

# The Right to Health as a Tool of Social Control: Compulsory Treatment Orders by Courts in Brazil

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## Abstract

Brazilian citizens have a constitutional right to health. This right has also been a powerful instrument in the judicial enforcement of drug dependence treatment in Brazil. This study reviews a sample of decisions from the state of São Paulo and provides evidence that the right to health has been used to justify compulsory admission to treatment for people deemed to have a drug use disorder. These claims are filed against the state, mainly by families, who argue that the right to health of individuals is being violated. This model of litigation—oriented toward the satisfaction of a presumed health care need—does not engage sufficiently with individual informed consent and participation in the delivery of treatment, as a person-centered approach would demand. Further, the judgments reveal a low level of awareness among judges about the procedural rights of people ordered to undergo compulsory treatment, despite the large-scale implementation of the right to health via courts in Brazil. This problematic interpretation of the right to health, in the context of mounting punitive policies and ideology in Brazil, can be harmful to people who use drugs and bring about an environment of more limited patient safeguards.

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## Introduction

For years, Brazil has been viewed as a controversial model for right to health litigation. The story of mass litigation in Brazil has been told through research suggesting the misspending of public resources and diversion of funds to the richer classes seeking the procurement of low-priority (and sometimes unproven) technologies.<sup>1</sup> The negative effects of courts in Brazil are still partially contested (even in this journal).<sup>2</sup> This paper describes one detrimental aspect, until now rarely explored: the misuse of the right to health as a normative tool to impose forced drug dependence treatment through court decisions.

In Brazil, compulsory drug dependence treatment is enforced via civil law rather than criminal law. Drug possession in Brazil remains a crime but is not widely prosecuted; more often it is subjected to non-detention sanctions, such as community service orders and educative programs.<sup>3</sup> According to Brazil's mental health legislation, involuntary treatment can be imposed either administratively following a doctor's evaluation or judicially (compulsory admissions) through civil actions initiated by public defenders or relatives.<sup>4</sup>

In the Brazilian court system, relatives are able to judicially enforce the compulsory treatment of family members who use drugs by lodging civil claims against the state on the basis of the right to health, regardless of the individual's consent or the admitted person's involvement in their care plan.<sup>5</sup> Considering this context, this study focuses on whether compulsory treatment in civil claims is proportionate and necessary: namely, whether it is essential to protect individuals from abusive practices and whether it can also be considered a justified interference with their liberties. Justifications include, at least as per the recommendations of the World Health Organization and the United Nations Office on Drugs and Crime, (1) a clinical evaluation and evidence-based treatment plan provided by a specialized medical doctor and confirmed by another doctor; (2) a short time limit for the forced treatment established in advance; and (3) judicial monitoring of the treatment progress and patient's recovery, personal well-being, and ongoing neces-

sity for continuation of the measures.<sup>6</sup> As the cases in this study will demonstrate, the jurisprudence so far has not fully addressed the procedural rights of patients, and there is no indication that legislation from 2019 will change this judicial behavior, given that more claims are expected to be brought under the right to health in the future.

In relation to procedural guarantees for individuals ordered to compulsory treatment, Brazilian lawmakers have historically failed to implement monitoring mechanisms or to determine precise rules for a process of appeal.<sup>7</sup> Some procedural guarantees for involuntary treatment and compulsory admissions are now provided in Law No 10.216 (2001), which provides for the protection and rights of people with mental disorders.<sup>8</sup> For compulsory admissions, the statute requires that the judge pay due regard to the "safety conditions of the care facility, as to the protection of the person in treatment, other patients and staff."<sup>9</sup> In 2019, lawmakers amended the country's drug law, which now explicitly includes procedural guarantees for nonjudicial admission (involuntary treatments) for people who use drugs, similar to the existing rights already conferred on all mental health patients.<sup>10</sup> The new law requires a doctor's recommendation with a treatment plan, notification to the Public Prosecutor's Office within 72 hours, and a maximum duration of admission of 90 days (unless a request for an extension is made).<sup>11</sup> This is basically the same as the requirement for involuntary treatment previously adopted for the general mental health law, but it is unclear whether judges are bound by these procedures, as the law regulates only nonjudicial interventions.

The aim of this paper is to qualitatively analyze the nature of these civil claims and the discourse used by a select number of decisions from a regional court in the state of São Paulo. This review of jurisprudence seeks to explore how courts construe the right to health in relation to compulsory drug treatment in Brazil and, in the process, deny patient autonomy and fail to ensure access to less restrictive measures respectful of individual liberties. The results of this analysis are contextualized in relation to recent legislative developments and

the political climate in Brazil, which promotes compulsory treatment for people who use drugs.

The first section describes the methodological approach of this jurisprudence review. The second section outlines the findings based on the attributes of the cases and narratives presented by the judicial opinions. It also observes how the right to health is applied and in which ways guarantees of fair procedure are observed. The final section contextualizes the contemporary political and cultural backdrop in Brazil that influences the use of compulsory treatment orders in the name of the right to health.

## Methods

This research tracked decisions concerning compulsory drug treatment orders in the state of São Paulo issued between January 1 and December 31, 2019. São Paulo is the most populous state of Brazil, with one of the highest levels of litigation. The jurisprudence available comes from appeal judgments published in the database of the State Court of São Paulo (Tribunal de Justiça de São Paulo), which acts as a second-instance court. Relevant decisions were identified by searching decision summaries for the term “compulsory admission” (*internação compulsória*), the common technical expression for this intervention. The law also prescribes “involuntary admissions,” but that is not the usual terminology used by judges (even though the law before 2019 distinguished compulsory treatments, made at the request of families, from compulsory ones, those determined by a judge). This search elicited 602 results, which were further refined to include only those containing the terms “drugs” or “alcohol,” resulting in 47 decisions included in this analysis.

Judgments in the sample differ from regular “community treatment orders” as they do not derive directly from a mental capacity assessment or proportionality test for an intervention within the patient’s community to avoid individual harm. Community treatment orders are defined as a course of treatment supervised by a doctor in a community, which in some jurisdictions can be monitored through court decisions (following a specific judicial procedure or an appeal).<sup>12</sup> In contrast,

judicial orders in the sample are issued on the basis of a medical diagnosis that needs to be complied with by virtue of a right to health obligation leading to compulsory admission in a hospital setting. While not all jurisdictions require a declaration of mental incapacity for a community treatment order, it is usual that, in any case, the intervention is the least restrictive among the possible solutions.<sup>13</sup>

Decisions were individually and manually screened to identify (1) litigant profile (family, public defender, or public prosecutor), (2) whether procedural patient rights guarantees were observed, (3) whether the right to health was applied as the basis of the decision, and (4) the merit of the decision (granting the forced treatment or not). Families were included because they are entitled to request that the court grant compulsory admission of a relative, and this has become a common practice.<sup>14</sup> They appear in the court register as plaintiffs and are qualified as a family member (generally parents) when mentioned in the decision. The subsequent classification was tabled as a survey questionnaire divided by individual features (case number, party, right to health application, doctor prescription, procedural rights, and award decision). Arguments and legal references used in the decisions were analyzed as doctrinal research to examine discourse practices around the right to health and patient autonomy.<sup>15</sup>

## Findings

The majority of the cases were filed by families (76%, or 36, of the 47 decisions screened). In comparison, public prosecutors lodged only eight procedures. Three cases out of the sample were excluded for being an appeal for reasons other than examining the merit of compulsory treatment for persons with substance use disorders. The right to health was the most commonly given legal basis (36 cases). In these cases, judges concluded that the state had a legal obligation to provide compulsory admission as a way of guaranteeing access to health care.

Almost all compulsory admissions were granted by judges, with only nine cases being refused. Most of the rulings in the sample did not

cover procedural aspects or consent as an individual guarantee (for instance, whether the patients could challenge the decision or were consulted about treatment preferences), save for five appeals (10.5% of the judgments). In general, those five appeals did not go into detail about possible interferences with patient freedoms or patients' right to influence their treatment.

Judicial reasoning is largely supported by doctor prescriptions and medical reports, illustrating how direct patient participation is not central to judicial scrutiny compared with expert opinion. Ten cases had no medical recommendations (in nine of which the order was declined), indicating that judges do not award admission without clinical reports.

### *The central role of family*

The legal argument supporting compulsory admission is not only a question of providing care to patients but also protecting the family (an issue raised both by claimants and by judges). This view seems to conflate the rights of the person in detention with the threat that may potentially be caused to the family (by physical aggression or personal conflicts).

In accepting this argument, the balance of interests tilts toward compulsory treatment since the expected benefit of keeping the person secluded exceeds any loss of individual liberties. In one of the cases, the court warranted a search to take a patient (who was never notified of the process) for a medical examination as a matter of precaution in a claim brought by a mother.<sup>16</sup>

Despite this, family members' view of the compulsory treatment of their relatives has more complex aspects than just safety. As Cristiana Araujo and Clarissa Corradi-Webster observe, families can understand interventions as a necessary punishment, or as required abstinence for recovery, while at the same time still recognizing it as a traumatic experience for the affected family member.<sup>17</sup>

### *Rights language and legal reasoning*

Legal analysis in these cases is rather superficial.

Judges hold that to realize the right to health for an individual, access to compulsory treatments must be awarded as a constitutional obligation. Jurisprudence refers either to the general right to health or to access to medicines, and in some instances specifically notes that the case concerns persons with substance disorders. No reference is made to any other set of individual rights that may clash with this type of measure. Judges merely reproduce a list of fundamental rights and state obligations in an exhortatory fashion, without pondering what impact the ruling might have on individual patient liberties, sense of control, and agency, as illustrated in the excerpt below (taken from the research sample):

*In avowal to the principle of dignity of all human beings, and aiming to protect the right to physical and mental health guaranteed by the Federal Constitution, I concur with the non-voluntary commission of the drug user for treatment and social rehabilitation, as well as for the protection of his family and the community around them.*<sup>18</sup>

Judges who hear such cases do not necessarily encounter mental health issues on a regular basis. Given that the lawsuits are lodged against the state, the cases go before judges specialized in disputes in relation to public law and government responsibilities, including the provision of health care services. Therefore, the judges concerned may overlook or be less predisposed to inquire into bioethical principles and patient rights in relation to compulsory treatments.

### *Procedural guarantees*

Decisions in favor of compulsory treatments were not issued in line with international best practices concerning procedural guarantees (as described earlier), despite being made following a single doctor recommendation. First, implementation of the right to health does not presuppose, in the judge's reasoning, an investigation of a less restrictive order and the direct participation of the patient in the care plan. However, judges are cautious about the appropriate medical evaluation as a precondition for compulsory treatment (e.g., dismissing

claims without clinical evaluation, as shown by the findings), but a second doctor's opinion is never required. In the evidence assessed, no references were made to patient preferences (through interviews or a preliminary court hearing with the person undergoing forced treatment) to explore alternative treatments.

Judges do not impose the same strict criteria for review and control of patient well-being and progress (for instance, compulsory orders should have a 90-day limit under current legislation, but this is not uniformly applied). The legal standing held by the patient in the judicial process (e.g., as an interested third party or a defendant represented by a legal guardian) is not clear, and the opportunity for involvement by the patient in the process is obscure, with no direct reference to patient intervention during the trial. For instance, judges tend not to comment on submissions made by the patient's independent legal representation (challenging the allegations), though in some instances the patient's name can appear in the process register as an interested third party.<sup>19</sup>

Another problematic feature in these decisions is that mental capacity is generally presumed (or indirectly attested by a medical evaluation with no reference to a patient's continuing competencies). Judges do not recognize transitional or varying degrees of incapacity or in which ways patient values and preferences could be preserved throughout the treatment. Incapacity, in such cases, is declared or assumed incidentally but not fully explored separately as a formal declaration of incapacity through a specific process or evidence assessment, for instance, considering the patient's decision-making ability.

### The context beyond courts

This research has provided a general picture of the way that the right to health is interpreted by judges in the state of São Paulo who order compulsory treatments for people with substance use disorders. This analysis may have some limitations. An important one is that some cases may deal with compulsory treatment without being indexed as

such. A similar term that could have been entered would be "involuntary admission" (mentioned above), but its occurrence is much less common during the period in question. As a comparison, for the period researched, 602 decisions were indexed as "compulsory admission," while only 52 had the term "involuntary admission." In addition, judges may not explicitly raise substance abuse in the facts, the database may be incomplete, and some decisions remain unpublished, especially if given "in camera."

Moreover, the necessity for judicial intervention for a compulsory treatment order was abolished in 2019, which may influence future litigation levels. Compulsory admission orders could arguably become less common, yet where public services are not accessible there is still scope for writs. Further, given the data set obtained from a single regional state jurisdiction, with its own demographic conditions and judicial behavior, these findings may not correspond to cases elsewhere in the country, where there is less litigation or where jurisprudence may have evolved differently.

Additionally, these findings cannot be understood in isolation from other important political factors influencing the rights of persons who use drugs. Forced treatments in Brazil are recognized among local scholars as a social cleansing strategy, a modality of biopolitics rooted in structural state violence, the police war on drugs, and prohibitionist policies.<sup>20</sup> Some structural issues affecting mental health policies in Brazil should be highlighted alongside the enforcement of the right to health devoid of procedural guarantees. Three main areas make this forceful employment of the right to health even more problematic: (1) pervasive legal and political incentives for compulsory treatment measures, (2) an underdeveloped legal culture of patient autonomy, and (3) risk of compulsory treatments as a means to solve urban problems of widespread substance use disorders.

### *Legal and political drivers of compulsory treatment*

As in many countries, current drug legislation in Brazil embodies a punitive mindset, which gained

more prominence after the extreme right came to power in the 2018 elections.<sup>21</sup> President Bolsonaro ratified a reform of mental health legislation to “abolish” (as it was described by the local media) the requirement of a judicial order for civil commitments of persons with substance disorders. The law was passed under the protest of jurists and public health experts who denounced the retrogression of patient rights.<sup>22</sup>

This legal reform corresponds more to political rhetoric and a cosmetic review than a real policy departure. This is because the legislation in Brazil has been ambiguous about the compulsory admission of persons with substance disorders, while this practice has been largely tolerated in society. A 1934 federal decree permitting forced therapy for “toxic substances” was thought to have lost its effect after the 1985 Constitution took effect.<sup>23</sup> Yet, modern legislation has not eliminated this model despite attempts to move to patient-centered approaches. Administrative admission for drug users remained officially unregulated, but its use was commonly justified by another statute legalizing compulsory treatment for general psychiatric disorders.<sup>24</sup> Because compulsory drug treatment for persons with substance use disorders has been a long-established practice in Brazil, families (and public authorities) have developed the culture of resorting to writs to commit persons who use drugs, particularly where no institution was able to accept new patients.

In 2019, a Bolsonaro-backed bill was passed in the Congress establishing doctors’ ultimate authority to explicitly provide in legislation forced treatments without a judicial order in cases of substance use disorders.<sup>25</sup> This change may reduce the level of litigation in Brazil on this topic, but as mentioned above, it was more the codification of an existing practice in the legal framework than a substantial departure. The outlook, though, should be of growth in litigation as a whole. Since many municipalities do not provide mental health services, families would still have to resort to filing new claims even if they could request this administratively.

The architecture of the current legislation places the family and the doctor (not the individual

who uses drugs) at the center, just as judges have done in jurisprudence. No procedural rights are conferred to individuals for compulsory treatment, save the notification to the Public Prosecutor’s Office (Ministério Público). Involuntary admission (outside courts) can now be made by the decision of a doctor after the request of the patient’s family as if they were a legal tutor or guardian, but without a previous judicial order or declaration of incapacity. The doctor’s prescription must state that no alternative was available, and the restriction can last for 90 days only (though the law is silent about successive renewals).

Another justification for the recent legal reform in Brazil was to bolster and legitimize the activities of “therapeutic communities” (TCs) as a form of social control over addiction. Provided by legislation since the 1970s, these private entities are generally led by religious organizations and are not to be confused with progressive and humanistic community-based services introduced in other countries. Different from the best international guidance on drug rehabilitation, TC facilities offer services of rehabilitation that essentially could not be regarded as such—they are heavily reliant on coercion and segregation, with poor technical capacity and no extensive social services, including work and education.<sup>26</sup> Researchers, local authorities, and news outlets have exposed TCs’ brutal detention regime as a form of a “total institution” where individuals are cut off from society at the mercy of their hosting organizations.<sup>27</sup> Defying best practices around abstinence, TCs compel patients to live in long periods of isolation from family and friends, with no access to external communication or entertainment, including books and television.<sup>28</sup> Some inspections have found TCs operating with very poor standards of hygiene and food, as well as overcrowded accommodations.<sup>29</sup> Therapies are commonly religious and oriented toward spiritual salvation.<sup>30</sup>

Again, families are an important factor in the promotion of a compulsory policy. TCs normally target advertisement and recruitment strategies at family members.<sup>31</sup> As an operational arm of a compulsory policy, there are accounts of families

“disposing of” undesired members, sometimes for ulterior motives such as disapproval of sexual preferences or lifestyles (some TCs also offer sexuality conversion therapies).

The pressure of TCs on legislation and subsequent implementation of human rights standards cannot be ignored, nor can the lack of judicial intervention deterring these harmful services. With the political turn in Brazil in 2018 in favor of evangelical coalitions, TCs forged a connection between religious movements and Bolsonaro’s ideological mandate. While the legal reform by Bolsonaro does not permit compulsory treatment in TCs, some of those institutions have operated as if they were fully staffed clinics. Under these circumstances, a substantive right to health becomes a dangerous instrument in the hands of litigants if TCs are absorbed into the health system or licensed as a full health service. In the absence of public contracts with TCs, judicial orders may finance the expansion of those private entities in areas with deficient access to a public mental health system. Moreover, the growth of litigation in Brazil has shown to bear some relation to an increase in the usage of private providers of substance disorder treatments. For instance, in the state of Espírito Santo, expenditures on compulsory treatment orders between 2015 and 2019 have increased from R\$13 million to R\$39 million, of which almost all resources went to private institutions (41.6% of them being established after 2011).<sup>32</sup>

#### *Lack of a legal culture sensitive to persons with substance disorders*

Not only is the legal framework in Brazil inadequate in recognizing patients’ autonomy, but it is also coupled with a widespread disinterest across the legal community about themes such as consent and ethics. One plausible reason for the limited recognition of patient guarantees in Brazilian judicial practice is that this matter has been largely overlooked by legal scholarship in Portuguese. Brazilian legal doctrine and course textbooks primarily address medical law as the sole study of liabilities in health care malpractice.<sup>33</sup> Only recently have authors promoted the concept of “human rights of the patient”

(as proposed by Albuquerque) or bioethics and law manuals to examine basic provisions of autonomy and consent not yet adopted by legislation.<sup>34</sup>

To a degree, it is at least contradictory that a country with more than three decades of a Constitution establishing a right to health consistently enforced by courts has never fleshed out a comprehensive set of rules for patients’ freedoms. This demonstrates that the constitutional right to health in Brazil has been successful only in setting forth substantive care provisions (access to health) but not in stipulating minimal procedural conditions acknowledged in the legal community.

Additionally, there are signs of a lack of referential background beyond public law in Brazil to discuss appropriate guarantees in compulsory treatments. Some studies refer back to other constitutional provisions, but since the right to health as constitutionally defined does particularize individual guarantees, this level of analysis is insufficient to determine the nature of state obligations.<sup>35</sup> References to principles in international law are also vague, and even domestic human rights institutions do not specify the nature of those obligations.

This seeming unfamiliarity or unawareness can be also seen in Brazil’s highest courts. In 2016, the Brazilian Supreme Court heard a case on whether the prosecution authority had a legal standing to apply for court orders for compulsory treatment of a person with alcohol dependence on the grounds of the right to health.<sup>36</sup> The municipal government had challenged the legal competence of the Public Prosecutor’s Office to request compulsory treatment for this patient on behalf of the family, after the local authority failed to provide the compulsory admission.

The legal question referred to the court was whether the request at issue should have been filed instead by public defenders or the family. What ensued was a discussion of the nature of the rights in compulsory treatments—the individual, the family, or the society. This judgment is symptomatic of the hazy conception of individual rights versus public health powers, anti-drug policies, and access to health care.

Justice Carmen Lucia wondered how there

could be legitimacy in the public prosecutor taking legal action on behalf of society if that process would outstrip the person's "individuality" or human condition by imposing a treatment against their will. In her dissenting vote, she "cherished" the fact that today's patients are compulsorily treated based on individual rights. She noted, however, that "public prosecutors can find tomorrow that a certain disease causes certain harm, they lodge a case and one patient commitment follows."<sup>37</sup> "What is at play is not a patrimonial question, but a health as a major concern, to the extent that it harms the safety of third parties (the family)," replied Justice Marco Aurelio.<sup>38</sup> This comment conforms to the type of balancing reasoning that plays individual patient rights against the family's well-being.

Ultimately, the judgment was deliberated on procedural grounds, not patients' procedural rights. The order could have been requested solely by the family or a public defender, given that there was no "matter of public interest." Nothing was said about patients' procedural rights; the court's reasoning lay somewhere between the collective and individual, accepting the family and the public defenders as the legitimate parties. The circumstance was relegated to the private sphere, but the court never fully examined whether preserving patient autonomy and procedural rights were "a matter of public interest" in themselves (to warrant public prosecution intervention), as a fundamental constitutional obligation.

### *Judicialization as part of a repressive program*

A potential risk to patients is public interest actions pursued by public authorities determined to eradicate persons with substance use disorders from public spaces. However, those claims are still rare and have been successful in bringing media attention to the need for minimum procedural guarantees for persons with substance use disorders.<sup>39</sup> In 2017, the São Paulo municipal administration sought a collective judicial warrant for the compulsory admission of an indeterminate number of persons with substance use disorders in the "Crackland" ("Cracolândia") region, an area of town used as an open-air drug space for hundreds

of people.<sup>40</sup> Focused more on restoring urban safety than the appropriate means for rehabilitation, the application was rejected by the São Paulo State Court. No right to health argument was made in the judgment dismissing the application.

However, one of the reasons to deny the motion was the lack of procedural guarantees, as the intervention did not ensure individual legal representation of all persons in custody. The court would need to serve several detention orders and force medical checks on homeless people and minors to then confirm the need for compulsory treatments.

A second noteworthy reason was that the municipal government lacked legal standing for that particular lawsuit. It is interesting to note that the initial lawsuit was an entirely different class action filed by the public prosecution seeking damages for police abuse in a raid of the area in 2012, where dozens of people were submitted to violence and illegal detentions.<sup>41</sup> In the original claim, human rights were articulated but very generically and with no reference to the right to health or patient autonomy.

This approach confirms that public authorities in Brazil may struggle to bring together human rights standards, ethics, and patient procedural safeguards. Even by seeking to protect human rights principles, there is no direct mention of minimum standards for patients with substance use disorders, such as participation in their health care plan. Thus, right to health decisions in Brazil are more likely to be driven by families and oriented toward forced treatments than structural litigation to change public health policies and mental health practice at a population level. This pattern has been raised by Octavio Ferraz in his discussion of the judicial interpretation of the right to health in Brazilian courts, where private actions are more determinant than collective claims.<sup>42</sup>

### **Conclusion: More dilemmas and future questions**

The present findings suggest that the Brazilian constitutional right to health, as applied in the jurisdiction of the state of São Paulo, does not automatically contribute to a well-established



framework of procedural guarantees for persons with substance disorders who are ordered compulsory treatment. The current approach of judges, as demonstrated through recurrent and uniform decisions, has shown a large misinterpretation of the right to health, focused only on the provision of care as a substantive and automatic entitlement, without considering patient preferences or informed consent as part of the obligations of such a right in mental health practice. More importantly, the combination of an easily enforceable substantive right to health with weakly observed patient autonomy can be harmful to individual rights if wielded indiscriminately by families, as indicated by the decisions studied. For other countries, a lesson that may be heeded is that a domestic recognition of the right to health in law may not be sufficient to guide judicial standards for compulsory treatments of patients lacking capacity.

In Brazil, the neglect of procedural guarantees in the judicial discourse is particularly concerning in light of a repressive policy and intolerance toward persons with substance use disorders, which allow families to directly access services from treatment providers willing to perform a repressive role based on faith and ideology.

Although there are legitimate reasons and safety needs argued by some families, these circumstances may potentially turn courts into a compulsory apparatus artfully employed by bad-intentioned litigants in league with treatment providers moved by economic, religious, or political interests in a country with a rampant detention culture. Further qualitative research is needed to narrate the individual experience of patients in these judicial processes and describe the extent to which they were involved in the treatment decision, whether they could have had a less restrictive measure, or whether they could have refused their admission. As it currently stands, the documentation does not allow for assessing those facts.

The substantive enforcement of the right to health in Brazil and the potential negative effects of mental health policies for persons with substance disorders cannot be read beyond the scope of those decisions. The findings here are no reason to call

into question the effectiveness of the right to health in other jurisdictions or the effectiveness of socioeconomic rights' implementation by other courts. Legal reasoning and rights enforcement may vary in Brazil depending on the public health policy in question (see, for instance, the valuable invisible use of the right to health in courts to increase sanitation services).<sup>43</sup> More positive and comprehensive public health developments may have been promoted by judicialization in other areas, requiring independent studies and other methods to track the impact of the positive right to health.

That said, the litigation described here may very well cause substantial de-prioritization of the full provision of care beyond in-hospital or residential programs. At the outset, this study made clear that it would not aspire to perform a quantitative analysis, such as that used to determine the economic cost of access-to-medicine litigation. However, considering the stance taken by courts to grant compulsory treatments, there is reason to suggest that the basic formula of health care litigation (a readily accessible right to health in courts by families) may point to similar directions in public spending.

Yet, to prevent unnecessary compulsory treatments, public policies must address resource issues in the mental health system. Brazil's legal framework is strikingly mindful of the need for adequate resources to respect patient decisions. It sets out that compulsory treatment is permitted only if "extra-hospital resources are proven to be insufficient."<sup>44</sup> In reality, the rule means that forced therapy is a last-resort resource, but if there are not many public resources available for alternative treatments, the scope of the patient's decision and the burden to prove that a compulsory treatment is the last possibility is lower.

As mentioned earlier, therapeutic communities, particularly in the religious sector, are historical promoters of compulsory services and have limited capacity for integral care. Public health expenditure on other forms of community services in Brazil was reduced between 2010 and 2019, and much of the funding is now being directed to religiously led community groups that do not follow international

best practices or evidence-based treatments.<sup>45</sup> A reform of Brazil's mental health services would need a whole new direction, putting patient preferences and autonomy at the center.

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