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Involuntary Admission of Substance Users—Total Institutions Through the Perspective of Individuals Deprived of Rights

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Abstract: Aim: To understand the perception of substance users involuntarily committed to a mental health clinic concerning the institution where they are enclosed against their will. Methods: This is a qualitative research study conducted in a Therapeutic Community in the state of Minas Gerais, Brazil. Data were collected through semi-structured interviews with nine substance users who were involuntarily committed to the TC. The participant observation technique was also used for data collection. The observation was carried out within the TC premises. The principal investigator used an observation script, focused on the TC infrastructure, hierarchical relationships, work routine and patient care routine, and verbal and non-verbal communication between patients and professionals. Results: Data analysis resulted in four major themes: (1) The individual and the institution; (2) The total institution—hierarchical relationships in the context of the Therapeutic Community; (3) Routine of work and care for the committed substance users; (4) Routine and religious manifestations in the Therapeutic Community. Results reveal Therapeutic Communities are regarded as places that reaffirm the power of the former mental asylum. Conclusions: From the study results, it is possible to conclude that substance users become vulnerable before the rigid structure of Therapeutic Communities, where the non-democratic, homogenous, and sometimes violent environment does not resemble the diverse, plural society to which the individual must return shortly.

Keywords: human rights; substance-related disorders; involuntary commitment; therapeutic communities; Brazil

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1. Introduction

Brazil is currently experiencing a rise in punitive and segregationist policies. The prison system houses more than 830,000 inmates in unhealthy, inhumane, and chaotic conditions. Additionally, other exclusionary spaces, such as judicial mental asylums, sanatoriums, and Therapeutic Communities (TCs), have been reinforced (Brazilian Public Security Forum 2024). This scenario reflects the stigma directed at individuals selected to occupy these spaces, especially psychoactive substance users, who are often viewed as "scapegoats" within a punitive and dualistic morality framework (Christie 1993).

Erving Goffman, in his work on total institutions, describes how such organizations isolate individuals from broader society, imposing strict rules that regulate every aspect of daily life. TCs in Brazil exemplify this dynamic, functioning as total institutions that aim to shape and control the behavior of their residents through strict discipline and regimented routines. These institutions, often of a confessional nature, use religion as a treatment strategy, regardless of the individual's religious beliefs (Fossi and Guareschi 2019).

Originally, TCs were not part of the healthcare network as they were not classified as health services. Their inclusion in the healthcare system is directly linked to security policies, with funding organized through public notices issued by the National Secretariat for Drug Policies (Secretaria Nacional de Políticas sobre Drogas—SENAD), under the Ministry of Justice and Public Security, as established by Ordinance No. 563 of 19 March 2019. However, even before their official authorization, TCs were already operating fully, combining psychiatric knowledge with a religious logic of moralizing individuals (Fossi and Guareschi 2019).

It is important to note that, in some cases, substance users voluntarily seek treatment. However, drug use can represent an expression of subjectivity and free choice or a way to find belonging. Regardless of its legalization, substance use can be respected as a personal choice in the context of a free society (Correia Junior and Ventura 2013).

On the other hand, Brazil is currently under the influence of the "law and order" or "zero tolerance" movement, deeply rooted in popular ideology. Such movements are reflected in public policies aimed at repressing criminality or excluding those who are maladjusted, marginalized (Carvalho 2008; Schwartz and Nogueira 2002), or unassimilated.

In this scenario, public health is consolidated as a right, while involuntary hospitalization, by definition, represents a violation of these rights, transforming medical clinics into spaces of exception, seclusion, exclusion, and segregation of minorities and the poor (Basaglia 1985). As a result, comprehensive care and the guarantee of citizenship are hindered in favor of the State's need to remove a portion of the population that does not fit into the capitalist framework (Baratta 1999). Between respecting personal choice and recognizing the need for support for the illness caused by substance abuse, society creates specific spaces for substance users, which allude to the intersection between health and Law.

Among the services provided for psychoactive substance users, this study focuses on Therapeutic Communities (TCs)[1], a model of asylum-based treatment widely used for individuals with chronic psychiatric disorders in several countries. These institutions are frequently employed in cases where individuals resist changing behaviors related to substance abuse, making it necessary to alter their environment and remove them from the context where the use occurs (Badagnan et al. 2013).

TCs are conceived as organized and structured spaces where people with chemical dependency or other challenges live together with the goal of promoting behavioral changes and facilitating social reintegration free from drugs. Furthermore, they play a significant role in the discursive construction of users' identities, shaping their experiences and perceptions during their time in the institution (Iudici et al. 2024).

This study focuses on psychoactive substance users who were involuntarily committed to a Therapeutic Community, aiming to understand their perceptions of the institution where they remain confined against their will. By adopting Goffman's perspective on total institutions, we seek to analyze how the practices of these institutions influence the lives of residents, regulating behaviors and perpetuating mechanisms of social control.

By analyzing TCs as total institutions, we aim to deepen the understanding of how these structures impact individuals' autonomy and subjectivity, contributing to broader debates on public health policies and human rights in the Brazilian context.

2. Materials and Methods

This is a qualitative study with a dialectical approach. We have chosen a Hegelian approach to dialectics, a dynamic method based on the principle that reality is volatile (Hegel 2016). In this sense, contradictory arguments can originate new contexts, requiring

new solutions, that must be designed while taking into consideration the social, political, and economic context that surrounds the problem (Lakatos and Marconi 1991).

2.1. Research Site

The TC[2] in question is located in Brazil, in the rural area between the states of Minas Gerais and São Paulo. At the time of the study, it had on average 70 inpatients from all over the Southeast region of Brazil, 25 of which were involuntarily committed. There were several reasons for choosing this particular clinic: first, the state of Minas Gerais has recently approved a flexible public health policy that allows for involuntary admission. That reality is very different from a few years back, when there were countless restrictions to committing to an institution.

This TC follows the same trajectory as many other similar establishments in Brazil. It was founded in the beginning of the 21st century by a former substance user, in the rural area of São Paulo. At first, it only accepted voluntary admission.

In most Therapeutic Communities and clinics, there is little to no involvement of professionals. The staff mostly comprised religious people and former substance users who have converted. The standard treatment consists of abstinence and latent religiosity, endorsing Wilson and Smith's twelve-step self-help program (Rodrigues and Almeida 2002). There were a few employees and only one professional who was truly equipped to deal with individuals in confinement, that being a nurse.

During the first decade of the 21st century, this community received authorization to function as a Therapeutic Community, and from then on, started taking in compulsory patients as well. The establishment, benefiting from policies that favored hospital admissions in the state of São Paulo, has accommodated more than 100 inpatients, most of them involuntarily committed.

At the time of data collection, approximately 70% of the beds were occupied[3]. Among these patients, nearly half were involuntarily or compulsorily committed, and three of them had been converted from involuntary to voluntary.

2.2. Study Participants

Substance users who are involuntarily committed to TCs represent a fragile and vulnerable thread in our social fabric. They were selected as participants for this study precisely because of how vital they are to the process of understanding the exclusion that affects a specific part of society. Furthermore, exclusionary places such as asylums and penitentiaries are consistent with the definition of total institutions (Goffman 2015). In this regard, it is important to listen to the inpatients who experience life within those walls (Goffman 2015).

The participants were selected according to the following eligibility criteria:

(a) Being a substance user who has been involuntarily committed to the Therapeutic Community where the data are being collected; (b) Aged 18 years or older; (c) Being legally responsible for their own actions; (d) Being in a psychological condition stable enough to remember their own life story, as assessed by the responsible team; (e) Having been through the detoxification program (two weeks) in compliance with the TC rules.

The participants were nine substance users who were involuntarily committed to the TC. They were all male, aged 18 to 29, single, liberal professionals[4], unemployed, had a high school diploma and resided in one of the cities nearby. This group of middle class or lower-middle class young men have been through financial problems.

2.3. Ethical Aspects

This study has been approved by the Ethics Committee of the Nursing School of Ribeirão Preto, University of São Paulo, CAAE protocol no. 42602814.8.0000.5393. The

study was carried out in accordance with the norms and principles that guide human subject research, established by the Brazilian National Health Council Resolution no. 466 (Brazilian National Health Council 2012). All participants involved in the study were provided with the informed consent form, which they reviewed and signed prior to participating. Additionally, all participants were informed about the study's objectives, their rights, and the confidentiality of their data.

2.4. Data Collection

This qualitative study was realized through semi-structured interviews based on dialectics, where the interviewee's narrative occupies the central role, and the researcher becomes an observer, who interprets their discourse and ponders about their personal, cultural, and social descriptions (Minayo 2009).

The interviews were designed to provide involuntarily committed substance users with a safe space to talk about their life experiences, specifically those related to being denied their freedom in the institution where they were enclosed. The main goal of the interviews was to create an interaction between the interviewer and interviewee while collecting data on the worldviews of substance users.

The observation was carried out within the dependencies of the TC. The lead researcher conducted the interviews and took notes in a field notebook, over a period of four alternating days. An observation script was also used; it focused on the TC infrastructure, hierarchical relationships, work routine and routine of patient care, and verbal and nonverbal communication between patients and professionals (Table 1).

Table 1. Observation script.

Observation Category	Details to Observe
1. Infrastructure Conditions of the Therapeutic Clinic	- **Location**: Accessibility, proximity to public services. - **Identification of the Place**: Signage, visibility. - **Physical Space**: Size, layout, condition of facilities. - **Lighting and Ventilation**: Adequacy for user comfort and health. - **Accommodations**: Sleeping quarters, privacy, shared spaces. - **Furniture**: Availability, condition, suitability for purpose. - **Cleanliness**: General hygiene of spaces. - **Accessibility**: Adaptations for users with mobility challenges. - **Safety**: Measures to prevent harm and ensure user security.
2. Hierarchical Relationships	- **Roles and Responsibilities**: Observed hierarchy among staff. - **Interaction Dynamics**: Power relations between staff and users. - **Decision-Making**: Who makes decisions about care and daily routines.
3. Work and Care Routine for Interned Drug Users	- **Daily Schedule**: Timetable and organization of activities. - **Care Practices**: Types of interventions offered. - **Staff Interaction**: Presence and role of professionals during activities. - **Activity Types**: Therapeutic, recreational, or punitive nature.
4. Religious Practices and Manifestations	- **Frequency and Nature of Activities**: Worship sessions, prayers, or religious events. - **Participation**: Voluntary or obligatory involvement of users. - **Symbols and Messages**: Religious symbols displayed in the facility, messages conveyed.
5. Verbal and Non-Verbal Communication	- **User-Professional Interaction**: Tone, clarity, and mutual respect in communication. - **Non-Verbal Cues**: Body language, expressions of authority or empathy. - **Conflicts or Misunderstandings**: Observed tensions or difficulties in communication.

The observation period lasted for 24 h, distributed over the four days of visitations preceding the interviews. Observation is the main tool for qualitative research, for when observing, the researcher must juxtapose all of their senses to search for information that will help them build a mental image of the reality under examination (Lofland et al. 2006).

2.5. Data Analysis

For data analysis, the reflexive thematic analysis proposed by Braun and Clarke (Braun and Clarke 2019) was used, which allows for greater flexibility and more immersive work on the research data.

The collected data were transcribed by the main author. Afterwards, readings and notes of the transcribed material were carried out, in order to familiarize themselves with the results. After this familiarization step, coding was performed, that is, the systematization of data by relevance. This step was followed by organizing the data into potential themes and reviewing these themes, using thematic maps that helped to have a better view of the essence of each theme.

With the exhaustion of these interpretations, descriptions, reports and expositions were obtained, which were discussed based on the Human Rights framework, and especially with regard to the freedoms and rights experienced in a closed institution with a rigid hierarchy.

Finally, interview data from participants were included as quotations to enhance the themes, and this paper was written to report the results.

3. Results and Discussion

3.1. The Individual and the Institution

The participants were nine substance users who were involuntarily committed to the TC. Although they were not questioned about it directly, most of them expressed difficulty in maintaining a relationship with their family, and lack of dialogue throughout their teenage years.

It is important to discuss the role of the involuntarily committed substance user inside the institution, and the impact of this establishment on the individual. In this sense, participant observation made it possible to examine how these individuals participate in the institutional cogwheel (Goffman 2015)[5]. Conclusions and insights are displayed in Table 2.

Table 2. The inmate facing the total institution.

1—Deprivation of opportunities: one of the most mentioned effects of institutionalization by the patients was the feeling of being deprived of opportunities for rehabilitation or reinsertion in society. *How can we talk about social inclusion in society (SIC) while being imprisoned. Are we gonna learn how to live there ((society)) by being locked away? (Patient 6).*
2—A total institution has more comprehensive effects if the inpatient has a sociocultural connection with the external world. If, instead, the world is denied to them, the total institution will have minor effects.
3—A clear process of deculturalization and subsequent acculturation befalls on the patients when entering the institution. That is, inmates go through a process of assimilation in total institutions.
4—The tension between the external and internal world is presently reinforced as a way of maintaining control inside the institution. That becomes clear in phrases such as: *I can't go out. What will I hold on to out there? (Patient 5).*
5—Since autonomy and individuality are not encouraged, in fact, they are forbidden within the institution, the involuntary patient must let go of their self-concept. *I am a psychic, but an Umbandist one, they won't accept it in here, I had to BECOME a Catholicist, otherwise I'd be punished (Patient 5).*

Table 2. *Cont.*

6—The involuntary patients suffer various types of degradation and mortification of the self with standardized processes designed to mutilate their personality.
7—Management and employees almost always emphasize the fragility of patients when faced with the power they exert, encouraging subjugation and stimulating docile behavior. They deny the right to diverge and consequently disempower the patients, hindering their construction of themselves as a subject of rights. The patients cannot distinguish their own rights. *Enforce my rights? You don't understand where we are, do you? ((laughs)) (Patient 3).*
8—Prohibition of visitations and outings mark a rupture with former social roles and undermine the possibilities of creating and consolidating new roles for a remote social rehabilitation.

Source: The authors.

Along the course of observation, we noticed that the patients were subjected to a series of physical indignities. Among them, the mandatory schedules for eating meals, going to sleep and waking up. The patients must always speak humbly to the staff, even when making relatively simple requests. For instance, there were times during the observation when they had to ask if they were allowed to stand up after a TV show ended, or go to the bathroom during religious activities. Handing over their belonging when first entering the clinic was also cited as a strong emotional experience by all interviewees.

With these data, it becomes clear that the relationship between the individual and institution is one of extreme subjection, both due to the vulnerable role the substance user plays in society, and because of the institution's structure, grounded on control.

3.2. Participant Observation—Control and Religiosity

This paper contains the researcher's perceptions on the establishment's location and its functioning, as a result of participant observation[6].

Observing a total institution with dozens of patients and employees requires attention to every detail. The researcher must observe not only the place, but its health care practices, and especially the subject—the one who is at the mercy of the institution and the one who executes its orders. The bottom line is acquiring a perspective on how "the practice happens" (Vieira Filho and Teixeira 2003).

In order to paint a picture of the substance users involuntarily committed to the TC, the researcher focused on daily life at the establishment. For that, it was necessary to accept and consider the spontaneity of situations, while discerning which of them were usual occurrences and which were isolated events (Vieira Filho and Teixeira 2003). With this in mind, the observations described in this paper contain the elements that were perceived as usual occurrences in daily life at the clinic.

3.2.1. The Total Institution—Hierarchical Relationships in the Context of the Therapeutic Community

The road leading to the TC is unpaved and located 14 km from the nearest city. While vehicle access is relatively easy due to recent road restoration, access by public transportation is infeasible, as there are no nearby bus routes. Walking access is also challenging and somewhat dangerous. In cases where patients might rebel against treatment and attempt to leave, the remote location significantly limits their ability to reach the nearest city or find transportation.

During observations, it became evident that the TC operates in a highly structured manner, with strict external control over daily routines and schedules. Patients' freedom and autonomy are limited, as activities are determined and monitored by the institution. This level of control extends to most aspects of daily life, reflecting a highly regulated environment aimed at maintaining order and adherence to treatment protocols (Fossi and Guareschi 2015; Melo and Corradi-Webster 2018).

When entering the clinic, even a researcher is required to go through a meticulous and sometimes humiliating inspection. The employees who do the inspection are the same ones that accumulate all other kinds of functions within the institution. There are no specialized workers, and their approach is authoritative and rude.

The voluntary inmates are accommodated in two of the five room complexes distributed throughout the clinic. From the moment they arrive, the staff defines their routine, with a series of programmed activities. For these inmates, not unlike the involuntary ones, there is no possibility of discussing the best course to follow concerning tasks.

The regulation of socialization deprives the individual from having power and autonomy over their own life, deviating from the ideal scenario of democratic relationships that encourage the individual to increase their possibilities and empowers them in the decision-making process (Araujo and Corradi-Webster 2022; Moll et al. 2022). Instead, what we see is an institution of denial, where there is no space for democratic conversations that would allow the patients to discuss and reflect upon their possibilities (Basaglia 1985).

Besides being denied the institution, involuntary inmates also receive a significantly different and more aggressive treatment, since their admission process is instilled with a series of hostile and invasive actions.

In most interviews, none of the involuntary inpatients said the staff forced them to do things or imposed behaviors in their daily life. The word they used the most was "suggestion". They did, however, make it clear that in the case they did not adhere to the suggestions, they were punished. These punishments included physical violence, restriction of freedom in the rooms destined for detoxification, torture, and sedation with clonazepam, diazepam, or other drugs.

The patients are usually brought in by the clinic's pickup truck, accompanied by their family and the institution's nursing technicians. They struggle and bawl, and sometimes are restrained with violence. One of the patients had both his hands and feet tied.

In the course of participant observation and informal conversations with the inpatients, some of them confided that in this clinic, and in others they have been in, force is always their method for "rescue" and some used the word "abduction". Many report that, during the "rescue" promoted by the institution, it is common practice to sedate the person in such a manner that they only wake up inside the clinic. This process, in which people are abducted, is called "rescue" and commonly occurs in TCs without any clinical evaluation, "followed by imprisonment and the immediate start of "treatment" that consists of slavery, heavy use of sedative drugs, forced religious conversion, and punishment in isolation cells" (Araujo and Corradi-Webster 2022, p. 2). This is always present among the charges pressed against clinics and TCs (Conselho Federal de Psicologia et al. 2018).

Studies show that the first contact during the admission process can significantly influence the level of perceived coercion or justice. Post hoc analysis indicates that patients brought in by the police report greater coercion throughout their commitment period (Golay et al. 2019). Additionally, these coercive practices, as discussed by Opsal et al. (2016), undermine the core principles of human rights and patient autonomy. The lack of informed consent, absence of clinical evaluation, and the use of force conflict with ethical and legal standards, highlighting a systemic disregard for the dignity and well-being of individuals. Such approaches not only contravene international human rights norms, but also perpetuate stigma and distrust towards mental health institutions.

The long-term effects of such coercion are significant, negatively influencing patients' cooperation throughout the treatment and potentially causing lasting trauma (Katsakou et al. 2011; Kinner et al. 2017). Moreover, perceptions of unfair and coercive treatment have been associated with a higher risk of suicide attempts after discharge (Jordan and McNiel 2020). Opsal et al. (2016) emphasize that such outcomes underscore the importance of

adopting less coercive, rights-based approaches to psychiatric care that prioritize dialogue, patient empowerment, and informed consent.

When questioned about their methods, staff members often justify these violent and coercive practices as necessary to protect patients. However, as noted in the literature, these approaches—characterized by force, lack of dialogue, and immediate sedation—may cause more harm than good. To address this, Opsal et al. (2016) advocate for systemic reforms that align practices with ethical frameworks and international standards, emphasizing the critical need for accountability and the development of alternative, less intrusive methods of care. A violent approach seems to be the rule and the lack of dialogue is inherent. Among the arguments and justifications heard from the employees, were:

> *((speaking quietly)) Of course we tie them, you know, IF WE LET THEM, THEY'LL KILL US, right?* (Staff 1)

When they arrive, patients are taken to a floor the staff calls "detoxification". There, they have no access to the external area nor can they interact with anyone. Their yelled protests and pleas for freedom can be heard throughout the facility on a daily basis. Some call for their family.

The detoxification period seems to vary, since the clinic's manager stated they last from 7 to 15 days, but other staff members speak of patients who have remained in enclosure for over a month. Some voluntary patients call the rooms "solitary". The hierarchical relationships on this floor are tougher and inflexible. The employees are less patient with the inmates on this floor. Hierarchical relationships become even more rigid, and the dialogue, non-existent.

A topic that must be addressed is the loss of identity of the patients, who are rarely called by name. Besides the loss of identity, we can also identify the alienation that is so common in hospitalizations and confinement, which enables even further violence and negligence (Pena and Gomide 2013).

The involuntarily committed inpatients, the object of our research, are enclosed in a confinement regime for up to four weeks. In some cases, they are not even allowed to leave their rooms to eat or pray with the others. Meals are brought to them by the staff.

The psychologist, who comes by twice a week, does not have contact with the inpatients in the detoxification phase. Only doctors make sporadic visits. This defines the commitment phase of many patients in the establishment, since the procedure is the same for every person who is admitted into the clinic, either voluntarily or compulsorily.

The hierarchy is arranged through the distribution of power, which ranges from total autonomy (doctors and the manager) to unquestioningly fulfilling orders (nurses, technicians, other staff, and volunteering former inmates). Everything that is done or planned is previously assessed by the manager. The only exception are specific medical procedures, since doctors can make decisions and prescribe treatments without direct need for approval.

The nurses and the psychologist seem to have more restrictions in their autonomy than the rest of the staff. Every step is closely monitored by the manager. Even some psychologist visits could not be performed privately.

These hierarchical relationships reveal a conviviality system based on orders and rules that are always established externally. Regardless of the type of admission, the patients cannot have a say in their treatment. There is no promotion of democracy nor encouragement of autonomy in decision-making. The clinic's manager claims to reinforce autonomy, but that only goes so far as theory. Therefore, the TC is evidently a typical total institution.

Its functioning exemplifies every defining characteristic of total institutions, as conceptualized by Goffman (2015). These institutions are marked by a single authority overseeing

operations under constant surveillance, creating an environment of control and compliance. People within these institutions are often organized into groups that perform the same tasks or, alternatively, refrain from specific activities, with each group treated uniformly, stripping individuals of their unique identities. A nondemocratic and rigidly predefined schedule dictates daily life, planned externally by individuals who typically lack familiarity with or empathy for the institution's inmates. Basic human needs are managed through a bureaucratic hierarchy, further entrenching the institutionalized structure. This environment fosters dualism and hostility, whether overt or covert, between inmates and supervisors, amplifying existing tensions. Stigma intensifies for all participants, perpetuating labeling through phenomena like the Lucifer Effect. This results in solidified roles that individuals are expected to occupy within the institution and beyond. Communication is tightly controlled, with attempts to manage interactions within the institution and restrict contact with the external world. This control reinforces stereotypes and widens the cultural and social gap between the two contrasting spheres. Whether through full involuntary or partial voluntary admission, the separation from external society becomes a defining feature, contributing to the inmates' alienation.

Work is imposed as an obligatory activity, often without any form of meaningful compensation, serving as the sole avenue for participation. The institution's way of life frequently clashes with inmates' previous norms, making post-institutional adaptation to domestic life particularly challenging. Ultimately, these total institutions emerge as social hybrids, blending elements of residential communities and formal organizations while eroding individuality and autonomy.

The TC hierarchy, similarly to its physical and labor structure, subdues the individual to a position where they are incapable of finding the means to rescue their own singularity. Personal property is undistinguished from the property of the institution (Goffman 2015).

Many are the tools for affirming hierarchy, among them labor and routine.

3.2.2. Routine of Work and Care for the Committed Substance Users

Labor therapy and group labor, symbolizing the rigid discipline associated to drug abstinence, are common aspects of Therapeutic Communities and clinics (Ribeiro and Minayo 2015). This structured hierarchical system of labor promoted in Saint Clare Clinic is also tied to religiosity.

Labor activities are performed in the interior of the clinic and its surroundings, especially on the roads. Inside, the labor is divided between planting and taking care of the community garden, general services and cleaning, kitchen assistance, and for some patients in an advanced stage of recovery, monitoring the labor and the religious activities. They also sporadically produce handicraft items.

Every daily task is directly connected to the spiritual principle of service in the twelve-step program. Thus, labor therapy is but another tool to cultivate resignation and discipline the body, while religious activities determine one's spirituality. As in most Therapeutic Communities and clinics, substance users are conceived as anomic and undisciplined individuals. Drug use allegedly establishes the user as weak and antisocial.

Therefore, impulses must be controlled, and one way to control them is through labor and discipline. These activities aim to adjust the subject to a social model, a norm, so that they cease to challenge society (Fossi and Guareschi 2015).

This norm and discipline are evident in the hierarchy of the whole labor process. A great part of the inmates are required to wake up at six, and breakfast is served at 6:30. The majority of the patients are already working by 7 a.m. Patients in advanced stages of treatment have the opportunity to work outside the clinic.

Labor is organized in various fronts and is coordinated by multiple employees, as well as voluntarily committed patients who are regarded as "recovered". During the observation period, external labor consisted of putting up fences along the road that leads to the clinic, and reforming and improving the road itself. These tasks are assigned to voluntarily committed patients.

Despite that, these tasks are also constantly monitored. There is a clear overlap between discipline and vigilance, supported by the continuously reinforced official goal of rehabilitating, curing, and educating. But paradoxically, this rigid labor structure produces regulated and unempowered individuals. Discipline and vigilance solidify in opposition to education, equating to tools for training and conditioning patients so that they become able to follow orders (Foucault 2014).

Inside, there is a different division of labor, and vigilance, although still present, is substantially reduced. All maintenance required in the facility is performed by patients. Similarly, the gardening work is divided between six to ten inmates, who work under direct exposure to the sun and only take breaks to have lunch, and to participate in the afternoon prayers.

The animal care tasks, including milking the cows and feeding pigs and chickens are performed by inmates under the omnipresent supervision of the clinic's employees. About five to nine patients perform these tasks. The cleaning tasks mobilize about six to ten patients, with the same workload as the others. Lastly, the only patients who had the right to choose their activity are kitchen assistants.

These patients are the only ones to be voluntarily assigned, since the manager specifies that such services must be performed by inmates who have at least a basic knowledge of culinary and food preparation.

Patients who complete their tasks quicker or more diligently than expected are rewarded, reinforcing a system that encourages productivity. This is particularly evident in tasks related to culinary activities and handicrafts, which not only occupy patients but also generate profit for the clinic. These practices align with the concept of docilization of the body as articulated by Foucault (2014). According to Foucault, discipline is a mechanism that operates to render bodies as both obedient and productive, serving broader political or economic aims.

In the context of the TC, this is observed through the regimented structuring of daily activities, where patients are taught to conform to specific behaviors and expectations. The focus on productivity as a measure of success mirrors Foucault's assertion that discipline transforms individuals into "docile bodies" that can be optimized for utility. The reward system further reinforces this dynamic by promoting compliance and incentivizing behavior that aligns with the institution's goals. This structure suggests that the institution not only seeks to rehabilitate, but also to regulate and capitalize on the labor of its patients.

The patients never had any possibility of desistance or abstention from any type of labor—they were unilaterally assigned by management. The external tasks, particularly, have always been entirely delegated. Although the vigilance on the inside is less strict, there was never a possibility of choosing work democratically. Thus, they are turned into submissive bodies, apt to work, but unempowered, for they are in a position of subjection (Foucault 2014).

Importantly, there are distinct differences in the work performed by patients who were voluntarily or involuntarily committed. The latter accept the labor and perform it accordingly. However, during the interviews, their latent discontent with how the work was imposed was made evident.

> *And there's something else ((pauses)) the work, right ((pauses)) it's absurd, you know ((pauses)) I'm a plastic artist, I make art, and here I have to do grunt work. They impose*

> *the work and I don't think it's right. I hate it and I'll confess ((speaking quietly)) I do it half-heartedly. [. . .] What do I think? I think it's absurd and it enrages me!* (Patient 3)

> *I didn't feel excluded for using drugs, no, not at all. I feel excluded in here, always having to do things I don't want to do. I feel agony (10) knowing that I have to wake up to this crap every morning. Cleaning bathrooms excludes ME. I'd rather be on drugs.* (Patient 8).

> *Is labor inclusion? I'm not sure if it is: I don't wanna be feeding pigs out there. The life I had was crazy enough ((laughs)).* (Patient 6)

> *You are talking about human rights in a community (sic) that forces me to get up at SIX and work. I don't see them. . .* (Patient 4)

Ostensive power generates oppression, fear of punishment, and revolt toward the vigilance (2014). Labor comes through in every spoken and unspoken sentence as a daily challenge to overcome, along with the dissatisfaction caused by its imposition, the lack of alterity, and the ostensive vigilance.

3.2.3. Routine and Religious Manifestations in the Therapeutic Community

Institutional power is achieved through the junction of discursive and non-discursive practices and customs. Religion plays a critical role in social control, due to its ideological bias and its moralizing, disciplinary nature (Foucault 2012).

Health knowledge, when executing disciplinary power, generally targets the vulnerable to attain "conduct regulation". Therapeutic Communities are the ideal space for this power-based intervention for two main reasons: first, the subject who is targeted (substance users), and second, the method used for treatment (spiritual) (Passos and Souza 2011).

Spirituality, here meaning Christian faith, emerges as the main instrument used to consolidate disciplinary power in confinement institutions for substance users. As observed in Saint Clare Clinic, religiosity is a vital piece of the treatment. It is depicted as the only way out, being used as a tool to solidify the stigma of the substance user as a fragile, vulnerable individual who has succumbed to the temptations of pleasure.

This approximation of drug use to the concept of the bad Christian is the basis for religious treatment: in distancing themselves from the substance, one can get closer to God. Abstinence is not reduced to a phase of treatment; it is the foundation for spiritual salvation. In the clinic, pleasure, and consequently vice, are constantly depicted as wrong.

In this sense, Passos and Souza (2011, p. 158) affirm that Christian morality, justice, and psychiatry form a network of institutions whose sole and common purpose is abstinence. But unlike psychiatry, which focuses on mental illness, and justice, which focuses on delinquency, religious moral adds a third element: the association of pleasure to evil.

Just beyond the entrance, there is a large image of Saint Clare on one of the walls of the main floor's balcony, and next to it are Bible verses about overcoming obstacles and keeping God in mind. Some sentences allude to abstinence and resignation as the only paths to God.

On the matter of social control, religiosity surpasses other instruments of constraint, such as prisons, clinics, and asylums. That is due to the fact that such devices are primarily physical, whereas religion goes beyond the institution's walls, following the individual wherever they go, shaping their behavior and regulating their conduct. Its power permeates the social structure that surrounds the individual (Foucault 2012).

Moreover, there are images of saints throughout the whole clinic, and a crucifix in every room. In the chapel, there are more images and crucifixes. These images are accompanied by sentences that reinforce ideologies from institutions of control and discipline, such as common laws and, especially, religious law. Every mention of drugs in sermons and

prayers inevitably passes through the discourse of the Other, a discourse detached from the subject.

The demonization of pleasure, always as the discourse of the Other, is inherent to prayers and has direct effects on the patients, who absorb this discourse lodged in Christian morality:

> *No, I had no religious bonds before coming here, I was too lost, you know. Here I found the Word of God. The Word is important. I owe that to the Clinic. Can't do it without God, can you? I was too loose-headed, had no breaks, now I know I can't do just about anything, HE ((pointing up)) is there.* (Patient 4)

> *It ain't right ((regarding drug use)), if it were, I wouldn't be here. The right thing would be to get myself together, but I couldn't. I couldn't resist it, I chose the drug ((in a subdued voice)).* (Patient 5)

Although the clinic considers religiosity the foundation of its treatment, during the participant observation there were no visits from priests, chaplains or deacons. All prayer sessions are organized by volunteering former inpatients. In conversations, we discovered that, although the clinic had a Catholic bias, there were frequent visits from pastors, which were encouraged by the manager.

The clinic follows the Twelve Steps, which potentiate spirituality as the main aspect of treatment (Fossi and Guareschi 2015). There is no possibility for any patient to fit into the clinic's activities and the institutional philosophy of treatment if they do not believe in God and all the dogmas related to him. This central nature of religiosity is so apparent that the manager always reiterates:

> *Without God, it is impossible to be cured of any evil, especially addiction.* (Manager)

Following the aforementioned disciplinary power structure, the Twelve Steps lead the treatment from the moment the substance user is admitted into the clinic. From the very first day of admission, prayers are mandatory, with the exception of a few involuntary inmates who are going through the detoxification period, and therefore are "unapproachable" and "violent".

Religiosity is entirely imposed and goes beyond mere spirituality, for non-Christian religions are demonized and discouraged, according to several reports from patients. The twelve-step program understands spirituality exclusively as Christian belief.

Through prayers, the clinic attempts to solidify one of the Twelve Steps foundations, which is to always emphasize the importance of hope in the treatment, hope for a "cure", hope that the substance user will be freed from "evil". As in other clinics, the confidence in the knowledge of Saint Clare's religious leaders can only develop through "trust and divine power" (Ribeiro and Minayo 2015).

The Twelve Steps are displayed in three banners, placed on the clinic's common areas, always highlighting spirituality. Another issue that is always associated to religiosity is abstinence. It is treated as a proof of faith, sometimes a destination for the believer, other times a path to redemption.

Importantly, religiosity and abstinence are the foundation for the twelve-step program. Thus, the ceasing of the use combined with religious devotion are crucial to the substance user's treatment. The subject must believe in all Twelve Steps and in the method's success (Fossi and Guareschi 2015).

Among the Twelve Steps displayed throughout the clinic's walls, two can be highlighted to exemplify the program's bias: 2. Came to believe that a Power greater than ourselves could restore us to sanity; 3. Made a decision to turn our will and our lives over to the care of God as we understood Him (Fossi and Guareschi 2015, p. 108).

Even though the patients have diverse characteristics and wills, the prayers are performed several times a day, including during meals. On weekends, masses are held in the presence of the families. As in labor, we found that adherence to activities is higher among voluntary patients, while involuntary patients display resistance. We also observed constant protests against prayers and swearing.

> *I have nothing to do with religiosity, no. Actually, I don't even believe it, there's no reason to believe. But I like it because it's a break from work. I prefer it when the pastor comes, it's more exciting, but since I'm here by force, seeing the Mass is the least bad part.* (Patient 8)

> *Look, I'm not very religious. First of all, I shouldn't be here, I'm fully conscious, I'm not crazy. And I want my freedom. It's easy for them to speak about God. I had a life out there, and it wasn't about going to church ((laughs)).* (Patient 6)

The clinic has a dense religious routine, and religiosity is imposed and mandatory to all patients. Most of the people who adhere to religious activities without protesting are voluntary inmates. Incidentally, they are the ones who actively participate in the prayers and claim to believe in the Twelve Steps. For the most part, the involuntarily committed inpatients feel uncomfortable and annoyed at the compulsiveness of such activities, especially those who were recently admitted.

4. Conclusions

It is noteworthy that there were several hurdles and limitations to the conclusion of this study. Most clinics closed their doors on us, withdrew agreements, and demanded us to disregard or destroy our material. After four years of research, a confidentiality agreement made it possible for the interviews to be performed. Another obstacle was the patients' lack of trust, their fear of speaking up about their worries, doubts, and fears.

This research is justified by the need for studies that do not comply with a moralizing, objectifying perspective that still considers the drug as the protagonist, while the individual and their reality assume a secondary position.

Participant observation allowed us to demonstrate that Therapeutic Communities are exclusionary spaces whose functioning is authorized by a legal apparatus, in overlap with Brazil's exclusionary drug policies.

This overlap provokes the emergence of a system of social control in which Therapeutic Communities, asylums, prisons, and detention homes function not only as total institutions, but also as mechanisms within the broader framework of power relations. Drawing from Foucault's concept of the microphysics of power, these institutions operate through subtle and diffuse mechanisms of control that permeate individual behavior and social interactions.

In this context, such institutions are not isolated entities but interconnected structures that reinforce norms and hierarchies, contributing to the perpetuation of social stratification. By regulating and disciplining individuals under their care, these establishments serve as instruments for maintaining societal order, aligning with economic and political systems that benefit from this stratification. The practices observed—such as strict schedules, surveillance, and reward systems—exemplify how power operates at a micro level to shape behavior and sustain broader structures of inequality.

Exclusionary spaces are cogs in this machine, and we presented as an example the Therapeutic Community, that manifested itself as a place that denies the existence of a subject of rights, suppressing their autonomy, thus characterizing a "non-place". The institution revealed itself as an environment of denial, depriving the patients of their freedom, family, dignity, and will. An establishment where involuntarily committed

inmates feel stripped of their rights and fundamental guarantees. An institution that, as a cog in the machine of social control, forces religious and labor subjection, and as an exclusionary space, silences the individual. These individuals must regain their own voices, for it is in the obstruction of dialogue that the greatest complaints arise, since it reduces, humiliates, and prevents the empowerment of the vulnerable.

Evidently, faith is not the driving force in the life of most participants, although Christian ceremonies and rites are mandatory. The clinic, as a total institution, maintains unreserved influence over the patients' lives, which includes full deprivation of freedom in places the inmates call "solitary". Thus, the institution is consolidated through the imposition of rules and the implementation of punishments and vexatious rituals aimed at docilizing patients.

This situation reveals the urgent need to view the substance user, who is in a vulnerable position inside TCs, as a subject of rights. In that way, they must be made aware of what they are entitled to as citizens, and of the purpose behind the restraining of their freedom, as a last measure, in the case that it ever occurs.

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Notes

1 The Brazilian legislation defines Therapeutic Communities as follows: civil society organizations, non-profit, regulated by their own law, whose main activity is the therapeutic model of care in a residential and transitional setting, through the voluntary admission and stay of individuals with problems related to the use or dependence on alcohol and other drugs, welcomed in a protected environment, technically and ethically guided, with the aim of promoting personal and social development through the promotion of abstinence and social reintegration, seeking overall improvement in the individual's quality of life (Brazil Ordinance n. 563 2019).

2 The mental health clinic in question will be referred to as Saint Clare (SC) throughout the discussion. We used a fictitious name with the primary intent of protecting the participants' secrecy, and the secondary purpose of alluding to all clinics within the rural region of Minas Gerais and the Northwest of São Paulo. All of these institutions are either named after Catholic saints or have names that make reference to God or Bible verses.

3 The 70% occupancy rate observed in the therapeutic clinics in the region reflects the predominant private care model. Since these clinics are privately operated and rely on families' financial resources to cover hospitalization costs, it is common for them not to operate at full capacity, as not all families can afford the expenses. This scenario differs from public or fully subsidized systems, where occupancy rates are typically at or even above full capacity.

4 In the Brazilian context, the term "liberal professionals" (profissionais liberais) refers to individuals who work autonomously or are self-employed, such as freelancers, consultants, or independent contractors, rather than being formally employed by a company. The participants were identified as liberal professionals based on their previous work history and skills, even though they were unemployed at the time of the study. Their unemployment was influenced by financial difficulties and the fact that they

were undergoing inpatient treatment, which limited their ability to work. This distinction reflects the cultural and labor context in which individuals may retain their professional identity even during periods without active income or formal employment.

[5] According to Goffman (2015), a total institution is "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life".

[6] As for the main researcher's participation in this project, we must first delineate the circumstances of participant observation in the context of scientific research. On that account, Vieira Filho and Teixeira assert: "the concept of participant research includes both participant observation and action research. What distinguishes them is, essentially, the place of the observer. Something that's common in both positions is the participative nature and the involvement with the reality being acted upon. In the first case, there is no intention of intervening in the reality being acted upon, but in the second, there is" (Vieira Filho and Teixeira 2003). Although we aim to produce results that will help change the reality of substance users who are involuntarily committed to institutions, our current goal is simply to portray reality as it was observed.

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