

# Expenditures on compulsory hospitalizations due to drug use in the state of Espírito Santo

*Gastos com internações compulsórias por consumo de drogas no estado do Espírito Santo*

Fabiola Xavier Leal<sup>1</sup>, Maria Lúcia Teixeira Garcia<sup>1</sup>, Mirian Cátia Vieira Basílio Denadai<sup>1</sup>, Lara da Silva Campanharo<sup>1</sup>

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**ABSTRACT** Compulsory hospitalization due to drug use has been questioned in the Mental Health Policy and expresses the struggle between the principles of Unified Health System (SUS)/Psychiatric Reform versus the private interests about remanicomialization. This paper analyses expenditures on compulsory hospitalizations due to drug use carried out by the State Health Secretariat of Espírito Santo (ES) between 2014 and 2019 and aims to identify its allocation. It outlines brief reflections on the right to health and the disputes over public funds. This is documentary research with data gathered from the ES Transparency Portal. Descriptive statistical analysis and categoric content analysis were used. The data show disputes over public funds and that this is not a transparent process to society. The struggles between the Executive and the Judiciary over the right of access to health treatment are points that must be discussed.

**KEYWORDS** Mental health. Public expenditures on health. Cost transparency.

**RESUMO** A internação compulsória pelo consumo de drogas vem sendo problematizada no campo da política de saúde mental e expressa a luta entre os princípios do Sistema Único de Saúde (SUS)/princípios da Reforma Psiquiátrica versus os interesses privados de remanicomialização. O artigo objetiva analisar os gastos com internações compulsórias por consumo de drogas realizadas pela Secretaria de Estado da Saúde do Espírito Santo (ES), entre 2014-2019, buscando identificar a sua destinação. Apresenta breves reflexões sobre o direito à saúde e a disputa pelo fundo público. Trata-se de pesquisa documental com levantamento de dados no Portal de Transparência do ES. Foram utilizadas a análise estatística descritiva e a análise de conteúdo categorial. Os dados evidenciam as disputas pelo Fundo público e que isso não é um processo evidente para a sociedade. Os embates entre Executivo e Judiciário em torno do direito de acesso ao tratamento da saúde são pontos que precisam ser problematizados.

**PALAVRAS-CHAVE** Saúde mental. Gastos públicos com saúde. Transparência dos gastos.

<sup>1</sup>Universidade Federal do Espírito Santo (Ufes) – Vitória (ES), Brasil.  
fabiola.leal@ufes.br



## Introduction

Compulsory Hospitalization (CH) has been discussed in the mental health policy globally, in Brazil, and Espírito Santo (ES)<sup>1-4</sup>. Sometimes stated as something new, compulsory hospitalization is an old phenomenon. According to a text by the European Commission – Health & Consumer Protection Directorate-General<sup>5</sup>, the involuntary or compulsory hospitalization of people in mental suffering is cited and has involved legal and ethical debates for over a century. What appears more recently is the CH of people under the justification of drug use.

While there are different definitions of forced or compulsory psychiatric treatment, this term is often used when people undergo medical treatment against their own will. The theme is recognized in the national and international legislation, discussing the right to health from the perspective of human rights. In this sense, psychiatry is a clear exception because other medical fields generally do not allow forced treatment. The types of forced treatment of people vary and do not only occur in hospitals – some may be forced to take psychoactive substances in other institutions, including their own homes. Compulsory treatment can be defined as an action that, in theory, would increase the probability of people starting and remaining in treatment<sup>6</sup>. The rules for applying what has come to be called ‘treatment’ vary from country to country. The Court orders these measures based on the assessments of general medical professionals. More than one opinion is required in some countries, and in others, just one is enough. Also, CH often involves conflicting perspectives: some indicate hospitalization – health professionals and the Judiciary – and others are the target of the action and will have their freedom limited by hospitalization. People undergoing coercive treatment experience it as a severe limitation on their freedom. Many people feel threatened

by decisions made about their lives without their consent. According to Lunze et al.<sup>1</sup>, in most legal systems, the basis of mandatory treatment is the presumption that the individual in question represents a risk to himself/herself or others.

Global evidence indicates that mandatory hospitalization for what is called ‘drug addiction’ conflicts with the human rights of people who use drugs and is not effective when talking about a possible ‘treatment’<sup>2</sup>. In a literature review, these authors highlight that there is no “[...] scientific literature evaluating compulsory drug treatment”<sup>2(2)</sup>, and add:

given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms<sup>2(2)</sup>.

Advocating for this procedure continues despite the lack of evidence of its efficacy and effectiveness. In legal terms, hospitalization without the patient’s consent is provided for in the Brazilian Psychiatric Reform (RP) Law N° 10.216/2001<sup>7</sup>, according to articles 4, 6, and 9, provided that it is indicated when extra-hospital resources are insufficient, in any of its modalities. This Law defines compulsory hospitalization as determined by the Court and is different from involuntary hospitalization (which takes place without the user’s consent and at the request of a third party)<sup>7</sup>.

Coelho and Oliveira<sup>8</sup> alert that how these hospitalizations have been required violates the constitutional principles of human dignity and health, which are also considered fundamental human rights. Considering that law science is grounded on the principle of legality, especially concerning deprivation of liberty, CH is determined only for cases provided for in the Brazilian legislation in force. In other words, it must be based on the hypotheses of the Criminal

Enforcement Law (LEP) (art. 99 to 101)<sup>9</sup> and the Penal Code (art. 96 and 99, wording given by Law N° 7.209)<sup>10</sup>. These articles address the CH of ‘patients with mental illness’ when they commit an act defined as a crime by criminal Law. In such cases, they will be transferred to custodial hospitals instead of being sent to prison<sup>8</sup>.

However, suppose the elements from the war on drugs are brought up (temporally demarcated at the beginning of the 19th century and reconfiguring itself throughout the 20th and 21st centuries)<sup>11</sup>. In that case, it can be said that the reasons for this public to become targets of compulsory hospitalizations are the most diverse and encompass different interests. Two main discourses stand out: that of the medical-legal statute, which strengthens the biomedical model as the primary scientific paradigm, with a specific conception of the body devoid of its social, cultural, racial, and gender determinants<sup>12</sup>; and the moral-legal discourse, which presents the faith-mediated strategy as an alternative to overcoming. From this perspective, we observe a growing movement of psychiatric clinics that stand as alternatives to the difficulties in accessing places in the public system. In the Brazilian case, this discourse occurs in expanding Pentecostal churches – the main organizers of Religious Therapeutic Communities (RTCs).

Here, the growth and strengthening of two types of institutions stand out in the context of remanicomialization of the National Mental Health Policy underway in the country, which is part of a general project to dismantle the Unified Health System (SUS)<sup>13</sup>. Thus, the thesis that the expenses with CH of drug users express in themselves the struggle between the principles of the public and universal SUS and those of the Brazilian anti-asylum PR versus the private interests of remanicomialization is advocated.

This text presents reflections articulating the institutions that carry out CH, the right to health, and the dispute for public

funds to decipher this phenomenon. Then, the methodological procedures and the analysis of expenses with CHs in ES will be presented. Therefore, this paper aims to analyze the expenses with compulsory hospitalizations due to drug use carried out by the State Health Secretariat of Espírito Santo (Sesa) from 2014 to 2019 to identify its allocation. Or, as in the words of Gilson Carvalho<sup>14</sup>, the question is: where does the CH money go in ES?

We start from the thesis that, on the one hand, there is a dispute between those who defend PR with the offer of care by the SUS for harm reduction and those who advocate for hospitalizations focused on abstinence. On the other hand, we observe disputes in the very field of these private institutions. In other words, psychiatric clinics compete for funding with the Therapeutic Communities (TCs), and both have allies and supporters in the three spheres of government and several non-governmental associations.

## Private institutions for compulsory hospitalization and competing for public funds

The TCs in Brazil have pressured the State to access public funds<sup>15</sup>, supported by an evangelical bench<sup>16</sup> in the National Congress<sup>17</sup>. The establishment and strengthening of these fronts and federations occurred in the context of the Dilma government (first and second mandates), which defended the idea of a crack ‘epidemic’, reinforcing the moral and conservative discourse.

The Brazilian Psychiatric Association (ABP) is also active in this regard. It advocates the lack of scientific evidence of the effectiveness of the type of treatment offered in RTCs but defends a traditional perspective centered on the biomedical model. That is, the action of the TCs is not

due to the lack of scientific proof of the proposed ‘treatment’ they promote, but, above all, competing for public resources, so that, around abstinence – defended by TCs and the ABP –, what differentiates them is the explanatory discourse of the phenomenon adopted by each one.

Also, the ‘new’ Drug Law 2019 (Law N° 13,840)<sup>18</sup> considered only two types of hospitalization in art. 23A (§ 3): voluntary and involuntary. It does not employ the word ‘compulsory’ in the text. However, it maintains the idea that this second modality – involuntary – takes place without the person’s consent, at the request of a family member or legal guardian or, in the absolute absence of this, a public servant in the field of health, social assistance, or public agency that are part of the National Drug System, determining how it should take place (§ 5). This law prohibits any hospitalization in TCs (§ 9)<sup>6</sup>. In other words, these regulations signal the Brazilian government’s stance on the issue through several prerogatives, including the non-liberation of any drug in the country, the CH of chronic users, and stricter punishment for small traffickers.

Since Law N° 11.343<sup>19</sup>, which is still in force (even with some repeals and amendments by Law N° 13.840/2019<sup>18</sup>), care and social reintegration of drug users and dependents could be carried out both by SUS services and by private institutions and non-profit civil society organizations (art. 3). In other words, these institutions, such as TCs and psychiatric clinics, became eligible for public subsidies, such as fiscal and financial benefits (art. 24).

There is evidence of a diachrony in the direction of the policies implemented by the Brazilian State in mental health, and, even with the expanded public system, the private sector is preserved as a supplement, so institutions’ dispute for public funds<sup>20</sup> is escalated and could lead to the underfunding of the Psychosocial Care Network (Raps) services. This is because the public

fund plays an active role in macroeconomic policies and is essential for productive accumulation and social policies, particularly social security. Thus, it has a relevant role in keeping capitalism in the economic sphere and ensuring the social contract<sup>21</sup>.

The financing of Brazilian mental health is far from reaching the goal proposed by the World Health Organization (WHO) (5% of the general health budget)<sup>22</sup>. Furthermore, the Ministry of Health (MS) informs that the existing service network covers 72% of the field’s demand<sup>23</sup>, leading to the denial of the principle of universal access daily. This historic health policy (and mental health) underfunding undergoes a new inflection: Constitutional Amendment 95, which imposes health underfunding<sup>24</sup>, with a freeze on social spending for 20 years. Thus, this context of intense attacks on social rights only exacerbates the contradictions and the deleterious effects of the crisis of capital, which affects more explicitly some layers of the working class.

People who use drugs and demand intervention in health are part of this setting. In many cases, CH is offered to them, which is consolidated as the main alternative, showing an invisible dimension of drug consumption, not always easy to be identified outside the walls of the services that perform this procedure or Judiciary rooms. This amazement today at the so-called growth of these CHs is the partial visibility they currently assume. Partial because it is subsumed that the logics of capital, its predatory and limitless expansion, must be deciphered, discovering and understanding these barbaric times<sup>25</sup>.

The right to health implies the offer of health care services and supplies. It is a social right and encompasses the individual and group dimensions for its realization. This right to health is recognized and related to human dignity, so that its incorporation into laws, public policies, and jurisprudence also reflects the tensions and perceptions

about the definitions of health and disease, how this should be achieved, the rights of the population, and the responsibilities of the State<sup>26</sup>. In the Brazilian reality, the right to health is expressly provided for as a social right under the 1988 Federal Constitution, in art. 196<sup>27</sup>, according to the expanded concept of health formulated by the VIII National Health Conference held in 1986<sup>5</sup>.

In this setting, the legal demand in the health field reflects an attempt to approach or implement an aspect of this right, which is access to the material means to achieve it<sup>28</sup>. Far from intending to exhaust the theme, we recognize that the term ‘judicialization’ is polysemic<sup>29</sup>, and here we seek an approximation with the debate on the right to health and the judicialization of life when the object in question is mental health. However, the reflection is not exhausted in this debate. It requires understanding the practical consequences of judicial decisions on individual demands and how the Court has sought to define which values currently contextualize the right to health<sup>30</sup>.

In this attempt, under the argument of preserving drug users to ensure their health, CH has been the primary justification pointed out by both the Judiciary and health professionals. However, as highlighted by Ventura et al.<sup>28</sup>, the expansion of this role of the Justice System affects the life of individuals targeted by the measure and management. There is a risk of developing the legal route as the primary means to secure access to ‘treatment’ and, in this sense, causing significant damage to the (individual and collective) effectiveness of the right to health<sup>31</sup>.

One element of this transition from health to the right to health is that the latter involves the satisfaction of an individual or private dimension. Individual, in the sense of respecting subjectivities, personal rights, and freedoms; and collective, in the sense of ensuring that this individual well-being has an acceptable cost to society. In other words, when trying to reconcile individual and group interests

based on the fulfillment of the State’s duties to protect the health of all, restrictions on the freedom of some may be necessary to achieve a specific collective good or social interest. The controversial issue in this conjunction is the legitimacy of the norm that restricts individual freedom, correlated to the idea of what is meant by a fair law. When relating to the Executive Branch, demanding that it comply with a certain measure, the Judiciary has caused a strong tension on the Judiciary’s legitimacy and technical or legal-institutional competence to decide on how the Executive of health must fulfill its task<sup>28</sup>. This comes with the grievance that the Judiciary, in general, is limited to determining compliance with the measure indicated by the claimant, supported by a medical prescription.

In general, this discussion has been carried out in several studies on the judicialization of health, highlighting those that emphasize the adverse effects of this type of demand in the management of health policies. This type of intervention in the SUS would allegedly deepen inequalities in access to health, favoring specific segments and individuals over others, while individual needs or specific groups would be met at the expense of the needs of other groups and individuals<sup>32-34</sup>. Other studies<sup>35</sup> point out the deficiencies and insufficiencies of the Brazilian Health and Justice systems to respond satisfactorily to the new and growing health demands. However, in the perspective adopted in this paper, the phenomenon involves other political, social, ethical, and health aspects, which go far beyond the legal and management, and governability component of public services. This debate must be conducted considering the principles of comprehensive care, universal access, and bioethics, so dear to the SUS.

The Judiciary Branch has been concerned with this phenomenon and has proposed some measures to debate and address health judicialization<sup>36</sup>, highly motivated by the demands for high-cost medicines. The current legal debate harbors different positions on the

effectiveness of the right to health and on the analysis of the possible action by the Judiciary in determining measures to be followed by the SUS. We can highlight some as follows: a) one position understands that the effectiveness of this right should be restricted to services and supplies available from the SUS, determined by the public manager; b) another argues that the right to health implies a guarantee of the individual's right to life and physical integrity, and the Judiciary should consider the absolute authority of Medicine, which issues its opinion in the lawsuit; c) and the third position understands that the effectiveness of the right to health should be as broad as possible, and the Judiciary should consider rights, assets, and interests at stake, in order to establish the content of the provision owed by the State<sup>28</sup>.

This third position, argues Leivas<sup>37</sup>, is the most adequate to the understanding between Health and Law in the search to secure the citizen's access to justice and health. In this case, the judge should consider several aspects, such as whether the therapeutic alternatives offered by the SUS can meet the needs of those who demand it and whether the individual medical prescription required, compared to what is available in the SUS, is supported by scientific evidence. This position seems to be the most appropriate for other authors and can be conducive to reducing the legal demand itself. It is based on a false idea of a crack use epidemic that the court decisions of the hospitalizations addressed here are justified.

If there is an understanding that the consumption of psychoactive drugs is cultural, the reasons for this use are attributable to several social needs. These reasons are socially determined and transform the way individuals relate to different psychoactive substances, changing their meaning and consumption patterns. Therefore, this use can occur in different ways: associated with scientifically proven indications; arise from self-administration; be sporadic; specific; recreational; or harmful. Thus, these distinctions (most commonly referred to as

'use and abuse') will not be addressed in this article. However, it is necessary to consider that the 'harmful or non-harmful use' of psychoactive drugs results from interactions involving the substance, the individual, and the particular social conditions. By dualizing what is licit and illicit, the drug prohibition paradigm prohibits individuals from their consumption through prejudice and stigma, focusing on excessive repression of drugs (and the subjects relating to them), regardless of the relationship of individuals with drugs and assuming that there is a demand for interventions in any situation. Conversely, by harm reduction (grounded on the SUS), we have the principle of respect for drug users for the right to their consumption of drugs. This right is sometimes protected in the legislation in force, even in cultures where the legislation in force does not prohibit the individual from the personal use of any product or substance, even if they are supposedly harmful, as in the case of the Brazilian legislation and many other countries<sup>38,39</sup>.

Therefore, in this normative context (which is related to a particular conception of this drug use), it is appropriate to question whether the population, when accessing the Judiciary and inflating the Executive with excessive demands for CH, generates inefficiency to management or whether these managements are previously inefficient when it comes to offering Raps services, although this alone is not the only determinant, and whether this phenomenon in mental health, in particular, due to the issue of drugs, can be considered as a legitimate resource for closing the gap between access to health rights or has been a resource that ends up violating other rights.

## Methods

This is documentary research with a survey of data available on the Espírito Santo Transparency Portal<sup>40</sup>, a tool developed in

2009 to disseminate the public data necessary for social control. Data referring to hospitalization payments for people who use drugs by court order were accessed on the portal – ‘beds for mental disorders and chemical dependence’. Hospitalization data were also

collected: length of stay, institution data, and the amount paid for each. As an ethical procedure, any data identifying the subject was preserved to guarantee the anonymity of these people. The regulations that instruct the CH at Sesa were also organized (*table 1*):

Table 1. List of Sesa's regulations on forced hospitalization in mental health/alcohol and drug beds, by year, government, and content. Espírito Santo, 2010-2019

Document	Year	Government	Content
Sesa Ordinance n <sup>o</sup> 237-R32 (revoked by Sesa Ordinance N <sup>o</sup> 32-R) <sup>28</sup>	2010	Paulo Hartung	Establishes that the Health Care Establishments must file the form established by Sesa to apply for the initial or the renewal of Health Licensing.
SESA Ordinance N <sup>o</sup> 155-R30 (revoked by SESA Ordinance N <sup>o</sup> 59-R, of 31/10/2017) <sup>27</sup>	2013	Renato Casa-grande	Regulates and establishes criteria for the functioning in the state territory of specialized clinics/mixed inpatient units that provide care services to people with biological impairment, mental and behavioral disorders, including those resulting from the use, abuse or dependence of psychoactive substances.
Sesa Ordinance N <sup>o</sup> 090-R <sup>29</sup>	2014	Renato Casa-grande	Defines the criteria for the hospitalization of patients in Specialized Clinics in the state of ES.
Sesa Ordinance N <sup>o</sup> 32-R <sup>28</sup>	2015	Renato Casa-grande	Provides for the health licensing of establishments/services of interest to health surveillance in the state of ES.
Sesa Ordinance N <sup>o</sup> 59-R <sup>27</sup>	2017	Paulo Hartung	Regulates and establishes criteria for the functioning of specialized inpatient clinics that provide care services to people with mental disorders and needs arising from the use of crack, alcohol, and other drugs in the state territory.
Accreditation Notice Sesa/SASS/Gecorc/NEC/N 006 <sup>26</sup>	2018	Paulo Hartung	Accreditation of private (profit and non-profit) institutions providing health services, interested in participating, in a complementary way, in the SUS of the state of ES (Article 24 of Law N <sup>o</sup> 8.080/1990).
Law N <sup>o</sup> 10.987 <sup>24</sup>	2019	Renato Casa-grande	Regulates procedures to be adopted by doctors and dentists linked to the SUS in the state of ES, in the prescription of medicines and the request for tests, health procedures, and forced hospitalizations that will be provided by Sesa.

Source: Own elaboration.

All this information was organized so that it was possible to identify the institutions that hospitalize, the amounts they received, the distribution by health region, the concentration in certain municipalities in ES, and how this is in line – or not – with existing regulations. As

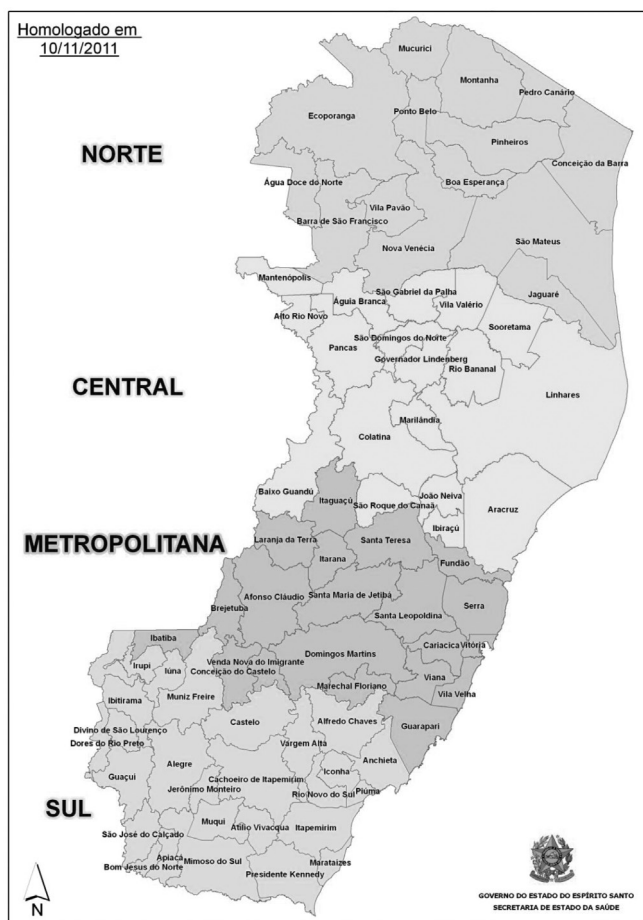
for the time frame (2014 to 2019), the choice was based on information from Sesa, which made available data on these admissions in the Secretariat's system only in 2014. Descriptive statistical analysis and categorical content analysis were used<sup>48</sup> to analyze data.

## Compulsory hospitalizations for drug use in the state of Espírito Santo: where does the money go?

ES has 78 municipalities, primarily small ones, that have been organizing the RAPS in the four health regions (Metropolitan, North, Central, and South) (figure 1)<sup>49</sup>, according to SUS guidelines/norms. However, there is still disproportionality of actions

and services in these health regions, as shown by previous studies<sup>50-52</sup>. In the case of spending on judicialization, these resources are not included in the Annual Health Plans or the Annual Budget Laws (LOA) of the state of ES. Sesa's funds for this judicialization are identified as Source 010400000, Health Actions and Services (0104), Activity 20.44.901.10302.00474705. Between 2015 and 2018, 40,000 cases were received, and R\$ 350 million were spent on health judicialization in ES<sup>53</sup>.

Figure 1. Master Plan for Regionalization of the State Health Secretariat with the Health Regions of the state of ES



Source: Transparency Portal<sup>40</sup>.



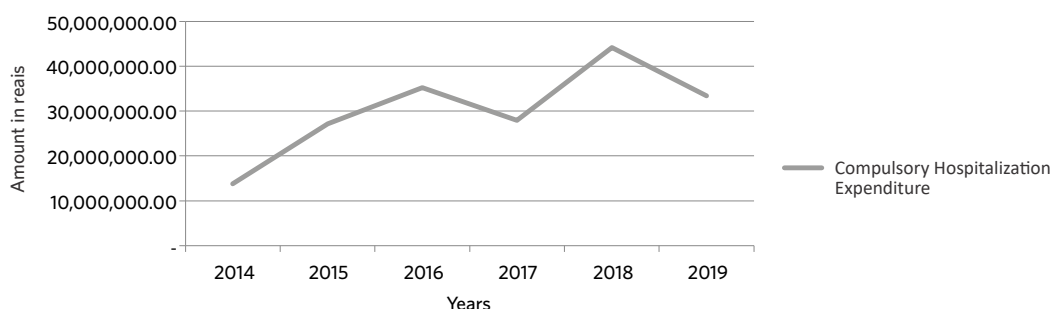
The ‘Sesa 2015-2018 Management Report’<sup>53</sup> presents an item, ‘Health Judicialization’, highlighting that this phenomenon has distorted the republican principles of equity in the SUS<sup>47</sup>. This item imposes unscheduled care costs on the manager, higher administrative costs to manage deadlines, and the legal burden of Court decisions. The situation is a matter of concern for state health, and although funding data are not detailed in the Report, 40 people were recruited in four years to join a sector that only addresses court orders<sup>47</sup>. Another aspect is the number of processes, and although the allocation is not specified, approximately 35% of R\$ 350 million was allocated to CH.

The Secretariat implemented a set of actions in the definition of regulations for the accreditation of private institutions (Ordinance N° 090-R and N° 59-R)<sup>44,45</sup>

aimed at the CH of drug users, from 2014 to 2019. No admissions to TCs and prioritizing accredited clinics were among the targeted actions. CH outside the SUS network would only be justified by ‘the lack of beds to meet the patient’s needs and the insufficient or depleted installed capacity in the SUS network’ (justification found in CH processes).

Regarding the CH data from 2014 to 2019 (six years), the expenditure jumped from around R\$ 13 million (with a deflated value of around R\$ 19 million) to R\$ 39 million (with a deflated value of around R\$41 million) (*graph 1*). These data were accounted for considering the sub-element of expenditure Code 4681 – Health sector Court orders – beds for mental disorders and chemical dependence. In other words, it also contains hospitalizations for alleged mental disorders unrelated to drug use.

Graph 1. CH expenditure for drug use per year (2014 to 2019) in the state of ES



Source: Own elaboration based on the Espírito Santo State Transparency Portal in 2019<sup>40</sup>.

Note: Values deflated for April 2020 by the IGP-M (FGV), using the citizen calculator.

All resources refer to the purchase of beds in private institutions, whether non-profit or not, except for one public institution (Association of SE Public Employees), which received around R\$ 25,000 in just one

year (2015). These resources derive from the Comprehensive Health Care Program as a complementary assistance action to the public network. Therefore, all payments are justified by the Court rulings with a tender

waiver, with the State Health Fund as the managing unit, from Source 104 (Health Actions and Services). Sesa has information about the beds available in existing private institutions and starts to buy these beds, considering that the Court orders generally establish a reduced period (around 24 to 72 hours) for the manager to meet the demand. This search must be done by the regulatory professional (doctor) when the SUS does not have an available bed, and he is responsible for judging and deciding on each case (Ordinance N° 2.048/2002/MS)<sup>54</sup>.

As for the amounts paid for hospitalization, although regulation has been in place since 2013 on the operating criteria for institutions, the amounts were regulated

only in 2018 through an accreditation notice (*table 2*). Before this, payments were made with different daily rates based on prices presented by institutions available in the market. Even with the regulation of daily rates from 2018, a persistent contradiction has always been brought about: the length of time people were hospitalized in these institutions contradicts the regulations on the length of stay. One of the institutions analyzed as an example (which received resources for four years), 72% of the 172 people admitted as CH stayed at some point for more than 60 days during their hospital stay, and we had some people whose stay reached a year uninterruptedly.

Table 2. ES State Health Secretariat CH regulations

Document	Daily rate	Number of beds	Maximum hospitalization time
SESA Ordinance N° 155-R/201330 (revoked)	Did not establish	Did not establish	Maximum two months
SESA Ordinance N° 090-R/201429	Does not establish	Does not establish	Maximum two months, with the possibility of a justified extension, for another month, totaling 90 days of hospitalization
NoticeSesa/SASS/ Gecorc/NEC/ N°006/201826	* 1-60 days - R\$ 398.00 * 61-90 days - R\$ 318.40 After 60 days of hospitalization, the daily rate will correspond to 80% of the initial value.	Maximum two months, with the possibility of a justified extension, for another month, totaling 90 days of hospitalization	Maximum two months, with the possibility of a justified extension, for another month, totaling 90 days of hospitalization

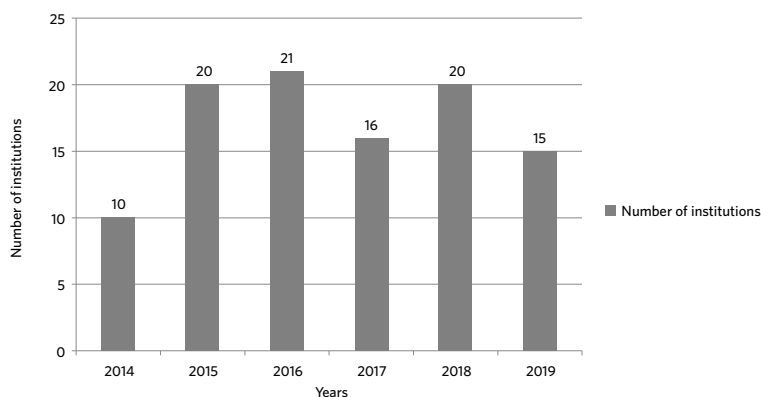
Source: Own elaboration.

\* Daily hospitalization rate per number of hospitalization days.

As for the allocation of resources, 36 institutions received for CH in this period (*graph 2*),

and four of these received it every year.

Graph 2. Number of institutions that received CH funding per year (2014 to 2019) in the state of ES



Source: Own elaboration based on the Espírito Santo State Transparency Portal in 2019<sup>40</sup>.

About the percentage received by each of these institutions, of the 36 institutions, six stand out for receiving the highest portion funds in this period, which corresponds to more than half (59.6%) of the resources used for CH, and they are: Espaço Vivere Saúde (16.9% of funds); Espaço Viver (9.7%); Instituto Nova Aliança (9.6%); Green House Clinic (9.6%); Vitale Clinic (7.4%); and Life Recovery Center (6.0%). The first differed from the others as it received more funds for four years (2014, 2017, 2018, and 2019) – BRL 31,078,802.95. This institution, called Espaço Vivere Saúde LTDA, is located in the municipality of Anchieta, in the south of the state, and its partner-owners are entrepreneurs from other branches in ES. They are also part of an Association of Psychiatry Clinics in the state of ES, created in 2019. The clinic has a branch – Clínica Vivere Infância e Juventude – in the same municipality that received funds in 2014 and 2019, totaling R\$ 36,450,943.10, which corresponds to 19.4% of the total expenditure.

As for the location of the 36 institutions, only one is located outside ES (in São Paulo – Hospital Santa Mônica, which received an appeal in 2016 for the admission of two adolescents). Distribution by health region was as follows: 62.8% in the Metropolitan region, 34.3% in the South region, and 2.9% in the

North. The concentration in the Metropolitan region ratifies previous studies<sup>50,51</sup>.

Regarding the year these Clinics were founded, 41.6% were created after 2011; 19.4% emerged between 2000 and 2010; and 11.1% were established before the 2000s. This information was not found for the others. The emergence of new institutions follows the rise of state payment by judicial measure. This phenomenon is not isolated from the country's social, cultural, and political situation, a time when the appeal, especially in the media, presents hospitalization as the primary means of 'minimizing family problems' caused by drug use. Also, the SUS network, which is not fully implemented in the territories, marks a void of services in various state regions.

## Final considerations

The data showed the disputes over the public fund without necessarily making this process evident to society. Monitoring the expenditure of public health policy resources with CH exposed the clashes between the Executive and the Judiciary regarding the right of access to health care. The disputes between the State Mental Health Coordination actions for the regulation of this process and the limits that

this imposes on Secretariat technicians were also highlighted. Despite the efforts made by Sesa's mental health sector to minimally regulate these processes, whether by the amounts paid for daily rates, or by the technical opinions of the Secretariat's professionals, or by regulating a maximum length of stay, among other measures, we note that the gaps between what should be done (ensuring compliance with legal regulations) and what actually occurs traverse varied and complex dimensions, which transcend the norm itself and the attributions of those who should have a certain amount of control to regulate, apply, and monitor this compliance. Also, oversight bodies, such as the Public Prosecutor's Office and public policy management councils (such as health and drugs), do not even reach information about what is happening in this

network parallel to the SUS. This analysis, therefore, indicates the need to maintain this monitoring based on new questions such as the arguments used by the Judiciary Branch to ratify CH requests; the impact of the use of the resources for the SUS more comprehensively; reflections on 'manicomialization' in mental health as argued by drug use in society, among many other questions that the phenomenon contains.

## Collaborators

Leal FX (0000-0003-1309-0909) \*, Garcia MLT (0000-0003-2672-9310) \*, Denadai MCVB (0000-0003-0713-9382) \* and Campanharo LS (0000-0002-9286-5874) equally contributed to the elaboration of the manuscript. ■

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## References

1. Lunze K, Idrisov B, Golichenko M, et al. Mandatory addiction treatment for people who use drugs: global health and human rights analysis. *BMJ*. 2016; (353):i2943.
2. Werb D, Kamarulzaman A, Rafful C, et al. The effectiveness of compulsory drug treatment: a systematic review. *Int J Drug Policy*. 2016; (28):1-9.
3. Bardi G. Entre a cruz e a caldeirinha: doses diárias de alienação nas comunidades terapêuticas religiosas [tese]. Vitória: Universidade Federal do Espírito Santo; 2019. 343 p.
4. Santos CCM, Leal FX, Jesus RS. Política Sobre Drogas no Estado do Espírito Santo: consolidando retrocessos. *Textos Cont*. 2016; (15):423-436.
5. European Union. Compulsory Admission and Involuntary Treatment of Mentally Ill Patients. Legislation and Practice in EU-Member States [internet]. Mannheim: European Commission; 2002. [acesso em 2019 dez 15]. Disponível em: [https://ec.europa.eu/health/ph\\_projects/2000/promotion/fp\\_promotion\\_2000\\_frep\\_08\\_en.pdf](https://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf).
6. Leukefeld CG, Tims FM. Compulsory Treatment of

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\*Orcid (Open Researcher and Contributor ID).

- Drug Abuse: Research and Clinical Practice. NIDA Research Monograph. 1988 [acesso em 2020 mar 29]; (86):236-51. Disponível em: [https://www.researchgate.net/publication/20016323\\_Compulsory\\_treatment\\_A\\_review\\_of\\_findings](https://www.researchgate.net/publication/20016323_Compulsory_treatment_A_review_of_findings).
7. Brasil. Lei nº 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Diário Oficial da União. 9 Abr 2001.
  8. Coelho I, Oliveira MHB. Internação compulsória e crack: um desserviço à saúde pública. Saúde debate. 2014; 38(101):359-367.
  9. Brasil. Lei nº 7210, de 11 de julho de 1984. Institui a Lei de Execução Penal. Diário Oficial da União. 11 Jul 1984.
  10. Brasil. Lei nº 7209. Altera dispositivos do Decreto-Lei nº 2.848, de 7 de dezembro de 1940 – Código Penal, e dá outras providências. Diário Oficial da União. 11 Jul 1984.
  11. Lima RCC. Uma história das drogas e do seu proibicionismo transnacional: relações Brasil – Estados Unidos e os organismos internacionais [tese]. Rio de Janeiro: Universidade Federal do Rio de Janeiro; 2009.
  12. Barbosa RHS. Mulheres, reprodução e Aids: as tramas da ideologia na assistência à saúde de gestantes HIV+. [tese]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2001.
  13. Guimarães TAA, Rosa LCS. A remanicomialização do cuidado em saúde mental no Brasil no período de 2010-2019: análise de uma conjuntura antirreformista. O Social em Questão. 2019 [acesso em 2020 mar 7]; 22(44):111-138. Disponível: [http://osocialemquestao.ser.puc-rio.br/media/OSQ\\_44\\_art5.pdf](http://osocialemquestao.ser.puc-rio.br/media/OSQ_44_art5.pdf).
  14. Carvalho G. Gasto da união com saúde nos anos 1995-2012. 2013. [acesso em 2013 ago 19]. Disponível em: <https://darcisioperondi.com.br/gasto-da-uniao-com-saude-nos-anos-1995-2012-gilson-carvalho/>.
  15. Garcia MLT, Leal FX, Abreu CC. A Política Antidrogas brasileira: velhos dilemas. Psicologia e Sociedade. 2008; 20:267-276.
  16. Departamento Intersindical de Assessoria Parlamentar. Radiografia do novo Congresso. Brasília, DF, 2018. [acesso 2019 dez 19]. Disponível em: <https://www.diap.org.br/index.php/publicacoes/finish/41-radiografia-do-novo-congresso/4045-radiografia-do-novo-congresso-legislatura-2019-2023-fevereiro-de-2019>.
  17. Basilio-Denadai MC. O processo de formulação da política sobre drogas no Brasil pelo Congresso Nacional [tese]. Rio de Janeiro: Universidade Federal do Rio de Janeiro; 2015. 343 p.
  18. Brasil. Lei nº 13.840, de 5 de junho de 2019. Dispõe sobre o Sistema Nacional de Políticas Públicas sobre Drogas e as condições de atenção aos usuários ou dependentes de drogas e para tratar do financiamento das políticas sobre drogas. Diário Oficial da União. 5 Jun 2019.
  19. Brasil. Lei nº 11.343, de 23 de agosto de 2006. Institui o Sistema Nacional de Políticas Públicas sobre Drogas – SISNAD; prescreve medidas para prevenção do uso indevido, atenção e reinserção social de usuários e dependentes de drogas; estabelece normas para repressão à produção não autorizada e ao tráfico ilícito de drogas; define crimes e dá outras providências. Diário Oficial da União. 24 Ago 2006.
  20. Cislighi JF. Privatização da saúde no Brasil. Em Pauta. 2019; 43(17):60-73.
  21. Salvador E. Fundo público e seguridade social no Brasil. São Paulo: Cortez; 2010.
  22. World Health Organization. Innovation in deinstitutionalization: A WHO expert survey. Geneva; 2014.
  23. Garcia MLT, Oliveira EA. An analysis of the Federal funding for mental health care in Brazil. Social Work in Health Care. 2017; (56):1-20.

24. Mendes AN, Carnut L. Capital, Estado, Crise e a Saúde Pública brasileira: golpe e desfinanciamento. *SER Social*. 2020; (22):9-32.
25. Barroco ML. Barbárie e neoconservadorismo: os desafios do projeto ético-político. *Serv. Soc. Soc.* 2011; (106):205-218.
26. Dallari SG. O Direito à Saúde. *Revista Saúde Pública*. 1988; 22(1):57-63.
27. Brasil. Constituição, 1988. Constituição da República Federativa do Brasil. Brasília, DF: Senado Federal; 1988.
28. Ventura M, Simas L, Pepe VLE, et al. Judicialização da saúde, acesso à justiça e a efetividade do direito à saúde. *Physis Rev. Saúde Colet.* 2010; 20(1):77-100.
29. Carvalho ER. Em busca da judicialização da política no Brasil: apontamentos para uma nova abordagem. *Rev. Sociol. Polít.* 2004; (23):115-126.
30. Lima TM. O direito à saúde revisitado entre os ideais da Constituição de 1988 e o drama jurídico atual. *Rev. Inf. Legis.* 2014 [acesso em 2020 mar 20]; 51(202):181-201. Disponível em: <http://www2.senado.leg.br/bdsf/handle/id/503044>.
31. Marques SB. Judicialização do direito à saúde. *Revista de Direito Sanitário*. 2008; 9(2):65-72.
32. Marques SB, Dallari SG. Garantia do direito social à assistência farmacêutica no Estado de São Paulo. *Rev. Saúde Pública*. 2007; 41(1):101-107.
33. Vieira FS, Zucchi P. Distorções causadas pelas ações judiciais à política de medicamentos no Brasil. *Rev. Saúde Pública*. 2007; 41(2):214-222.
34. Chieffi AL, Barata R. Judicialização da política pública de assistência farmacêutica e equidade. *Cad. Saúde Pública*. 2009 [acesso em 2020 abr 25]; 25(8):1839-1849. Disponível em: <https://www.scielo.br/pdf/csp/v25n8/20.pdf>.
35. Messeder AM, Osorio de Castro CGS, Luiza VL. Mandados judiciais como ferramenta para garantia do acesso a medicamentos no setor público: a experiência do Estado do Rio de Janeiro. *Cad. Saúde Pública*. 2005; 21(2):525-534.
36. Dias ER, Silva Junior GBJ. Evidence-Based Medicine in judicial decisions concerning right to healthcare. *Einstein*. 2016 [acesso em 2020 jan 19]; 14(1). Disponível em: <http://www.scielo.br/scielo.php?script=sci-arttext&pid=S1679-45082016000100002>.
37. Leivas PGC. Princípios de direito e de justiça na distribuição de recursos escassos. *Rev. Bioética*. 2006; 14(1).
38. Conselho Federal de Serviço Social. O estigma do uso de drogas. *Série Assistente Social no combate ao preconceito*. Brasília, DF: CFESS; 2016.
39. Andrade TM. Redução de danos: um novo paradigma? In: Tavares LA, Almeida ARB, Alves Filho AN, et al. *Drogas: tempos, lugares e olhares sobre seu consumo*. Salvador: EDUFBA; 2004. p. 87-95.
40. Espírito Santo. Portal da Transparência do Espírito Santo, Protest. [acesso em 2020 jan 19]. Disponível em: <https://transparencia.es.gov.br>.
41. Espírito Santo. Secretaria de Estado da Saúde. Portaria SESA nº 237-R, de 23 de dezembro de 2010. Estabelece que para requerer o Licenciamento Sanitário, inicial ou de renovação, os Estabelecimentos de Assistência à Saúde deverão protocolar o formulário estabelecido pela Secretaria de Estado da Saúde (SESA). [acesso em 2020 jan 19]. Disponível em: [https://www.normasbrasil.com.br/norma/portaria-237-2010-es\\_126597.html](https://www.normasbrasil.com.br/norma/portaria-237-2010-es_126597.html).
42. Espírito Santo. Secretaria de Estado da Saúde. Portaria SESA nº 32-R, de 19 de junho de 2015. Dispõe sobre o processo de licenciamento sanitário de estabelecimentos/serviços de interesse da vigilância sanitária no Estado do Espírito Santo. 2015. [acesso em 2020 mar 20]. Disponível em: <https://www.legisweb.com.br/legislacao/?id=285994>.
43. Espírito Santo. Secretaria de Estado da Saúde. Por-

- taria SESA nº 155-R/2013, de 17 de maio de 2013. Regulamenta e estabelece critérios de funcionamento no território estadual de clínicas especializadas/unidades mistas de internação que prestem serviços de atenção a pessoas com comprometimento biológico, transtornos mentais e comportamentais incluindo os decorrentes do uso, abuso ou dependência de substâncias psicoativas (SPA). Departamento de Imprensa Oficial do Espírito Santo; 17 Maio 2013.
44. Espírito Santo. Secretaria de Estado da Saúde. Portaria SESA nº 59-R, de 31 de outubro de 2017. Define os critérios para internação de pacientes nas Clínicas Especializadas no Estado do Espírito Santo. Departamento de Imprensa Oficial do Espírito Santo; 31 Out 2017.
  45. Espírito Santo. Secretaria de Estado da Saúde. Portaria SESA nº 090-R. Define os critérios para internação de pacientes nas Clínicas Especializadas no Estado do Espírito Santo. Departamento de Imprensa Oficial do Espírito Santo; 14 Out 2014. [acesso em 2020 mar 20]. Disponível em: <https://www.legisweb.com.br/legislacao/?id=275778>.
  46. Espírito Santo. Secretaria de Estado da Saúde. SESA/SASS/GECORC/NEC/Nº006/2018, 28 de dezembro de 2018. Credenciamento de instituições privadas (com fins lucrativos e sem fins lucrativos) prestadoras de serviços de saúde, interessadas em participar, de forma complementar, do Sistema Único de Saúde do Estado do Espírito Santo (artigo 24, da Lei 8.080/1990), conforme Processo no 83802525, devidamente aprovado pela autoridade competente, sendo regido pelas Leis Federais nº 8.666/93, no 8.080/90 e Lei Estadual no 9.090/2008 e suas alterações, bem como pelas demais normas pertinentes e condições estabelecidas no presente Edital. Departamento de Imprensa Oficial do Espírito Santo; 28 Dez 2018.
  47. Espírito Santo. Lei nº 10.987, de 26 de abril de 2019. Disciplina procedimentos a serem adotados pelos médicos e odontólogos vinculados ao Sistema Único de Saúde – SUS no Estado do Espírito Santo, na prescrição de medicamentos e na solicitação de exames, procedimentos de saúde e internações compulsórias que serão prestados pela Secretaria de Estado da Saúde – SESA e estabelece outras providências [internet]. Departamento de Imprensa Oficial do Espírito Santo; 30 Abr 2019. [acesso em 2020 mar 3]. Disponível em: [https://saude.es.gov.br/Media/sesa/Documentos/diario\\_oficial\\_2019-04-30\\_pag\\_9.pdf](https://saude.es.gov.br/Media/sesa/Documentos/diario_oficial_2019-04-30_pag_9.pdf).
  48. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1977.
  49. Espírito Santo. Secretaria de Estado da Saúde. Plano Diretor de Regionalização – PDR – ES 2011. 2011. [acesso em 2020 jan 20]. Disponível em: [https://saude.es.gov.br/Media/sesa/Descentraliza%C3%A7%C3%A3o/PDR\\_PlanodiretordeRegionalizacao\\_ES\\_2011.pdf](https://saude.es.gov.br/Media/sesa/Descentraliza%C3%A7%C3%A3o/PDR_PlanodiretordeRegionalizacao_ES_2011.pdf).
  50. Santos CCM, Leal FX, Jesus RS. Política sobre drogas no estado do Espírito Santo: consolidando retrocessos. *Text. Cont.* 2016; (15):423-436.
  51. Garcia MLT, Siqueira MM. Instituições especializadas em dependência química no Estado do Espírito Santo. *J. Bras. Psiq.* 2005; 54(3):192-196.
  52. Oliveira EFA, Garcia MLT. The mental health policy in the State of Espírito Santo, Brazil: between achievements and disappointments. *Best Pract. Mental Health: An Inter. J.* 2011; (7):60-71.
  53. Espírito Santo. Secretaria de Estado da Saúde. Relatório Gestão 2015-2018: Avanços e Perspectivas. 2019. [acesso 2020 mar 10]. Disponível em: <https://saude.es.gov.br/GrupodeArquivos/relatorio-de-gestao-3>.
  54. Brasil. Ministério da Saúde. Portaria nº 2.048, de 5 de novembro de 2002. Regulamento Técnico dos Sistemas Estaduais de Urgência e Emergência. *Diário Oficial da União.* 5 Nov 2002.

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