The standardization of conducts carried out by the Therapeutic Communities

A normatização de condutas realizadas pelas Comunidades Terapêuticas

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ABSTRACT In this article we analyze the subjective consequences resulting from hospitalization in a network of Therapeutic Communities (TC), based on the voices of the graduates. It is a qualitative research, through semi-structured interviews with ten subjects. The results are presented by examining the therapy carried out in the TC. The participants described it as based on deprivation of freedom, the media and social life, making it clear that the objective is to promote total isolation and produce the standardization of conducts. The researched network is configured as a total institution because it was idealized to offer hospitalization to drug users, who are seen as subjects unable to take care of themselves and who present a high degree of danger to everyone around them, which is why they need to be cloistered and severed from their social coexistence. Those institutions are anchored on four pillars: discipline, work, coexistence and, especially, on the religious approach, in order to promote the annulment of past subjectivities, their singularities and desires in favor of a new subjectivity – one that is immobilized in accordance with the prerogatives that thrive in those spaces, which makes them similar to the predominant confinements in the old asylums.

KEYWORDS Public policy. Therapeutic community. Mental health.

RESUMO *Neste artigo, foram analisadas as consequências subjetivas decorrentes da internação em uma rede de Comunidades Terapêuticas (CT) a partir das vozes dos egressos. Trata-se de uma pesquisa de abordagem qualitativa, por meio de entrevistas semiestruturadas com dez sujeitos. Os resultados são apresentados esmiuçando a terapêutica realizada nas CT. Os participantes a descreveram como baseada em privação de liberdade, dos meios de comunicação e do convívio social, ficando patente que o objetivo é promover o total isolamento e produzir a normatização de condutas. A rede pesquisada configura-se como instituição total por ser idealizada para oferecer internação aos usuários de drogas, entendidos como sujeitos impossibilitados de cuidar de si e que apresentam elevado grau de perigo para todos que estão a sua volta, razão pela qual precisam ser enclausurados e apartados do seu convívio social. Essas instituições ancoram-se em quatro pilares: disciplina, trabalho, convivência e, especialmente, abordagem religiosa, a fim de promover a anulação das subjetividades pregressas, suas singularidades e desejos em prol de uma nova subjetividade – aquela engessada segundo as prerrogativas que vicejam nesses espaços, o que as torna semelhantes aos confinamentos predominantes nos antigos manicômios.*

PALAVRAS-CHAVE *Política pública. Comunidade terapêutica. Saúde mental.*

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Introduction

Since 1990, there has been a considerable increase in the demand for treatment for those who abuse Psychoactive Substances (PS) and in the expansion of the number of Therapeutic Communities (TCs) in Brazil[1]. Such institutions arose because of the empty space left by public policies in relation to the problem, since it was only in 2003 that a specific policy concerning this matter was enacted by the Ministry of Health[2,3].

Such communities were regulated by Resolution No. 29 of June 2011, of the National Health Surveillance Agency (Anvisa); and, in December 2011, Ordinance No. 3,088 / 2011 included them as one of the services of the Psychosocial Care Network (Raps), which implies being funded by the Unified Health System (SUS)[4,5]. They offer a closed residential treatment, based on the understanding that it is necessary to change the condition, the context itself of the patient, and to have him removed from the environment in which consumption occurs, given the need to cause a personality transformation that will make his social reintegration possible. It is understood that the means to encourage this transformation is a treatment made of personal and social interventions, in which duties and responsibilities are assigned to the residents, understanding that they are in a drug-free context which is, therefore, facilitator of the development of new values, such as solidarity, honesty, responsibility, love and spirituality[6].

Ribeiro and Minayo[7] state that the set of ideas behind Brazilian TCs assumes that the recovery and rehabilitation of users can only occur through evangelization and religious conversion. In addition, although there are specificities pertaining each TC, they all share a few basic guidelines: they are based on a well-structured system that defines schedules and rules that strictly outline the responsibilities of each resident; they are mostly located in the rural area; they are based on strict rules and discipline, and aspects of such to be highlighted are: the distancing of the residents from their places of origin and the use of labor therapy, group work and total abstinence from drug use as a requirement for remaining in the center as a resident.

It is worth noting that this type of center has received several criticisms, complaints and undergone rigorous inspections, such as that carried out by the Federal Board of Psychology (CFP), which led to the publication of the 'Report of the 4th National Human Rights Inspection: places of hospitalization for drug users'. This document pointed out practices that do not comply with what is advocated by the psychiatric reform movement and the anti-asylum struggle in Brazil. What stands out among them is the lack of respect for users' citizenship and the presence of methods providing evidence of human rights violations[5,8]. The Federal Board of Social Work (CFESS) also took a stand against qualifying such places as health service providers, as it understands that this treatment should be under the responsibility of the Unified Health System (SUS) and in line with what was decided at the IV Mental Health Conference in 2010, the XIV National Health Conference in 2011 and, above all, by Law nº 10,216/2001[9]. In addition to this, what can also be remarked is: the 'Report of the national inspection in TCs', which found evidence of deprivation of freedom; clear asylum and segregation characteristics; violation of rights; severance of social ties; and use of an approach that does not privilege the subject's uniqueness, since it does not have a therapeutic project for each individual, as required by Ordinance No. 3,088/2011[10].

In the wake of the disapproval to these institutions, Ribeiro and Minayo[7] criticize the approach used by them: keeping distance between the subject and the community, which leads to breaking up with social, community, employment, education and health bonds; a recovery process that does not include the individual confronting the use of drugs, since it offers the idea of a 'safe context', a context distant from that where consumption occurs;

the exploration of work, covered by the discourse of labor therapy as a therapeutic resource; the overly religious emphasis; and, yet, the disagreement between what public policies outline and what is practiced by such communities. In this context, Pitta[11] states that such a service model only fences the problem and prevails solely when a more effective and efficient intervention by the state is missed. In addition to these, the study by Leal, Santos and Jesus[12] revealed that, in the state of Espirito Santo, the solution offered to people making use various types of substances has been to isolate them in private institutions, clinics or TCs, revealing a marked gap between what is advocated by the psychiatric reform and what is actually practiced.

In view of the above, the urgency for research that aims to know what happens in these services and what are the repercussions to the lives of residents is clear. Thus, in this article, the subjective consequences arising from hospitalization in a TC network are discussed from the viewpoints and the voices of those who are their former residents.

Material and methods

The research makes use of a qualitative approach, considering the perspective of the former resident of such as an element of analysis. For data collection, individual interviews were carried out following a semi-structured script, aiming to explore in depth the experiences of these individuals[13]. 10 men of 18 years of age or above were interviewed, all of them coming from the biggest network of communities in the Country[14]. This research was submitted to Plataforma Brazil, under registration number 86616218.4.0000.5065 and opinion nº 2.618.473, being given approval by Committee for Ethics in Research of the Higher School of Science of the Santa Casa de Misericórdia de Vitória – CEP/Emescam.

All interviews were recorded, fully transcribed and submitted to the contente analysis proposed by Bardin[15], encompassing three phases: pre-analysus; exploration of material; and treatment of results. Aiming to preserve anonymity, the excerpts of speeches are identified by letter 'E'.

Results and discussion

With the purpose of emphasizing the critical analysis, results were grouped according to the therapeutic category followed; and in order to simplify the understanding of their dimensions, they were further divided into: deprivation experienced, discipline, spirituality and work.

The therapeutic proposal

When inquired about the 'treatment' given in these institutions, the participants emphasized that the hospitalization was aimed at 'something beyond', given that, in these places, the goal is not to provide care to people making use PSs, but to re-educate them, which implies a change of life, habits and feelings. As the report shows, the participant seems to agree with what is accomplished by the TC:

> *The purpose of the Community is not to cure from drug use. What it offers, what it intends to give you, is a new a life... [...] there, you will have to live a new life. A change of life, of habits, of patterns.* (E5).

Natalino[16] points out that the ultimate purpose of this type of institution is to infuse in the user a new identity, producing new subjects that correspond to the moral model pre-established by these services. In other words, substance users are required to become disciplined, production oriented and God-fearing individuals. To that purpose, the path to this new life is the same for all residents: renounce the external world, renounce the previous life in its entirety and adopt the ideologies that are advocated there. What is expected by means of this is to manage the

reinvention of this internal self, narrowing the extent to which it can remake bonds with society, thus strengthening the dependence on the moral and disciplinary universe fostered by these services.

Santos[17] mentions that the proposal for re-education is supported by the perception that these services have about the resident. In these institutions, they are regarded as individuals who lost control over their impulses, unable to postpone their satisfaction and who visualize reality in a dysfunctional way. Therefore, they are recognized as being sick and morally weak, whereas chemical addiction is seen as persistent and incurable. The current thinking in these services is that the resident's lifestyle is not consistent with the moral codes and social norms that govern life in society. In addition, they understand that the individual who makes use of PSs causes family conflicts and becomes a manipulative and irresponsible individual, alienated from his sanity and power of will, eventually becoming a criminal involved in thefts. This serves as a justification to re-educate and morally reform him, with the purpose of giving him back to society with an identity fully forged by a new moral code: a new identity. This is made evident by the following excerpt:

> *[...] there* [at the TC] *you will need a new life. A change of life, of habits, of patterns, you will need to let go of your selfishness, your arrogance, your sense of superiority, which are all drugs far worse than cocaine. It is a re-education, it is a new life, a change of habits, of patterns, they take you by the hand as if you were a child and you start it all over. And that is how it is supposed to be.* (E5).

It can be seen that the way users are approached is detached from any social context and that the use of PSs is given a connotation of sin or of incurable disease: a problem peculiar to the individual himself, which can only be overcome by the individual himself[18]. So, it is worth asking: what subjectivities are produced by this reeducation?

Assis, Barreiros and Conceição[19] guarantee that when the treatment proposed requires a need to isolate the person from society, in order to mold him according to a standardized way of existence, what actually happens is the annulment of the desires of the subject, by blocking the process of building free and autonomous subjectivities. In this sense, they point out[20] that, in such institutions, the subjectivity of each resident is not recognized and valued, since everyone must adapt to pre-established truths.

In addition, their approach to the use of PSs is one based on guilt, where what prevails regarding the PSs is abstinence, leaving aside historic, social, political and economic aspects which are inherent to such an issue. Such ideas are even more evident in the subcategory described below.

The deprivation experienced

The perception that prevails about the communities is that they are a place of deprivation of freedom, of the media, of social interaction, and even of family members. It is clear how the objective is to promote total segregation and isolation from the outside world, and not just from the substance that led patients to be admitted to the service.

The subjects show that the deprivations experienced during the hospitalization process are close to those that occur in prisons and that this is a shocking reality for those who are brought inside. The confinement experiences were identified as responsible for the feeling of longing for the family and are also said to be experiences that result in emotional and psychological distress. This can be seen in the reports:

> *I had never been hospitalized and suddenly you see yourself trapped, far from home. It is not jail, but you are deprived of many things. Television and radio are things you won't find, you can't use your cell phone either, and your family is kept away from you.* (E3).

> *At the* [therapeutic] *community we are unable to see our families for three months. And it is really shocking to be kept away from the family for three months. The whole treatment is shocking. It is a reality shocking to anyone. It is shocking to see yourself deprived of everything*. (E5).

> *This confinement situation left me psychologically and emotionally stressed. It took me to my limit and after completing six months there, I left. And I missed my family, because we are kept away from our relatives as we are only allowed to receive visits after three months, and after that we are only visited by our families once a month.* (E7).

The testimonies are reason for concern and make us think about what used to take place in asylums in the past. There are those who speak in favor of those communities, arguing that such comparison is inadequate, given that the permanence at the TCs is voluntary. However, it must be said that many times it is done in a compulsory manner with the collaboration of the Judiciary, that may agree to sending the substance user to the community at request of the family.

The type of approach recommends that the subject should only be able to return to society after at least 12 months of hospitalization. The reports obtained through the interviews make it clear that those are places of deprivation of freedom, closed and that they reissue the system of isolation, segregation, sequestration and confinement, prevalent in the old asylums and leper colonies.

Such characteristics were also found by several studies[15,10,21-24] that pointed out frequent practices that violate the user's right to come and go, in addition to prohibiting the use of the means of communication, which keeps the away from their family members.

In regards to the comparison between these institutions and the asylum model, Fossi and Guareschi[22] remark that the deprivation of freedom experienced by the residents is analogous to the understanding of mental health treatment as something that would leave to individuals considered insane no choice but social exclusion, acceptance of rules of conduct and incarceration in venues kept away from society.

The isolation of the one considered lunatic was justified by his dangerousness. Currently, these practices are based on the assumption that the person making abusive use of PSs is a risk to his family and to society itself, as the disease will make it impossible for him to have any control over his instincts, making him become a perilous and uncontrollable individual, to the extent of having to be confined. The fact that the media only stresses such image is something that strengthens the discourse in favor of hospitalization[25].

The current communities, alike the old asylums, can be understood as 'total institutions', given that they are, in essence, closed and total, something which is expressed by means of the deprivations and restrictions related to the outside world[26]. Goffman[26] also states that a total institution is a venue for residing and working, a place built to keep away from social interaction individuals in a situation resembling that of an outcast, making them live a life formally closed and administered, marked by a daily routine, along with a group of people with the same institutional status, which, in the case of our research, is the status of abusive user of a psychoactive substance. He remarks that total institutions can be regarded as greenhouses to change people. For that purpose, they make use of strategies to humiliate, degrade, demoralize, mortify and desecrate the internal 'self', so as to provide to the subject a new and standardized identity.

In that sense, the TC network is defined as a total institution, conceived to offer a treatment that will place the substance users in venues far from social interaction, with an obligation to perform daily chores and to adhere to religious principles, under the justification that otherwise they will become highly perilous.

The inmates give account of having undergone irreparable harm resulting from the

period they were hospitalized: harm to their professional career, educational development, love relationships and child raising. Some legal roles can also be harmed as a consequence of the barrier that separates them from the outside world, such as the temporary loss of the right to deal with money, to show opposition to an adoption or divorce process, to exercise their citizenship through voting. That is why it is common to find among residents a prevalent feeling that the confined period was a time they had suppressed from them, mainly due to the social losses resulting from the hospitalization process.

The subjects of this study demonstrated to have undergone losses in the affective and material scope, showing that, after hospitalization, they were taken by the desire to have back everything that was lost due to the hospitalization process; as can be seen in the report:

> *When you are dismissed, many times, you want back everything you lost. I lost a relationship of eight years and a house, which I left behind when I was admitted to the center. It was not easy. Dreams, plans, I had to 'kill' my dream of becoming a father because of my hospitalization. And it sometimes makes me feel very frustrated. Many times, I look back and I see that if only I hadn't distanced myself so much, perhaps I wouldn't have lost my things.* (E3).

The discipline

It was found that the discipline in these places works through the imposition of very strict norms and rules, as well as through punishing the resident in case he does not comply with the rules and norms. The residents are coerced to comply with all rules and schedules and are led to guide their daily life according to what is dictated to them by the management. It is emphasized that the discipline imposed becomes so rooted and normalized by the residents that punishments and obligations are not seen as such.

> *In the community, there are rules, and, if you do not follow them, you are... They eliminate you, you see? They won't let you stay. But there is nothing mandatory in what you have to do. You have a role there. My role, for example, was to work in the vegetable garden. But if I didn't do it, I would be sent away.* (E4).

> *[...] I would ask, why can't I do this? Why can't I go beyond the fence? Why can't I go to the other house? I would really question things, I would always want to know the reason and the purpose. I wanted to understand the process so I could accept the recovery. And that would bother the coordinators, because they thought: 'He asks too many questions', so they would leave me a whole week at the vegetable garden, to make me stop questioning, and that would me stress me out to an extent. We were not allowed to go beyond those boundaries of the farm, there were rules and we had to obey.* (E7).

This is a discipline deeply rooted in such institutions and is aimed at attaining continuous and absolute control over the subjects, recurring to control of their postures, activities and time, this being understood as essential to train these individuals, not without punishment. Repression through punishment is imperative for the residents to submit themselves to the discipline being imposed[27].

Interviewees see themselves as individuals with an aversion to rules and norms and who, therefore, need them for their re-education. In this sense, Goffman[26] points out that it is common in total institutions for residents to undergo what he calls 'brainwashing'. This corresponds to the process of acceptance of the conduct model preached by its leaders as being the best for the resident.

There are also privileges granted to those who are obedient to the rules imposed. In the studied TCs, these advantages consist of having access provided to the practice of sports and to reading books. On the other hand, the consequence of disobedience is the punishment of residents, such as the temporary or

permanent withdrawal of benefits. Both punishments and privileges are understood to be peculiar to total institutions, where there is no room for personal choices, which are to be cancelled and replaced by specific obligations. So simple choices, such as the time to get out of bed in the morning and to have lunch, become an issue[26].

Finally, it is also opportune to resort to the reflection on control devices suggested by Foucault[28]. For this theorist, discipline aims at manufacturing docile bodies, submissive bodies, capable of being exercised, easily trained to become productive and useful. Thus, it can be said that the discipline proposed in these services aims at producing docile and trained bodies who will submit themselves to the proposed treatment ideal, in order to be transformed according to the moralizing and normative prerogatives that operate in these spaces. This question, in fact, "limits the possibilities of rescuing the concept of subject and subjectivity in the process of producing care for people in psychological distress"[29(178)].

The work

Nicknamed as labor therapy, work represents 92.90% of the resources used by Brazilian TCs[30]. Such prevalence is due to the assumption that it is capable of generating self-discipline and self-control, seen as fundamental to guarantee success in social life after hospitalization.

The conception of work as a therapeutic resource dates from the 18th century, under the influence of the moral treatment theory developed by Pinel. According to it, work has a corrective, disciplinary and alienating function, used as a means for the organization and maintenance of the asylum context, being at the same time opposed to idleness. This resource was regarded as therapeutic because, supposedly, it was able to bring the subject back to his lost rationality, reorganizing his behaviors and reestablishing his healthy habits[31].

In that context, the valuation of work was in line with the wishes of the new capitalist society, which rejected idleness and overvalued productivity. This scenario was only modified by the replacement of the asylum-based treatment model for a territory based psychosocial care network, in which work started to be used as an instrument for the social reintegration of patients assisted by the mental health policy[31].

At this point, the findings of this research express that such institutions have returned to the conception of work prevalent in the 18th century. This is made evident by the speeches of the former residents, since they seem to submit themselves to the proposed treatment ideal, as docile bodies:

> *You work a lot there, like eight hours a day. But I enjoy work, that is the good part, I learned to milk cows, bake bread, cookies, cakes, crafts, praying the rosary, prepare food for 20, 30 pessoas. The boys would even joke, and I would joke as well: 'Look what happened to me, holding a shovel under that hot sun. 'See what happens when you make use of drugs'.* (E10).

Bolonheis-Ramos and Boarini[23] emphasize that there are many criticisms of this treatment resource that is widely used in communities. Such criticisms are based, especially, on the understanding that the ultimate purpose of work in these places is only to keep the TC itself working, thus not encompassing any therapeutic purpose capable of contributing to the social reinsertion of the resident.

According to Melo[32], the work proposed in these establishments is not capable of offering instruments of citizenship or autonomy. On the contrary, it performs a moral disciplining function, which aims to imprison and regulate the life of the residents, according to the standards required by these institutions; and, thus, to limit their diverse possibilities of life, to mortify their trajectories and peculiarities, instilling in them a new identity that I consistent with the assumptions of these centers.

Considering that mandatory work is one of the pillars of these centers, it is necessary to question whether, in fact, this resource, the way it is used, may be able to foster the self-esteem and creativity of the resident. One can also question if the purpose of this resource is in any way therapeutic, in the sense of providing contributions to the subsequent social reintegration of the resident.

In the wake of these questions, the results of the inspection carried out by the CFP[10] sustain that the activities developed by the residents in these spaces have no therapeutic objective. Far from that, they are a form of exploitation, aiming to increase the profits of the service by replacing the labor of actual professionals by that of the residents who work for free and, generally, forced, in precarious conditions and without any labor legislation guarantee. In these spaces, work is used as an instrument of discipline and punishment, not favoring individual expression, neither contributing to the process of bringing the resident back to society, as it does not facilitate the development of any personal potential or professional qualification.

Religiosity

The way the interviewees' see it, the spirituality pillar is materialized through the practice of praying the rosary, reading, experiencing the word of the day and participating in masses. For these individuals, these practices are the source of the strength they need to obtain the so-called cure and help them accept the rules, overwrite their desires and correct inappropriate behaviors.

> *There is much spirituality there, it is big, it strengthens us. There are priests, people who are there to help us. That is somethings that offers us a new life, in the sense of understanding that things are not the way I want them to be, and that I need to accept how things are in order to have a new life. And then you don't ask why there is no TV? Why is there no radio? Why should the lighting be this way? There are so many 'whys', but eventually no more 'whys' are left, your will dies out and you do what has to be done. We are supposed to wake up at seven in the morning and take a nap at two in the afternoon. It is something you must accept. Things are not like I would like them to be. So that is the change the farm makes us go through: accepting the way things are.* (E5).

Data published by the Institute for Applied Economic Research (Ipea) 30 show that spirituality represents 95.6% of the methods used by Brazilian TCs. However, the spirituality encouraged by these services is meant to promote the users' faith in a higher being or instance, aiming to transform their lives, aiming to morally frame them, alleviate their pain and suffering and assist them in overcoming the use of PSs. Thus, it was possible to perceive that the term spirituality that appears in the institution's advertising pamphlets refers to an euphemism, since spirituality is only understood and practiced according to a given religious order, which is imposed as the only one correct.

By using the belief system originating from Catholicism, the analyzed services seek to mold the residents according to the precepts of that religion, so that a 'new man is born' and the 'old man' is exterminated, which is to say that it is necessary to cancel the previous personality to give way to a new personality, in line with the ways of life desired by these institutions.

> *We learn that there is an old man and a new man. The old man cannot be born, so I have to allow the new man to be born every day.* (E5).

> *Much of my will died. The farm teaches you to let your own self die, the death of this self. Like if someone does something disagreeable to you, you let it be, you don't react, you let your ego die, and if you don't keep on talking about it, if you keep calm, it won't hurt you, and you will let the will of God prevail.* (E10).

The conclusion one arrives at relates to the study carried out by Fossi and Guareschi[22], showing that the religious rituals commonly

performed in several of these institutions are a means to make the individual renounce his own will. Medeiros[33] also points out that, in these places drug use is seen as a disease, curse, punishment and a 'spiritual' evil caused by the subject's sudden abandonment of socially accepted codes. Based on this understanding, the path to healing consists of religious conversion, because only then will the residents become able to obey the orders given to them. However, this cure is only possible when the resident recognizes his own deviation or disobedience and, thus, reflects and repents of his deviant and sinful acts. In addition, religious rituals are used by these institutions as a means to bring the subject to a condition of emotional fragility, vulnerability and humiliation, understood as an indispensable condition to educate and regulate the residents - this is because, in this context, the resident is recognized as unable to take care of himself and actually hands over the government of his life to the coordinators of these services. It is worth mentioning that, in the studied TCs, these coordinators are usually residents who are in their last month of hospitalization and who work as volunteers to maintain their routine, not being required to have any technical and/or academic training to occupy the position.

The discipline in these centers is made explicit through the imposition of norms and rules that manage the residents' time, based on a standardized routine and on adherence to the religious precepts that are advocated there. In addition, punishment is revealed as the main artifice to make people become humble, well trained and obedient to the norms and rules imposed.

The conclusion is that the religious approach employed is meant to moralize, discipline, put blame and violate rights. It moralizes as it proposes a moral review of the subject's lifestyle. It is disciplinary, since it uses religious rituals as a means for its residents to become humble and capable of better obeying and accepting the orders given. It blames as it considers drug use a problem of the individual, thus disregarding the historical, economic, social and political aspects pervading this use, so as to make the individual the only one responsible for his recovery. It is violator of rights, since participation in religious practices, scheduled routines and work is mandatory, even if the individual does not share the values prescribed there.

These questions challenge the effectiveness of TCs, to the extent that the evaluation and monitoring by the State is essential. Furthermore, it is necessary to invest in territorial devices, focusing on Psychosocial Care Centers for Alcohol and Drugs, in order to provide an approach that seeks user autonomy, with individualized proposals that value different subjectivities.

Final remarks

When analyzing the subjective consequences of being admitted to a TC network, one can see that it constitutes a means to standardize its residents. Therefore, it is based on four pillars: discipline, work, coexistence and, especially, a religious approach, in order to promote the annulment of the past subjectivity of the residents, in favor of a new subjectivity: the one that is forged according to the prerogatives that operate in these spaces.

Collaborators

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References

1. Alves VS. Modelos de atenção à saúde de usuários de álcool e outras drogas: discursos políticos, saberes e práticas. Cad. Saúde Pública. 2009; 23(11):2309-2319.

2. Costa SF. As políticas públicas e as comunidades terapêuticas nos atendimentos à dependência química. Serv. Soc. Rev. 2009; 3(2):1-14.

3. Brasil. Ministério da Saúde, Coordenação Nacional de DST e AIDS. Política do Ministério da Saúde para atenção integral a usuários de álcool e outras drogas. Brasília, DF: MS; 2003.

4. Brasil. Ministério da Saúde. Resolução da Diretoria Colegiada nº 29, de 30 de junho de 2011. Dispõe sobre os requisitos de segurança sanitária para o funcionamento de instituições que prestem serviços de atenção a pessoas com transtornos decorrentes do uso, abuso ou dependência de substâncias psicoativas. Diário Oficial da União. 30 Jun 2011.

5. Brasil. Ministério da Saúde. Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde. Diário Oficial da União. 23 Dez 2011.

6. Sabino NM, Cazanave SOS. Comunidades terapêuticas como forma de tratamento para a dependência de substâncias psicoativas. Estud. Psicol. 2005; 22(2):167-174.

7. Ribeiro FML, Minayo MCS. As Comunidades Terapêuticas religiosas na recuperação de dependentes de drogas: o caso de Manguinhos, RJ, Brasil. Interface (Botucatu). 2015: 19(54):515-526.

8. Conselho Federal de Psicologia. Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas. 2. ed. Brasília, DF: Conselho Federal de Psicologia; 2011.

9. Conselho Federal de Serviço Social. Nota sobre a regulamentação das comunidades terapêuticas: contribuições do CFESS para o debate. Brasília, DF: CFSN; 2014.

10. Conselho Federal de Psicologia. CFP repudia mudanças na política de saúde mental. Brasília, DF: CFP; 2017.

11. Pitta AMF. Um balanço da reforma psiquiátrica brasileira: instituições, atores e políticas. Ciênc. Saúde Colet. 2011; 16(12):4579-4589.

12. Leal FX, Santos CCM, Jesus RS. Política Sobre Drogas no Estado do Espírito Santo: consolidando retrocessos. Text. & Cont. 2016; 15(2):423-436.

13. Gaskell G. Entrevistas individuais e grupais. In: Bauer MW, Gaskell G, editores. Pesquisa qualitativa com texto: imagem e som: um manual prático. Petrópolis: Vozes; 2002.

14. Galindo D, Moura M, Pimentel-Mello R. Comunidades terapêuticas para pessoas que fazem uso de drogas: uma política de confinamento. Barbarói. 2017; (50):226-247.

15. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.

16. Natalino MAC. Isolamento, disciplina e destino social em comunidades terapêuticas. In: Santos MPG, organizador. Comunidades terapêuticas: temas para reflexão. Rio de Janeiro: IPEA; 2018. p. 37-60.

17. Santos MPG. Comunidades terapêuticas e a disputa sobre modelos de atenção a usuários de drogas no Brasil. In: Santos MPG, organizador. Comunidades terapêuticas: temas para reflexão. Rio de Janeiro: IPEA; 2018. p. 17-36.

18. Loeck JF. Comunidades terapêuticas e a transformação moral dos indivíduos: entre o religioso-espiritual e o técnico-científico. In: Santos MPG, organizador. Comunidades terapêuticas: temas para reflexão, Rio de Janeiro: IPEA; 2018. p. 77-100.

19. Assis JT, Barreiros GB, Conceição MIG. A internação para usuários de drogas: diálogos com a reforma psiquiátrica. Rev. Latino Am. Psicopatol. Fundam. 2013; 16(4):584-596.

20. Raupp LM, Sapiro CM. A "reeducação" de adolescentes em uma comunidade terapêutica: o tratamento da drogadição em uma instituição religiosa. Psic.: Teor. e Pesq. 2008; 24(3):361-368.

21. Pacheco AL, Scisleski A. Vivências em uma comunidade terapêutica. Rev. Psicol. Saúde. 2013; 5(2):165-173.

22. Fossi LB, Guareschi NMF. O modelo de tratamento das comunidades terapêuticas: práticas confessionais na conformação dos sujeitos. Estud. Pesqui. 23. Bolonheis-Ramos RCM, Boarini ML. Comunidades terapêuticas: "novas" perspectivas e propostas higienistas. História, Ciências, Saúde-manguinhos. 2015; 22(4):1231-1248.

23. Bolonheis-Ramos RCM, Boarini ML. Comunidades terapêuticas: "novas" perspectivas e propostas higienistas. História, Ciências, Saúde-manguinhos. 2015; 22(4):1231-1248.

24. Ferrazza DA, Sanches RR, Justo JS. Comunidades Terapêuticas em novas configurações do manicomialismo. ECOS. Estud. Contemp. Subj. 2017; 2(7):363-375.

25. Andrade TM. Reflexões sobre políticas de drogas no Brasil. Ciênc. Saúde Colet. 2011; 16(12):4665-4674.

26. Goffman E. Manicômios, prisões e conventos. São Paulo: Perspectiva; 1987.

27. Amarante P. Entrevista: Paulo Amarante fala sobre a proposta de reformulação da Política Nacional de Saúde Mental. Rio de Janeiro: Laps; ENSP; Fiocruz; 2017.

28. Foucault M. Microfísica do Poder. 29. ed. Rio de Janeiro: Edições Graal; 2011.

29. Barbosa VFB, Martinhago F, Hoepfner AMS, et al. O cuidado em saúde mental no Brasil: uma leitura a partir dos dispositivos de biopoder e biopolítica. Saúde debate. 2016: 40(108):178-189.

30. Instituto de Pesquisa Econômica Aplicada. Nota técnica perfil das comunidades terapêuticas brasileiras. nº 21, Diretoria de Estudos e Políticas do Estado, das Instituições e da Democracia. Brasília, DF: IPEA; 2017.

31. Shimoguiri AFDT, Costa-Rosa A. Do tratamento moral à atenção psicossocial: a terapia ocupacional a partir da reforma psiquiátrica brasileira. Interface (Botucatu). 2017: 21(63):845-856.

32. Melo JRF, Maciel SC. Representação Social do Usuário de Drogas na Perspectiva de Dependentes Químicos. Psicologia: Ciênc. Prof. 2016; 36(1):76-87.

33. Medeiros R. Construção social das drogas e do crack e as respostas institucionais e terapêuticas instituídas. Saúde Soc. 2014; 23(1):105-117.

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