SMAD, Rev. Eletrônica Saúde Mental Álcool Drog.
2024;20:e-218260
DOI: 10.11606/issn.1806-6976.smad.2024.218260
www.revistas.usp.br/smad/

Original Article

Psychosocial Care Centers for alcohol and other drugs: an implementation overview*

Denise Alves Guimarães[1]
https://orcid.org/0000-0002-3539-6733
Nilciany Aparecida de Sousa Ribeiro[1,2]
https://orcid.org/0000-0001-8554-715X
Vívian Andrade Araújo Coelho[3]
https://orcid.org/0000-0002-0167-5697
Carlos Alberto Pegolo da Gama[1]
https://orcid.org/0000-0002-6345-7476

* Supported by Fundação de Amparo à Pesquisa do Estado de Minas Gerais (FAPEMIG), Grant#APQ 03913-17, Brazil.

[1] Universidade Federal de São João del-Rei, Campus Dona Lindu, Divinópolis, MG, Brazil.
[2] Scholarship holder at the Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), Brazil.
[3] Universidade Federal de Ouro Preto, Campus Ouro Preto, Ouro Preto, MG, Brazil.

Objective: to analyze the implementation of Psychosocial Care Centers for alcohol and other drugs in a region of the national territory. **Methodology:** this is a thematic section of a cross-sectional study on the implementation of the Psychosocial Care Network in the region, based on the organization and analysis of information collected from government databases and consultation with the National Mental Health Coordination. The 853 municipalities in the region were considered and, after organizing the data in a single database, indicators of implementation of the Psychosocial Care Network and the services that comprise it were produced. The indicator values were analyzed considering the coverage established by the Ministry of Health and the classification of the state's health regions based on socioeconomic development, supply, and complexity of services. **Results:** the region has good implementation of Psychosocial Care Centers, with 369 units and an implementation rate of 1.41. Of these, those focused on alcohol and other drugs represent 58 units, and the implementation rate for this service is 0.30. **Conclusion:** the implementation of alcohol and drug services is at an initial stage in the region surveyed, characterized by regional heterogeneity, which should guide strategies for expanding and strengthening these services.

Descriptors: Mental Health Assistance; Alcoholic Beverages; Illicit Drugs; Public Health Services; Regional Health Planning.

How to cite this article

Guimarães DA, Ribeiro NAS, Coelho VAA, Gama CAP. Psychosocial Care Centers for alcohol and other drugs: an implementation overview. SMAD, Rev Eletrônica Saúde Mental Álcool Drog. 2024;20:e-218260 [cited year month day]. Available from: URL. https://doi.org/10.11606/issn.1806-6976.smad.2024.218260

Centros de Atenção Psicossocial álcool e outras drogas: panorama de implantação

Objetivo: analisar a implantação dos Centros de Atenção Psicossocial voltados para álcool e outras drogas em região do território nacional. **Metodologia:** trata-se de um recorte temático que integra um estudo transversal sobre a implantação da Rede de Atenção Psicossocial da região, com base na organização e análise de informações coletadas em bases de dados governamentais e consulta à Coordenação Nacional de Saúde Mental. Foram considerados os 853 municípios da região e, após a organização dos dados em banco único, foram produzidos indicadores de implantação da Rede de Atenção Psicossocial e dos serviços que a compõem. Os valores dos indicadores foram analisados considerando-se a cobertura estabelecida pelo Ministério da Saúde e a classificação das regiões de saúde do estado a partir do desenvolvimento socioeconômico, da oferta e da complexidade de serviços. **Resultados:** a região possui boa implantação de Centros de Atenção Psicossocial, com 369 unidades e índice de implantação de 1,41. Desses, aqueles voltados para álcool e outras drogas representam 58 unidades e o índice de implantação desse serviço é de 0,30. **Conclusão:** o cenário de implantação dos serviços voltados para álcool e drogas é inicial na região pesquisada, caracterizada por heterogeneidades regionais, o que deve nortear estratégias para ampliação e fortalecimento desses serviços.

Descritores: Assistência à Saúde Mental; Bebidas Alcoólicas; Drogas Ilícitas; Serviços Públicos de Saúde; Regionalização da Saúde.

Centros de Atención Psicosocial para alcohol y otras drogas: panorama de implementación

Objetivo: analizar la implementación de Centros de Atención Psicosocial enfocados al alcohol y otras drogas en una región del territorio nacional. **Metodología:** recorte temático que integra un estudio transversal sobre la implementación de la Red de Atención Psicosocial en la región, a partir del análisis de información recopilada en bases de datos gubernamentales y consultas a la Coordinación Nacional de Salud Mental. Se consideraron los 853 municipios de la región y luego de organizar los datos en una sola base de datos se produjeron indicadores de implementación de la Red de Atención Psicosocial y de los servicios que la componen. Los valores de los indicadores se analizaron considerando la cobertura establecida por el Ministerio de Salud y la clasificación de las regiones de salud del estado, a partir del desarrollo socioeconómico regional, la oferta y la complejidad de los servicios. **Resultados:** la región posee buena implementación de Centros de Atención Psicosocial con 369 unidades. De ellos, los enfocados al alcohol y otras drogas representan 58 unidades y la tasa de implementación de este servicio es de 0,30. **Conclusión:** el escenario de la implementación de servicios orientados a alcohol y drogas es incipiente en la región investigada, y se caracteriza por heterogeneidades regionales, hecho que debe orientar estrategias de ampliación y fortalecimiento de estos servicios.

Descriptores: Atención a la Salud Mental; Bebidas Alcohólicas; Drogas Ilícitas; Servicios de Salud Pública; Regionalización.

Introduction

The Psychiatric Reform (PR) brought about a paradigm shift in Mental Health (MH) care in Brazil and was made official in 2001 as a law that guaranteed the rights of people suffering from mental illness. This process began in the 1970s and redirected the MH care model, proposing to replace the asylums and hospital-centered logic with health care focused on psychosocial care, resulting in a reduction in hospitalizations and significant advances related to the increase in expanded clinical practices focused on patient demands and the territory[1-6].

In order to reorganize mental health care in Brazil, the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS) was created in 2011, with a focus on comprehensive care based on services and strategies that replace hospital institutions, promoting citizenship, autonomy and social inclusion and stimulating the decentralized organization of mental health services. It is an integrated system that seeks to offer comprehensive care to the entire population with mental health needs. To this end, it is made up of services of various modalities and complexity levels, from Primary Health Care (PHC) to General Hospitals, and operates from a territorial perspective to guarantee the articulation and integration of the network's points of care in each territory[7-8].

Among the demands met by RAPS is care for users of Alcohol and Other Drugs (AD), given that the harmful use of psychoactive substances (PAS) is a major public health problem worldwide. It is a complex issue, associated with various problems that affect not only the physical and mental health of individuals, but also social and family dynamics[9]. The complexity related to the PAS consumption stands out, as it is characterized as a historical-cultural phenomenon with implications for medicine, politics, religion, public safety, and the economy. These substances are used to seek pleasure, relieve worries and tensions, control mood and expand consciousness[10-11].

Despite the criticism directed at the effectiveness of the proposals in the 2006 Drug Law and the emphasis that was placed on increasing the punitive nature of the law, it represented the first legal milestone in the quest to articulate the criminalizing discourse and the medical-social discourse, with the aim of establishing a distinction between trafficking and the use of illicit PAS, and thus adopting measures to punish dealers and direct users of these substances to treatment in the RAPS and social assistance facilities[10,12]. From this perspective, care for users with demands related to the harmful use of alcohol and other drugs in the Unified Health System (*Sistema Único de Saúde*, SUS) has taken on new directions, seeking to develop strategies to consolidate a multifactorial care model that takes into account the complexity of the issue[7,13].

Although Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS) have existed since 1986, it was only in 2002 that the Alcohol and Other Drugs Psychosocial Care Center (*Centro de Atenção Psicossocial álcool e outras drogas*, CAPSad) was created, specializing in demands related to alcohol and other drug abuse, and it was only in 2011, with the creation of the RAPS, that this demand became part of an integrated system that articulates various care levels. In 2003, the Comprehensive Care Policy for Drug Users was introduced, introducing Harm Reduction (*Redução de Danos*, RD) as a method of approach which, in opposition to the logic of abstinence-based treatment, sought to intensify health care that recognized the specificity of each patient and proposed strategies aimed at increasing their degree of freedom and co-responsibility, as well as guaranteeing human rights and social inclusion[14-18].

In Brazil, RD still has very timid initiatives when compared to those on the international scene[15] and, since its implementation, it has faced barriers related to the moralizing and criminalizing perspectives linked to the use of PAS[10]. In recent years, attention to the demands related to AD has faced setbacks from the point of view of public policies, since the New National Drug Policy[19] of 2019 had resumed the perspective of treatment based on abstinence, reaffirming the prohibitionist model in force in the country, discouraging RD practices[18,20]. This situation began to be reversed in 2023, with the changes brought about by the presidential elections and the repeal of the National Drug Policy of 2019, and the reintroduction of the RD paradigm[21].

Currently, care for people with AD-related demands in the RAPS is structured with the following services and devices: Alcohol and Other Drug Psychosocial Care Centers (CAPSad and CAPSad III); Street Consulting Team (*Equipe de Consultórios de Rua*, ECR); Adult Reception Units (*Unidades de Acolhimento Adulto*, UAA) or Children's Reception Units (*Unidades de Acolhimento Infanto-Juvenil*, UAI); Therapeutic Residential Services (TRS) and Services offered in General Hospitals (LHG)[8]. In addition, in 2011, Therapeutic Communities (TC) were recognized as belonging to RAPS, and in 2012 they began to receive public funding[20].

In Brazil and around the world, therapeutic communities are one of the most popular models for recovering from AD addiction[22]. In Brazil, many practices in these institutions violate human rights and the problems range from physical aggression, the use of chemical restraint against the individual's will and without the family's consent, disrespect for sexual orientation,

religious imposition, unworthy living conditions related to food, housing and basic sanitation, and even situations of private imprisonment[23]. In addition, these institutions are based on encouraging abstinence as the central form of treatment, diverging from what is offered by the AD care facilities in the RAPS[10,20,22,24]. However, in recent years, the country has seen a systematic increase in public funding for hospital/asylum institutions, totally contrary to the principles of the Psychiatric Reform and the Anti-Asylum Struggle[21,25-26].

Many advances have been made with the implementation of the RAPS and the services aimed at users with AD-related demands since the PR. However, there are many difficulties, some of which are related to and exacerbated by the setbacks in public policies, the lack of community support, the existence of stigmas, the scarcity of work-generating activities, difficulties in family participation in treatment, the lack of public investment and training for professionals in the field[15-16,21,26-27], as well as the pace of service implementation that guarantees care for these populations[26].

In the Minas Gerais state (MG), in 2011 there were only 21 CAPSad services specifically geared towards AD, none of which operated 24 hours a day. In 2019, there was an improvement in implementation, with 58 CAPSad in the state. Despite the growth in the implementation of these services, there is still a shortage, which may be related to a set of difficulties that can precipitate admission to a psychiatric hospital[28].

Considering the need to advance in the implementation of public policies that meet the demands related to AD, this study sought to analyze the implementation of CAPS aimed at the demands of AD users included in the RAPS in the Minas Gerais state.

Methodology

Type or study design

This section is part of a larger cross-sectional study entitled "The Implementation of the Psychosocial Care Network in the Health Macro-Regions of the Minas Gerais State", funded by Minas Gerais State Research Support Foundation (*Fundação de Amparo à Pesquisa do Estado de Minas Gerais*, FAPEMIG), which analyzed the regionalization of RAPS services in Minas Gerais and whose results have been published[8,29-30].

Location or setting

The field of study consisted of the 853 municipalities that made up the 13 Extended Health Regions of the Minas Gerais state (macro-regions). The data was organized considering the distribution already established on the Regions and Networks platform, in order to list the 853 municipalities in Minas Gerais, organized into 13 macro-regions and 77 micro-regions or health regions (HR)[29,31].

Period

The data was collected between May 2019 and January 2020.

Data collection

The data was collected using government databases (DATASUS - SUS Information Technology Department and eGESTORab - Primary Care Information and Management) and direct consultation with the National Mental Health Coordination. After organizing the data in a single database, indicators were produced based on the number of services in relation to the population, considering the e-Gestor data as a reference on June 1, 2018[8].

Study variables

The study calculated the implementation indices of the services offered, namely: iCAPS (CAPS Index - Psychosocial Care Center); iNASF (NASF Index - Expanded Family Health Center); iLHG (LHG Index - Psychosocial Beds in General Hospitals); iESF (ESF Index - Family Health Strategy), with the aim of calculating iRAPS (RAPS implementation index). These indices were calculated taking into account the maximum coverage value for each service offered. The iCAPS was calculated following the logic of the CAPS/100,000 inhabitants' indicator and also took into account the criteria for funding this service, which establish: CAPS I, more than 15,000 inhabitants; CAPS II, CAPSad (alcohol and drugs) and CAPSi (children and young people): more than 70,000 inhabitants; CAPS III and CAPSad III: more than 150,000 inhabitants. The iNASF was calculated considering modalities I, II and III with the maximum coverage in each of them, i.e. nine eSF (Family Health teams), four eSF and two eSF, respectively, and that each team serves up to 3,450 inhabitants. iLHG was calculated considering the value stipulated by the Ministry of Health (MS) of one bed for every 23,000 inhabitants. The iESF was calculated considering the population covered by this service and the total population. iRAPS was calculated as a general index of the implementation of RAPS services in MG and represents the arithmetic mean of the four indicators (iCAPS + iNASF + iLHG + iESF)[8].

Data processing and analysis

The implementation index values are interpreted taking into account the coverage established by the Ministry of Health. Therefore, values equal to or greater than 1 indicate that the region has reached or exceeded the number of services defined by federal legislation;

when this value is less than 1, it indicates that the region has not reached the number of services[8].

In the next step, the results of the regional RAPS structuring in MG, found from the calculations described above, were analyzed in the light of the typologies of health regions[32], grouped based on socioeconomic development, supply and complexity of health services. In addition, municipalities were grouped by population size, based on the following categories: 1) small: municipalities with less than 50,000 inhabitants; 2) medium-small: municipalities between 50,000 and 99,999; 3) medium-sized: municipalities between 100,000 and 299,999; 4) medium-large: municipalities between 300,000 and 499,999; and 5) large: municipalities with more than 500,000 inhabitants[8].

Considering the analyses carried out using the iRAPS (RAPS implementation index) and the typologies of the health regions[32], it was possible to establish a general overview of the mental health situation in Minas Gerais, based on an analysis of the macro-regions and HR. For the purposes of this article, an overview was drawn up of the reality of the CAPS implementation, highlighting those focused on the AD demands of the macro-regions.

Ethical aspects

This study is part of a study on the RAPS implementation in Minas Gerais and was approved by the Ethics Committee for Research Involving Human Beings, under protocol number 77798217.1.3001.5091.

Results

The Minas Gerais state is the second most populous in Brazil, with 21,040,662 inhabitants, and has the largest number of municipalities per territory, currently with 853 municipalities, of which 782 are small, 36 medium-small, 27 medium-sized, three medium-large and five large. According to the population survey of municipalities carried out in 2010, 91.92% of the population was located in municipalities with an adequate or partially adequate RAPS[8].

Analysis of the distribution of RAPS components in the state showed that ESF coverage is high (78.97%), with a total of 5,594 teams in place. Similarly, there is good coverage of NASF in the state, with 958 teams. Considering the different types of CAPS, 369 services had been set up by 2019, of which 176 were CAPS I, which is to be expected for a state with a prevalence of small municipalities. It should be noted that CAPS I, II and III are services that receive patients on demand and are not specifically geared towards AD-related demands[8]. When we consider the supply of CAPS specifically geared to AD-related demands in MG's 13 macro-regions (Table 1), we see a scenario of initial implementation, with only 47 CAPSad units and 11 CAPSad III units.

Table 1 - CAPS* by macro-region and regional population size. Minas Gerais, Brazil, 2019

Macro-region	Population	CAPS I†	CAPS II‡	CAPS III§	Children's CAPS‖	CAPS ad¶	CAPS adIII**
Center	6.611.614	18	18	13	18	9	3
South Center	787.099	4	3	1	2	4	0
Jequitinhonha	295.599	4	1	0	0	1	0
East	1.538.706	18	5	0	4	3	0
South East	693.810	12	4	0	2	1	0
Northeast	922.509	19	3	0	3	5	0
Northwest	701.65	8	1	0	0	1	1
North	1.676.413	20	6	1	5	4	1
West	1.289.538	16	5	2	2	4	1
Southeast	1.668.069	21	4	1	3	3	2
South	2.779.095	26	12	0	3	8	1
Northern Triangle	1.294.816	6	5	1	1	1	2
Southern Triangle	781.789	4	4	0	2	3	0
Minas Gerais	21.040.662	176	71	19	45	47	11

*CAPS = Psychosocial Care Center; †CAPS I = Psychosocial Care Center I; ‡CAPS II = Psychosocial Care Center II; §CAPS III = Psychosocial Care Center III; ‖Children's CAPS = Children's Psychosocial Care Center; ¶CAPSad = Psychosocial Care Centers for alcohol and other drugs; **CAPSadIII = Psychosocial Care Centers for alcohol and other drugs III

The state has set up 20 Transitional Care Units for adults and children (UAA and UAI), and 59 Street Consulting Teams (ECR). There are 118 Therapeutic Residential Services (TRS) in the state, 30.5% of them in the capital, and 385 Psychosocial Beds in General Hospitals (LHG), mostly in small municipalities[8]. Although a large part of the Minas Gerais population is located in municipalities with adequate RAPS implementation, when considering the relationship between the population size of each of the regions and the implementation of services (iRAPS), this index is lower than expected (Table 2), considered to be of medium effectiveness, the same classification as the national iRAPS. The rate of implementation of CAPS geared towards the demands of AD indicates an intense shortage of these services[8].

Minas Gerais has 48 HR with more than 150,000 inhabitants and the necessary conditions to set up CAPS III and CAPSad. Of these, only nine have CAPS III (18.7%) and 10 have CAPSad (20%). When analyzing the macro-regions, six do not have CAPSad III (43%), even though their population size is sufficient for this[8].

Table 2 shows the implementation indices for RAPS (iRAPS), CAPS (iCAPS) and CAPSad (iCAPSad), which only takes CAPSad and CAPSad III into account. Implementation index values equal to or greater than 1 indicate that the region has reached or exceeded the number of services defined by federal legislation; less than 1 indicates that the region has not reached the recommended number of services. It also shows the number of HR per macro-region and the classification by typology[32], according to socio-economic development, supply and complexity of health services. Thus, the regions are classified as: G1 - low socioeconomic development and low supply of services; G2 - medium or high socioeconomic development and low supply of services; G3 - medium socioeconomic development and medium supply of services; G4 - high socioeconomic development and medium supply of services; and G5 - high socioeconomic development and high supply of services[32].

Table 2 - Implementation index of RAPS*, CAPS† and CAPSad‡ and classification of Health Regions. Minas Gerais, Brazil, 2019

Macro-region	iRAPS§	iCAPS‖	iCAPSad¶	N**HR†† G1‡‡	Regions typology				
					G2§§	G3 ‖‖	G4¶¶	G5***	
Center	0.76	1.18	0.2	10	1	1	4	3	1
South Center	1.04	1.59	0.51	3	0	0	3	0	0
Jequitinhonha	1.19	1.35	0.34	2	2	0	0	0	0
East	0.94	1.36	0.19	7	4	0	3	0	0
South East	1.19	1.87	0.14	3	2	0	1	0	0
Northeast	1.35	2.22	0.54	8	7	1	0	0	0
Northwest	0.69	1.07	0.36	3	0	2	1	0	0
North	1.09	1.67	0.33	9	7	1	1	0	0
West	0.92	1.82	0.43	6	1	1	4	0	0
Southeast	1	1.5	0.36	8	1	0	6	0	1
South	0.82	1.35	0.34	12	0	0	10	0	2
Northern Triangle	0.8	1.12	0.31	3	0	1	1	0	1
Southern Triangle	0.68	1.41	0.38	3	0	0	1	1	1
Minas Gerais	0.89	1.41	0.30	77	Not applicable				

*RAPS = Psychosocial Care Network; †CAPS = Psychosocial Care Center; ‡CAPSad = Psychosocial Care Centers for alcohol and other drugs; §iRAPS = Psychosocial Care Network Implementation Indexes; ‖iCAPS = Psychosocial Care Center Implementation Indexes; ¶iCAPSad = Implementation rates of Psychosocial Care Centers for alcohol and other drugs; **N = Number; ††HR = Health Regions; ‡‡G1 = Low socio-economic development and low service supply; §§G2 = Medium or high socio-economic development and low services supply; ‖‖G3 = Medium socio-economic development and medium service range; ¶¶G4 = High socio-economic development and medium service range; ***G5 = High socio-economic development and a wide service range

An analysis of this table shows that the majority of the state's HRs are adequately implemented when looking at the iCAPS but have a shortage of services for alcohol and other drug users (iCAPSad). There is a structural precariousness in relation to the CAPS implementation specifically geared towards meeting the demands of AD, which is demonstrated when analyzing MG's iCAPSad in isolation, with a value of 0.30, a very small number in relation to the state's iCAPS, with a value of 1.41, a pattern that is repeated in the macro-regions. Furthermore, of the total of 77 HRs, only six are in group 5, with high socio-economic development and a high services offer, while 25 HRs are in group 1, with low socio-economic development and a low services supply[8].

Discussion

The Minas Gerais state was the scene of one of the greatest mental health atrocities experienced in Brazil, at the Barbacena Psychiatric Hospital Center (*Centro Hospitalar Psiquiátrico de Barbacena*, CHPB), a situation that became known as the Brazilian Holocaust, representing the horrors suffered by the inmates and their families[33]. This tragic event contributed to the state becoming a pioneer in the process of implementing policies and services focused on mental health care. In 1979, the Reform of Mental Health Care began, promoted by Hospital Foundation of the Minas Gerais State (*Fundação Hospitalar do Estado de Minas Gerais*, FHEMIG), involving not only psychiatric professionals, but also psychologists, nurses, social workers, social science professionals, biologists, sanitarians and legal professionals, who became actively involved in transforming the model of mental health care in line with the principles of the Anti-Asylum Struggle[34]. In addition, in 1999, organizations were created in the state to help people suffering from mental illness, with the aim of providing social interaction and treatment, recognizing and guaranteeing the rights of citizenship, human dignity and freedom, as well as representing a reaction by various social segments against violent and exclusionary practices[28,33].

In 2016, Minas Gerais approved the State Policy on Mental Health, Alcohol and Other Drugs, working

to develop fundamental points related to mental health care, ranging from combating poverty and reducing inequalities to expanding rights for specific groups of the population in situations of greater vulnerability, while also strengthening democratic debate and social participation[14].

The RAPS implementation situation in MG, assessed by the iRAPS calculation, shows that the state's situation is better than the national implementation scenario, which showed an index of 0.65 in 2019[8,35]. Despite the progress made, demonstrated by the robust expansion of the RAPS in MG and the path marked by the interest and protagonism of the state and civil society in matters related to MS care[33-34], much remains to be done when considering the indices related to structures specifically geared towards AD care (iCAPSad)[8]. In this sense, despite the progress made in the state between 2015 and 2019, when the CAPS implementation rates went from 0.95 to 1.41, it should be noted that the CAPS implementation aimed at AD users has fallen, demonstrating the difficulty of regional agreements on more structured services[8]. This data shows that MG is following the trend observed in a national survey, which registered a significant number of municipalities that did not have CAPSad or CAPSad III, even though they had criteria for implementing these services. From this perspective, the single analysis of iCAPS in Minas Gerais masks the reality of services aimed at AD demands in different regional contexts.

It should be noted, however, that analyzing the discrepancies between the iCAPSad of the Macro-Regions is not simple and requires in-depth research into the specificities of each regional context. The existence of care gaps and regional imbalances is directly related to difficulties in reaching agreements between municipalities, discrepancies in the socio-economic development of the different Health Macro-Regions, population specificities, the distance between municipalities in the same health region, difficulties in coordinating professionals, difficulties related to MH work processes, access to transportation, and differences in the supply and complexity of health services[8,26,36].

The complexity of this analysis can be seen by considering the iCAPSad of the Central region, which has the lowest index of all the regions (0.2). Analyzing this region's iCAPSad in isolation does not allow us to understand that it includes the municipality of Belo Horizonte, the state capital, whose CAPSad structure is a reference for the entire state of Minas Gerais. However, due to the impact of the Metropolitan Region's population on the calculation of iCAPSad, this index is very small[8].

An example of problems related to regionalization and the functioning of agreements within the RAPS in MG was identified in a study carried out in the Midwest macro-region of MG, in relation to specific services to meet the AD demands, such as CAPSad III in the municipality of Oliveira, which covers only nine of the 13 municipalities (55% of the region's population), and CAPSad III in Divinópolis, the macro-region's hub municipality, which only meets the demands of the municipality itself[3].

It is important to emphasize that the existence of services that are central to AD care, such as CAPSad and CAPSad III, is justified by the fact that such demands require specific public policies, with the development of intersectoral actions, contrary to the hospital-centric logic and services and practices aimed at social reintegration and building autonomy and citizenship for users and their families[37]. However, we must not lose sight of the fact that the RAPS was designed to work as a whole and with the integration of all existing structures, which implies that issues related to the demands of harmful use of AD are not the sole responsibility of CAPSad and CAPSad III and therefore need to be discussed from the perspective of PHC. In municipalities where there is no CAPSad, the AD demand is often directed to the CAPS, which causes an overload in care, and mixing users with very different psychopathological conditions is not recommended.

Despite the good PHC coverage in Minas Gerais[8], there are weaknesses in its ability to become a gateway for users with demands related to the harmful use of ADs. A study carried out in Minas Gerais identified a set of difficulties involving health professionals, managers and the population in general, which are related to the prejudices surrounding these issues, the difficulties in understanding the complexity of the problems involved and the lack of access to Permanent Health Education (PHE) actions, which help health teams to welcome and handle both the specific AD demands of users and their families and the health demands of these users[17], aspects that are compatible with what has already been observed in other regions of Brazil[26,38].

Similarly, the national reality[26] and studies carried out in Minas Gerais[17,36] have identified difficulties faced by NASF professionals in dealing with MS demands in general and with users with AD-related demands, such as: prejudices, distancing and unpreparedness in their daily lives, fear of dealing with AD users and stigmatized views about them and their relationship with PAS. In addition, in the reality of Minas Gerais, problems were identified related to articulation and communication between RAPS services and professionals and the resulting difficulty in partnerships between PHC, NASF and CAPS[17], as well as problems related to the precariousness of health work and its impacts on mental health care[34], also discussed as a serious problem on the national scene[36].

The presence of care gaps in relation to AD users in all of MG's macro-regions, as well as throughout the country, is closely related to the unbridled expansion of TCs throughout the country[26]. In Brazil, these institutions follow the logic of hospitalization models as a form of treatment, going in the opposite direction to what was advocated by the PR. Their inclusion in the RAPS and the massive public funding they receive are highly controversial[26,39].

In 2015, there were already 1,863 TCs in operation nationwide, an expansion that was taking place during a period in which we were already seeing an increase in the number of hospitalizations and a treatment logic that combines criminalization, pathologization and Christianization[26,39]. In 2018, there was a major boost for the implementation of TCs, with funds being made available to increase the number of places offered, totaling around R$90 million for the service[40], a move that represents the public costing of the asylum structure[33]. In addition, with these changes, the number of TCs has already surpassed that of CAPSad, generating an inversion of the curve in relation to the one reached in 2011, in which the hospital-centered model was being surpassed, both in terms of the number of services and the priority of funding[41].

Thus, it is important to emphasize that the inclusion of this service in the RAPS is related to major impacts on the configuration of the network, which go beyond the simple fact that it does not follow the same anti-asylum logic. This is because the presence of TCs is directly related to the decrease in investment in specialized services such as CAPSad and CAPSad III, exacerbating the tension that already exists in society regarding treatment for harmful use of PAS. In addition, the significant public investment in these institutions brings legitimacy to managers, health professionals, family members and the population in general, who consider this to be the main form of treatment for the demands of AD users[26]. In the reality of some municipalities in Minas Gerais, some health professionals mentioned that the TCs represented the only PHC resource for the referral of demands related to the harmful use of ADs[17].

The scenario in Minas Gerais, like the national scenario, has seen advances and setbacks in public policies aimed at dealing with the demands arising from the harmful use of ADs. This situation reflects the fact that social and cultural conceptions of treatment for these problems are not a consensus and even have contradictory aspects. Thus, these conceptions, contradictions and tensions over treatments related to problems resulting from the harmful use of PAS are present in public policies, which sometimes express prohibitionist and criminalizing perspectives, which support discourses and practices based on the demand for abstinence, and sometimes express perspectives based on harm reduction[14,17,24,34].

The study's limitations are related to the failure to include the perspective of users and their families in the evaluation of the services analyzed, as well as the possibilities for accessing them. In addition, it should be borne in mind that the indicators are important for establishing a panoramic view of the RAPS implementation process, but they do not make it possible to analyze locoregional specificities and, in these cases, aspects linked to sufficiency and adequacy in terms of the quality of care provided by the services implemented. The Minas Gerais state has a large number of municipalities and HRs with very different characteristics, which therefore has an impact on access and the agreement to share services[28], demonstrating the need for future studies that can delve into aspects not covered in this investigation, which are fundamental to understanding regional realities. Finally, it is also considered that not including TCs does not allow us to analyze the impact of the divergent treatment perspectives present in the RAPS for users and health professionals.

Conclusion

The panorama presented here on the implementation of services geared towards the AD demands reveals a challenge to be overcome by public policies and the mobilization of civil society, which has historically been involved in the struggles and achievements in the area of MH in Brazil and in the Minas Gerais state. This challenge involves not only making progress in the number of services, but also in offering and guaranteeing health care based on the preservation and promotion of human rights, as well as making progress in understanding the specificities involved in a scenario of rich diversity, such as the varied municipal and regional realities that make up Minas Gerais.

In the current scenario, it is important to work towards stricter legislation regarding the financing and supervision of TCs, in the sense of minimally incorporating qualified professionals and technicians, as well as other measures that can guarantee respect for the human rights of users and their families.

In addition, given the diversity of HRs, considering the implementation of services and agreements between municipalities, one strategy to be considered and developed is to promote exchanges between successful experiences and challenging scenarios. From this perspective, it becomes possible to create a space for dialogue in which it is possible to learn both from the experiences developed by older, more structured regions and services and from the challenges faced

by regions and services with unfavorable socio-economic development, supply, and complexity of services, and which have no or little experience in dealing with AD.

In this sense, the need to improve services for users with AD-related demands is reaffirmed, with a view to constantly fighting for the preservation and expansion of Public Mental Health Policies based on the principles of Psychiatric Reform and the Anti-Asylum Struggle.

References

1. Amarante P, Nunes MO. Psychiatric reform in the SUS and the struggle for a society without asylums. Cien Saude Colet. 2018;23(6):2067-74. https://doi.org/10.1590/1413-81232018236.07082018
2. Cortez PA, Souza MVR, Oliveira LFA. Princípios de uma política alternativa aos manicômios judiciais. Saúde Soc. 2018;27(4):1206-17. https://doi.org/10.1590/s0104-12902018180409
3. Gama CAP, Guimarães DA, Coelho VAA, Carvalho RC, Campos CG, Fraga AM. A implantação da rede de atenção psicossocial na Região Ampliada de Saúde Oeste de Minas Gerais-BR. Cad Saúde Colet. 2020;28(2):278-87. http://doi.org/10.1590/1414-462X202028020301
4. Sampaio ML, Bispo JP Júnior. Network of Psychosocial Care: evaluation of the structure and process of mental healthcare linkage. Cad Saúde Pública. 2021;37(3):e00042620V. https://doi.org/10.1590/0102-311X00042620
5. Araújo TM, Torrenté MON. Mental Health in Brazil: challenges for building care policies and monitoring determinants. Rev SUS. 2023;32(1):e2023098. https://doi.org/10.1590/s2237-96222023000100028
6. Yasui S, Barzaghi N. História, Memória e Luta: A construção da Reforma Psiquiátrica no Brasil. In: Convención Internacional de Salud - Cuba Salud 2018 [Internet]. 2018 [cited 2023 Jan 16] Apr 23-27; La Habana. Available from: http://convencionsalud2018.sld.cu/index.php/connvencionsalud/2018/paper/viewFile/792/895
7. Lima DKRR, Guimarães J. A Rede de Atenção Psicossocial sob o olhar da complexidade: quem cuida da saúde mental? Saúde Debate. 2019;43(122):883-96. https://doi.org/10.1590/0103-1104201912218
8. Coelho VAA, Andrade LI, Guimarães DA, Pereira LSM, Modena CM, Guimarães EAA, et al. Regionalization of psychosocial care: a panoramic view of the Psychosocial Care Network of Minas Gerais state, Brazil. Cien Saude Colet. 2022;27(5):1895-909. https://doi.org/10.1590/1413-81232022275.11212021
9. United Nations Office on Drugs and Crime. World Drug Report. Vienna: UNODC; 2021 [cited 2022 Sep 03]. Available from: https://www.unodc.org/res/wdr2021/field/WDR21_Booklet_2.pdf
10. Medeiros D, Tófoli LF. Mitos e evidências na construção das Políticas sobre drogas. Bol Análise Político-Institucional [Internet]. 2018 [cited 2023 Feb 18];18:53-61. Available from: https://repositorio.ipea.gov.br/bitstream/11058/8880/1/bapi_18_cap_6.pdf
11. Bastos FIPM, Vasconcellos MTL, Boni RB, Reis NB, Coutinho CFS, organizators. 3rd National Survey on Drug Use by the Brazilian Population [Internet]. Rio de Janeiro: Fiocruz; 2017 [cited 2022 Mar 15]. Available from: https://www.arca.fiocruz.br/handle/icict/34614
12. Brandão B. Por ora, menos que a metade: a lei de drogas brasileira. Rev Bras Cien Soc. 2021;36(105):e3610516. https://doi.org/10.1590/3610516/2020
13. Costa MIS, Lotta GS. From "mentally ill" to "citizens": historical analysis of the construction of political categories in mental health in Brazil. Cien Saude Colet. 2021;26(suppl 2):3467-79. https://doi.org/10.1590/1413-81232021269.2.22712019
14. Silva MAB, Abrahão AL. Comprehensive care policy for users of alcohol and other drugs: A narrative-guided analysis. Interface. 2020;24:e190080. https://doi.org/10.1590/interface.190080
15. Gomes TB, Vecchia MD. Harm reduction strategies regarding the misuse of alcohol and other drugs: A review of the literature. Cien Saude Colet. 2018;23(7):2327-38. https://doi.org/10.1590/1413-81232018237.21152016
16. Sanches LR, Vecchia MD. Psychosocial rehabilitation and social inclusion of people with issues resulting from alcohol and drug use: deadlocks and challenges. Interface. 2020;24. https://doi.org/10.1590/interface.200239
17. Oliveira V, Guimarães DA, Gama CAP, Coelho VAA, Coelho FBP. Tensionamentos no cuidado em Saúde Mental relacionados ao uso de Substâncias Psicoativas: dificuldades identificadas por profissionais da saúde pública. Saúde Debate. 2023;47(137):133-45. https://doi.org/10.1590/0103-1104202313709
18. Dias MAS, Lopes LO, Marangoni VSL. The damage reduction policy and the applicability of care in a specialized health unit to people that make use of alcohol and other drugs. Braz J Health Rev. 2020;3(2):1943-52. https://doi.org/10.34119/bjhrv3n2-053
19. Presidência da República (BR), Casa Civil. Decreto nº 9.761, de 11 de abril de 2019. Aprova a Política Nacional Sobre Drogas. Diário Oficial da União [Internet]. 2019 [cited 2023 Jan 01]. Available from: https://www.planalto.gov.br/ccivil_03/_ato2019-2022/2019/decreto/d9761.htm
20. Cruz NFO, Gonçalves RW, Delgado PGG. Retrocesso da reforma psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019. Trab Educ Saúde. 2020. https://doi.org/10.1590/1981-7746-sol00285

21. Presidência da República (BR), Casa Civil. Decreto nº 11.480, de 6 de abril de 2023. Dispõe sobre o Conselho Nacional de Políticas sobre Drogas. Diário Oficial da União [Internet]. 2023 [cited 2023 Aug 01]. Available from: http://www.planalto.gov.br/ccivil_03/_ato2023-2026/2023/decreto/D11480.htm#:~:text=DECRETO%20N%C2%BA%2011.480%2C%20DE%206,que%20lhe%20confere%20o%20art

22. Perrone PAK. A comunidade terapêutica para recuperação da dependência do álcool e outras drogas no Brasil: Mão ou contramão da reforma psiquiátrica? Cien Saude Colet. 2014;19(2):569-80. https://doi.org/10.1590/1413-81232014192.00382013

23. Conselho Federal de Psicologia; Mecanismo Nacional de Prevenção e Combate à Tortura; Procuradoria Federal dos Direitos do Cidadão/Ministério Público Federal. Relatório da Inspeção Nacional em Comunidades Terapêuticas [Internet]. Brasília: CFP; 2018 [cited 2023 Jan 14]. Available from: https://site.cfp.org.br/wp-content/uploads/2018/06/Relat%C3%B3rio-da-Inspe%C3%A7%C3%A3o-Nacional-em-Comunidades-Terap%C3%AAuticas.pdf

24. Quintas ACMO, Tavares ASPB. Entre Caps AD e Comunidades Terapêuticas: o cuidado pela perspectiva dos usuários de um Caps AD. Saúde Debate. 2020;44(3):198-209. https://doi.org/10.1590/0103-11042020E317

25. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Pragmáticas Estratégicas. Nota Técnica nº 11/22019-CGMAD/DAPES/SAS/MS [Internet]. Brasília: Ministério da Saúde; 2019 [cited 2023 Aug 13]. Available from: https://pbpd.org.br/wp-content/uploads/2019/02/0656ad6e.pdf

26. Macedo JP, Abreu MM, Dimenstein M. Regionalization of psychosocial care of alcohol and Other drug addiction in Brazil. Tempus. 2018;11(3):144-62. https://doi.org/10.18569/tempus.v11i3.2432

27. Gama CAP, Lourenço RF, Coelho VAA, Campos CG, Guimarães DA. Os profissionais da Atenção Primária à Saúde diante das demandas de Saúde Mental: perspectivas e desafios. Interface. 2021;25. https://doi.org/10.1590/interface.200438

28. Coelho VAA, Volpe FM, Diniz SSL, Silva EM, Cunha CF. Alteration of profile of treatment of the public psychiatric hospitals of Belo Horizonte, Brazil, in the context of mental health care reform. Cien Saude Colet. 2014;19(8):3605-16. https://doi.org/10.1590/1413-81232014198.11922013

29. Coelho VAA, Pauferro ALM, Silva MA, Guimarães DA, Gama CAP, Modena CM, et al. Psychosocial Care Network: development and validation of a multidimensional instrument to assess implementation (IMAI-RAPS). Physis. 2023;33. https://doi.org/10.1590/s0103-7331202333004

30. Coelho VAA, Gama CAP, Andrade LI, Silva MA, Guimarães DA, Azevedo EA, et al. Community mental health care network: an evaluative approach in a Brazilian state. Int J Ment Health Syst. 2023;17(1):9. https://doi.org/10.1186/s13033-023-00578-7

31. Malachias I, Leles FAG, Pinto MAS. Plano Diretor de Regionalização da Saúde de Minas Gerais (PDR/MG) [Internet]. Belo Horizonte: Secretaria de Estado da Saúde; 2011 [cited 2022 Aug 19]. Available from: http://vigilancia.saude.mg.gov.br/index.php/regionalizacao-minas-gerais/

32. Viana ALD, Bousquat A, Pereira APCM, Uchimura LYT, Albuquerque MC, Mota PHS, et al. Typology of health regions: structural determinants of regionalization in Brazil. Saúde Soc. 2015;24(2):413-22. https://doi.org/10.1590/S0104-12902015000200002

33. Kyrillos F Neto, Dunker CIL. Depois do Holocausto: Efeitos Colaterais do Hospital Colônia em Barbacena. Psicol Rev. 2017;952-74. https://doi.org/10.5752/P.1678-9563.2017v23n3p952-974

34. Silva MV, Gonçalves AM, Lopes FM. Uma História da Luta Antimanicomial e da Reforma da Assistência à Saúde Mental no Brasil (1979-2021): o que podemos e devemos comemorar. Memorandum. 2022;39. https://doi.org/10.35699/1676-1669.2022.39251

35. Santos A Filho, Velasco W, Lima A, Vieira L. Saúde Mental: Análise da Rede de Atenção Psicossocial em Goiás [Internet]. Goiânia: Subsecretaria de Saúde; 2021 [cited 2022 Aug 23]. Available from: https://goias.gov.br/saude/wp-content/uploads/sites/34/files/conecta-sus/produtos-tecnicos/2020/Comunidades%20Terap%C3%AAuticas.pdf

36. Guimarães DA, Oliveira VCP, Coelho VAA, Gama CAP. Dificuldades no trabalho em saúde mental: percepção de trabalhadores do Núcleo de Apoio à Saúde da Família na Macrorregião Oeste de Minas Gerais. Physis. 2023;33. https://doi.org/10.1590/S0103-7331202333052

37. Borges CD, Schneider DR. O Processo do Cuidado em um CAPSAD na Perspectiva de Usuários e Familiares. Bol Acad Paul Psicol [Internet]. 2020 [cited 2023 Apr 27];227-40. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1415-711X2020000200007#:~:text=O%20cuidado%20no%20contexto%20do,%2C%20humaniza%C3%A7%C3%A3o%2C%20v%C3%ADnculo%20e%20corresponsabiliza%C3%A7%C3%A3o

38. Subrinho LQ, Sena ELS, Santos VTC, Carvalho PAL. Cuidado ao consumidor de drogas: percepção de enfermeiros da Estratégia de Saúde da Família. Saúde Soc. 2018;27(3):834-44. https://doi.org/10.1590/S0104-12902018180079

39. Galindo D, Pimentél-Méllo R, Moura M. Comunidades terapêuticas para pessoas que fazem uso de drogas: uma política de confinamento. Barbarói. 2017;2(50):226-44. https://doi.org/10.17058/barbaroi.v0i0.11239

40. Lima A, Dourado P. Comunidades Terapêuticas [Internet]. Goiânia: Subsecretaria de Saúde; 2020 [cited 2022 Nov 30]. Available from: https://www.saude.go.gov.br/files//conecta-sus/produtos-tecnicos/2020/Comunidades%20Terap%C3%AAuticas.pdf

41. Nunes MO, Lima JM Júnior, Portugal CM, Torrenté M. Psychiatric reform and counter-reform: An analysis of a socio-political and sanitary crisis at National and Regional level. Cien Saude Colet. 2019;24(12):4489-98. https://doi.org/10.1590/1413-812320182412.25252019

Authors' contribution

Study concept and design: Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro, Vívian Andrade Araújo Coelho, Carlos Alberto Pegolo da Gama. **Obtaining data:** Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro, Vívian Andrade Araújo Coelho, Carlos Alberto Pegolo da Gama. **Data analysis and interpretation:** Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro, Carlos Alberto Pegolo da Gama. **Statistical analysis:** Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro, Carlos Alberto Pegolo da Gama. **Obtaining financing:** Denise Alves Guimarães, Vívian Andrade Araújo Coelho, Carlos Alberto Pegolo da Gama. **Drafting the manuscript:** Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro. **Critical review of the manuscript as to its relevant intellectual content:** Denise Alves Guimarães, Nilciany Aparecida de Sousa Ribeiro, Vívian Andrade Araújo Coelho, Carlos Alberto Pegolo da Gama. **Others (Project coordinator):** Denise Alves Guimarães, Carlos Alberto Pegolo da Gama.

All authors approved the final version of the text.

Conflict of interest: the authors have declared that there is no conflict of interest.

Received: Nov 6th 2023
Accepted: Mar 26th 2024

Associate Editor:
Margarita Antônia Villar Luís

Corresponding Author:
Denise Alves Guimarães
E-mail: alvesguimaraesdenise@gmail.com
https://orcid.org/0000-0002-3539-6733