religion can be conceived as the non-expulsive element of the TC, and it is this aspect that makes it a form of exile, a refuge. If there is something of which the religious is "accused," it is its immersive, proselytizing quality, the desire to capture people, the persuasive force that makes them stay. But little thought is given to what religion, and particularly Pentecostalism, contains that is non-expulsive, even for what society considers to be repulsive.

There is a particular moral aspect to the religious exile of the TCs. Given the diversity of these institutions, their profiles and their institutionality, the triage processes that decide who can stay at a TC obey diverse logics, more or less aligned with state and judicial logics. The *condition of exile* is a situation of being hosted, which enables the flexibilization of moral and legal criteria—indeed exile is itself a border on which what constitutes a "crime" can be redefined, as in the case of political exiles. Moral and disciplinary control is a strong feature, or even an imposition, of life in the TCs, but it does not necessarily prevent access or entrance to these spaces.

The Pentecostalism of the urban peripheries, and its spiritual battle, interprets every situation as an opportunity for redemption, a divine action on suffering bodies and souls. Hence, it receives, does not force people to leave, does not expel, and, while everyone and *anyone* is within its radius of action, it tries to mediate spiritual and social restoration. This fact has been taken to its ultimate consequences by Pentecostalism, which "invades" prisons, police stations, violent territories, public locations where drugs are consumed. The spiritual battle of urban Pentecostalism operates not only as a *representation* of conflicts, but as an *intervention* in their urban setting.

URBAN ZONES FOR RECOVERING LIFE

The condition of exile is reflected negatively in terms of what *is lost through it*, but also positively in terms of what *is produced through it*, what is created, and the possibility of inventing a new world. Exile is thus also treated in dialectical terms as a strategy, a resource, a discovery, a possibility, an apprenticeship. Exile is shaped by the dimensions of a future project, a horizon of expectations related to *life projects*.[30]

Sílvio lived in the streets, stayed in the shelter, knocked on the door of the church, was admitted to the TC, and asserts decisively that "a recovery center does not recover anyone." For him, as cited earlier, the period of admission in a TC is the moment when people are kept "distant" from their problems. But recovery needs other spaces and another time:

> Nobody recovers there. They recover here outside. Your choice is here outside. Because then you've got money and say, "I'm not going to drink," I'm not going to smoke cigarettes, I'm not going to snort cocaine, I'm not going to smoke marijuana. Your choice is here outside.

[30] Jensen, "Sobre la política," 13–20; Sznajder and Roniger, *The Politics of Exile in Latin America*.

In Silvio's case, the church was the urban inscription that has made his recovery possible to date. Through the church, Silvio recuperated his work as a builder, both in the endless works at the church itself, or at the houses of his brothers. The evangelical religious community to which Silvio belongs provided him with a territory of life and affection. "They love me, they care for me."

Silvio was careful to define his place of residence outside the TC and outside the church. The first house they offered him as a home was located inside a *favela*:

> When I left the recovery center, I came here. So I stayed here [at the church]. Then I was given a plot of land there in the community. But it's not my thing, living in a *favela*. So I thought: gosh… it's not here. My business isn't here.
>
> So the pastor asked what was happening. "Do you want the church to buy the [construction] material for you?" So I said… no, I don't want to. God doesn't want me there…. Me, in the *favela*… I felt sick because I saw a lot of drugs… I saw alcohol, it was young girls prostituting themselves around the clock, a lot of alcoholism. So I said: my God, I'll lapse.

Silvio told us that he began to look for a house to live in and, when he found one in a location closer to the church, went to talk to a brother from his unit; "with God's blessing," he discovered that he was the owner of the small house in question, where he moved and where he still lives today. Gradually, he reassembled his life.

> I've got my food. I've even got air conditioning… I have the best television; I have the best bed. I have the best wardrobe. I have everything you can imagine. There's nothing missing! For someone who used to sleep on some cardboard…

Silvio carefully follows a daily routine, sticking to the timetable of his activities, the time he spends close to the bar and, in practice, he chooses to spend most of his time in the church itself. He is known for spending the whole day at church, where he feels protected.

> My life is here inside. I got out… I work here, I leave at 5 p.m., go home, and I return here again… I stay here, even when there is no service… I stay here listening to people worshipping, while they are rehearsing. I stay here everyday. If I could, I would live inside here. My life is here.

The church also confirmed itself as a zone of recovery in Dino's life. After months spend at a TC with people involved in drugs and crime, and after witnessing cures made "by the power of God," Dino immersed himself in the church as a missionary. Outside the church, Dino was also invited to take part in a project called *Metanoia Radical*, the activities of which are described on its website as follows: "during much of the project, situations will arise that demand physical, emotional, and psychic effort. This being the case, people with serious health problems, whether physical or mental, will not be allowed to participate." Dino's process of recovery, after a period staying in a TC, is directly related to his experiences in *Metanoia Radical*, as well as his own process of conversion. Dino's religious engagement with the gospel is driven by effort, tests, trials, and confirmations of God's power to act and transform lives. And this is the process that he presents in his testimonies.

Alexandre, after seventeen years "imprisoned in drugs," after seeing his cousin killed, has lived for nine years in and around the TC that received him. Like many others, today he is coordinator of the

institution where he had been admitted. His status as a "former drug addict," which is a demerit in other fields of work, qualifies him especially for work in the TC:

> And today I am the institution's coordinator. Happily. I can say happily because today I am happy with what I do, the life that I live. Despite having lost many things, the main thing I didn't lose, my life, because… I can cite a text from the Bible, which says what profits a man if he gains the whole world but loses his own soul?

The credibility gained by Alexandre in the eyes of the TC and his church, where he participates intensely and is on duty at the weekends, supervising the parking lot, allowed him to win back his family territory and neighborhood. Despite coordinating the TC, he no longer lives there but above his mother's house, in the "family yard," where they hold parties together, "to which everyone goes." Alexandre proudly recounts that today he is the person who people seek out for help. "So, my heart is filled with joy because the glory is not mine, the glory is God's."

Like Silvio, Alexandre underlines what a life in recovery needs: to take decisions concerning one's personal relationships, the places where one circulates, and the people one must avoid. "For this reason, I am still standing today. Because I am doing what is suggested, okay?" The space of recovery, after the time spent in the TC, opened a window of time onto the future for Alexandre.

> Because I'm involved with people who are good people, I have other thoughts, thoughts about the future, thoughts of growth and thoughts of peace, not bad thoughts. Because when we're addicted to drugs, we only have bad thoughts. Hell, I've stolen in the past… I can't speak about everything I've done, right? But I've already done many things.

The church that proved a space of recovery for Silvio and Alexandre was not so welcoming for Jailson, the young man who, over his life trajectory, sought refuge in FEEM, in his mother-in-law's house, and in the TC. His admission to a TC was in 2002 and, though a pastor today, he only immersed himself in religious life in 2018. The sixteen years between the two moments were a period of instability, filled with conflicts in the day-to-day religious life outside the disciplinary space of the TC. He saw that the church also "kicks people out" and explained to us that to become a real part of religious communities, you must deal with many things.

> In these sixteen years, I've had some lapses. Some slip-ups, for this very reason, because people do not consider or respect your history and your past. People want to see if you really are [over the drugs], if you've rid of all that. People aren't genuinely concerned, they don't care.
>
> We, Evangelical Christians, we say that Jesus cures, saves, frees, baptizes in the Holy Spirit. But we're not prepared to welcome these people… to welcome a drug addict, a former drug addict, to welcome a prostitute, or better, a former prostitute, welcome people of this level. A person involved in adultery, a person who fornicates… We preach much about this, but when these types of people arrive at our church, we don't know how to deal with them. The same way people enter, so we also expel them. Because we know a lot about the text, but we don't know how to treat these people.

Jailson showed his concern through the combination of pastoral missionary action and financial commitments. He identifies with the pastoral mission but notices the complexity of the association

between this office and a wage, financial issues, and the economic life of the pastor, his family, and the church.

> Now, I'm not going to lie: one of the things I find most difficult, which I am praying a lot to God about… I'm the kind of person who likes to visit the church member in hospital, I like to visit their home. If they miss a church meeting, I call. I like to take the Holy Supper to those who are ill, I like to show up, I like to participate in the burial… But I've met with a lot of difficulties, because I believe that the pastor, when he works to a contract, when he is forced to comply with set working hours, it causes many, many problems.

For Jailson, the church is a complex zone of recovery. He presented his dilemmas and the difficulties of his everyday ecclesiastical life work, which are certainly not exclusive to him. He admitted that churches sometimes see a financial advantage working to assist drug users, and indeed encourage such initiatives as a way to receive income. This annoys and saddens him greatly. Life in the churches is difficult, especially for those who take on positions like that of pastor. Silvio is active at the church as a worker and a builder. Dino is a preacher but does not look after a church like a pastor. Jailson is managing a church and experiencing the economic life associated with the job, which is no simple process for him. Furthermore, the timeline of his life involves many years of consuming drugs, some months in a TC, sixteen years of relapses after this period of admission, and, up to now, two years of pastoral work. Recovery of a life is a process that goes far beyond recovery from drugs. And this is an aspect that must be considered in all its complexity.

Luciano, after losing his way, disoriented, trying to kill himself, spending time in a psychiatric hospital, and deciding that he had to go to a recovery center, now leads his life dealing with the everyday challenges of his relationship to cocaine. Luciano is not evangelical. His admission to the TC was based on the principles of Narcotics Anonymous (NA) and his spirituality combines elements from diverse religious practices. Luciano does not like religious institutions. His life after the stay in the TC has included periods of abstinence and relapses. When this research was being conducted, his option was harm reduction.[31] He remains off cocaine but still uses marijuana and alcohol. His personal narrative makes clear the difficulties arising from this choice.

Luciano ceased frequenting the NA group because it was a project of total abstinence. For Luciano, NA is a "sacred place" and he refuses to stay in the group without being completely sincere with his peers. The dilemmas of the space–time of Luciano's recovery revolve above all around the sociability and morality in relation to his family and friends:

> It was interesting to spend a year clean. That way you see that you can live without using anything. That is interesting too. Only there is this question of the social weight of the family, why does it happen? People, they will drink, they will smoke, they will snort, they will… they will do all that and then you end up somewhat displaced socially. That is another question…. And the colleagues from NA too, I've never went further than just the interactions with them inside the NA room, because outside I didn't have much to do with any of them, you know? So, I didn't

[31] The harm reduction approach is based on the premise that healthcare professionals are responsible for minimizing the adverse consequences of drug use, not for eradicating consumption. The aim is to replace repressive strategies with those recognizing the individual's autonomy. In terms of the right to citizenship and health, it shifts the focus to care.

> make new friends, you know? So I kind of ended up returning to that older circuit again. Friends who aren't really friends.

For Luciano, in his option for harm reduction, finding an inscription for his recovery is complicated daily work. In a way, he lives in a *non-place*, undertaking experimentations, which leads him to ponder the subtleties of what "recovery" means.

> So, I mean, when we use the term recover… recover what, exactly? This is a big question. I think: what have I recovered in this entire situation? I recovered living in a slightly more normal way. I put it like that. I managed to do things… work… without drugs interfering directly in this. I managed to be with someone… some of my objectives… make progress on some projects.

Like Alexandre, for Luciano recovery is directed towards a future time. A horizon of plans that will remove him from the circular condition of an infinite now inscribed by drugs, and their mental, social, and territorial circuits:

> There is another maxim quite common among addicts, which says that addicts are engineers of unfinished works, because they act in this way a lot too, very impulsively.... So, I think that, today, I can manage to see this in some ways too…. Follow-up on things. Ensure things progress.

As Souza analyzes, while drug use is marked by an immediate temporality, the time of recovery demands the "patient reconstruction of a new temporal horizon that allows a way out of the vicious circle of the here and now,"[32] a "future perspective," "a minimal planning of life." Souza adds, "what matters is that there exists a beginning and that the gains in terms of organizing individual identity afforded by the future perspective are effectively 'lived' by the user, enabling their future deepening."[33]

Abdias, the young man of thirty-three who spent ten years in prison, circulated through the streets and through seven TCs without engaging in the rehabilitation process in any of them, encountered his zone of recovery in the shelter where we interviewed him: a shelter where the stay became exceptionally lengthened due to the Covid-19 pandemic. Stopping and being able to stay at the shelter allowed sufficient time for Abdias to care for himself and to *learn to wait*. And waiting signifies projecting oneself towards a possible future:

> I'm feeling very well here. Now I'm learning something that I didn't have at the time, which is patience. I didn't know how to wait for anything. Things had to happen in my time. And that's not how things are. Take now, I went out to the bank, but I didn't get it sorted. You must wait. But it's all working out, thanks to God I'm looking into doing a course, even if it's online…. Yesterday I also started watching some baking classes, just to remember, it's been some time since I did these courses. And then it was this. I'm waiting for things to happen.

Abdias had already spent more than three months in the shelter when the interview was conducted. In this space for pause, he had inscribed his process of recovery. He said that the last time he had used crack had been in the doorway of the shelter before entering. Restrictions are placed on leaving the

[32] Jessé Souza, *Crack e exclusão social* (Brasília: Ministério da Justiça e da Cidadania, Secretaria Nacional de Política sobre Drogas, 2016), 27.
[33] Ibid.

shelter and residents can only leave when accompanied by social workers. Since his arrival at the shelter, Abdias has managed to buy a mobile phone and has tried to build future horizons. He sees himself as an "addict" and claims that "addiction is for the rest of your life." He does not believe in medicated treatments for his addictions. "No medicines cure you," he said. His project is to find work, an occupation. And he is using the space and time of the shelter to put his plans into practice.

CONCLUSION

Thinking of TCs as *zones of urban exile* stimulated the formulation of other questions on this topic that undoubtedly deserve to be developed much further. These questions may go beyond the particular case of the TCs and contribute to the reflection on other urban processes that lead to forced mobilities: Who are these people who move about? What were and are their trajectories of mobility? From what kinds of violence do their movements originate? Which actors intervened to help and guide them during different moments of this experience? What are the specific characteristics and consequences of these forced mobilities?[34]

The perspective of exile also shaped an approach to the religious within the dynamic of urban life, consistent with those dimensions informing a reading of *postsecular cities*, which demands a repositioning of the question of religion, not only in terms of its relationship to the state (through the channel of public policies) but through the perspective of the governance of the populations of cities and their peripheries. Many authors from the field of urban studies have emphasized the relevance of thinking about the city not as the field where continuous negotiations are held between religious and secular projects, but as a *constitutive element* indispensable to the construction of these boundaries.[35]

By way of conclusion, it is worth emphasizing how, in the conversations realized for this work, many of the men remarked on the overwhelming power of sheltered care (*acolhimento*), being allowed to enter and stay, hugging, listening, the friendly word, feeling loved. It is essential to include these affective dimensions in our analyses of Pentecostalism and its practices in the urban peripheries. While much is known about the production and reproduction of violence, we still have a lot to learn about the escape routes from these violent dynamics. Nonetheless, it needs to be emphasized that, in violent contexts and forced displacements, *zones of exile* are situated on the boundaries between sheltered care, control, and violence. In brutal conditions of existence, the calculation of what is "best for one's life" erodes the limits of the possible, the acceptable, and the bearable. Analyzing TCs from the viewpoint of urban conflicts does not signify asserting their efficacy in terms of *treatment*, and indeed this was not the focus of the analysis here, but situating them more broadly in a complex, entangled scenario constituted by many blind alleys and few routes of escape.

[34] Enrique Coraza Santos and Maria Soledad Lastra, ed., *Miradas a las migraciones, las fronteras y los exílios* (Buenos Aires: CLACSO, 2020).
[35] Arie Molendijk, Justin Beaumont and Christoph Jedan, *Exploring the postsecular: the religious, the political and the urban* (Boston: Brill, 2010).

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INSPECTION OF THERAPEUTIC COMMUNITIES BY A MUNICIPAL HEALTH REGULATORY AGENCY AND ITS PRACTICAL IMPLICATIONS: THE CASE OF A LARGE BRAZILIAN MUNICIPALITY

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“WE’RE SHARING EXPERIENCES!”: CONVERGENCES AND DIVERGENCES IN THE POLITICAL ARTICULATION OF TC REPRESENTATIVES IN BRAZIL

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INTERFACES BETWEEN RELIGION, PROBLEMATIC DRUG USE, MORALITIES, AND GENDER IN THERAPEUTIC COMMUNITIES

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THERAPEUTIC COMMUNITIES: A STUDY OF ACCESS AND BARRIERS TO HEALTHCARE

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IMPRISONED ON THE OUTSIDE: THERAPEUTIC COMMUNITIES AS ZONES OF URBAN EXILE

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