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Unravelling the skein of care networks on drugs: a narrative review of the literature

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Abstract *Heated debates on given models of treatment for drug users have raged in the halls of academia, in public policies, not to mention in the media. The care network on drugs is presented in this context as an important mechanism for users, but its construction turns out to be a challenge. Therefore, a critical analysis and narrative review of the scientific literature on the care network on drugs was conducted, seeking to pinpoint the challenges and opportunities for its consolidation. The results found include: a) a lack of specific studies on the care network on drugs; b) insufficient and disjointed coverage regarding the demand for treatment; c) the need to rethink the role of the Psychosocial Care Centers for Alcohol and other Drugs, seeking to strengthen, expand, structurally improve and readjust their practices; d) lack of critical analysis about the construction process of care models on drugs in public services; and e) the State's responsibility to provide better alternatives to the existing panorama revealed, making progress on strengthening intersectorial actions, structuring care and improving working conditions.*
Key words *Delivery of health care, Substance-related disorders, Substance abuse treatment centers, Mental health services*

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Introduction

A heated debate exists in the media, political and academic spheres over approaches to the treatment of illicit drug users. This debate raises the following question: what are the reasons for the lack of problematisation of the drug abuse and addiction support network in these discussions? It is therefore believed that any debate on modes of treatment should be preceded by an assessment of the following: a) the complete picture of care provision for drug users; b) the extent and adequacy of care coverage; c) current service organisation and access.

These three points cannot be considered in isolation. An in-depth understanding of the structuring and organisation of health services to meet demand is necessary before improvements can be made in order to strengthen the care system and improve treatment of drug abuse and addiction. Based on this assertion, the objective of this study is to perform a critical analysis of relevant academic literature on drug abuse and addiction support networks (hereafter referred to as "drug support networks") by undertaking a narrative review.

The epidemiological transition currently witnessed in Brazil inevitably leads to changes in the configuration of health services[1]. Changes in behaviour and unhealthy lifestyles, together with changing socio-demographic, economic and environmental conditions, have led to changing patterns of death, morbidity and disability[2] and the emergence of a new pattern of health problems.

One of the major problems that has emerged within this context is drug abuse and addiction[3]which in turn has led to a need to review and widen conceptions about health care. The focus has been on the psychosocial aspects of drug abuse and better facilities in order to improve the quality of services and adapt them to the needs of the target population[4]. A number of changes have been witnessed including: a greater focus on the epidemiological approach to chronic conditions that emphasise prevention, treatment, and monitoring; increased interdisciplinarity; and the development of integrated health networks[5].

Against this background, there is a push to replace fragmented health care with a system based on health care networks (*redes de atenção à saúde – RAS,* acronym in Portuguese)[1]. RASs are considered "an organisational arrangement of health actions and services, using differing levels of healthcare technologies, integrated through a technical, logistic and management support system that aims to guarantee comprehensive care"[6]. RASs show better results in a number aspects of health systems such as access to services, a reduction in care fragmentation, improvements in the overall efficiency of systems, reduction in costs, and improved health outcomes for patients[1,7].

However, to guarantee an integrated approach to health care networks, it is necessary to overcome fragmentation in health practice that results in lack of dialogue, communication and interaction between the actors, care facilities and sectors that make up the system, and polarization between hospital and primary care[5]. As Hartz and Contandriopoulos[8] elucidate, despite the emphasis placed on coordination and cooperation between healthcare providers under the integrated approach, in practice systematic monitoring and assessment of integration is incipient.

The context outlined above is witnessed in the implementation of the Brazilian drug policy which encompasses the following instruments: the National Policy on Drugs (PNAD, acronym in Portuguese) of the National Secretariat of Policy on Drugs[9], the Health Ministry's Policy for Comprehensive Alcohol and Substance Abuse Treatment (PAIUAD, acronym in Portuguese)[10] and, more recently, the Integrated Plan to Combat Crack and Other Drugs (PIEC, acronym in Portuguese)[11].

Despite their peculiarities, the PNAD, PAIUAD and PIEC share a common goal and perspective, which is to implement and strengthen support networks for people with substance use disorders [9-11] and promote treatment and social reintegration of these individuals within this integrated support network. The PAIUAD propagates the Centres for Psychosocial Support for Alcohol and Drug Abuse (CAPSad, acronym in Portuguese) as the main pillars of this network. The CAPSad are responsible for providing direct support under the Universal Health System (SUS, acronym in Portuguese) and Universal Social Support System (SUAS, acronym in Portuguese), and operate together with Primary Health Care (APS, acronym in Portuguese) through the Family Health Strategy (ESF, acronym in Portuguese) teams, with the Social Services Centres (CRAS, acronym in Portuguese), and Social Services Reference Centres (CREAS, acronym in Portuguese)[10].

However, the drug support network is shaped by the RAS and Psychosocial Support Network (RAPS, acronym in Portuguese). The RAPS may be understood as coordinated care for people with mental health disorders and needs resulting from drug abuse through health care facili-

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ties which are part of the SUS[12]. The drug support network is therefore based on the RAS and RAPS, and treatment of drug users is coordinated together with basic care and mental health care services based on the principles of the SUS and Brazil's Psychiatric Reform (RP, acronym in Portuguese).

The drug support network can therefore be understood as "a support network centred on community care associated with a network of health and social services, with emphasis on rehabilitation and social reintegration of users, and considering that care provision for people with problems resulting from the use of alcohol and other drugs should be based on out-of-hospital specialised psychosocial treatment measures"[10]. However, the drug support network is limited: the number of CAPSads in the country is insufficient, activities need to be expanded, practices need to be readapted[14], and services need be integrated[15]. Structuring and strengthening an effective integrated and intersectoral drug support network is therefore a major challenge[13].

In light of the above, this study aims to problematise and gain a deeper understanding of drug support networks by undertaking a critical a review of relevant scientific literature and identify challenges and possibilities that should be considered in the creation and implementation of networks based on an integrated approach to service organisation and patient flow.

Methodology

The present study is a narrative review. According to Rother[16] "narrative literature review articles are comprehensive publications which are appropriate for discussing and describing the development of or 'the state of the art' of a given subject, from a theoretical or conceptual point of view". Such texts represent the analysis of scientific literature based on the interpretation and critical analysis of the author. Despite being regarded as a relatively weak form of evidence because they are not considered reproducible, narrative reviews are a means of contributing to the debate on a given subject, identifying important relative issues and gaining and updating knowledge in a relatively short period of time[16].

A non-systematic literature review was undertaken between July 2012 and July 2013 using scientific databases such as Scielo, Medline, Lilacs, Pubmed and Psycinfo complemented by articles recommended by specialists on the topic. The selected articles were read thoroughly, categorised and critically analysed.

Results and discussion

(De)constructing the drug support network: general characteristics

Drug support networks are generally organised based on a fragmented approach to healthcare, have limited coverage, and provide poor quality services which are insufficient to meet treatment demands[17]. The construction of these networks is considered a reorganisation of health services and should therefore be guided by the *underlying purpose of* replacing psychiatric hospitals and progressing with the RP process[18].

Although the concept of drug abuse used in political discourse has widened since the RP and creation of the SUS in the 1980s[16], in practice the approach to care remains isolated, formulated and sectorial. As a result, care practices do not make a significant impact on the complex realities of the actors that make up the support network[19].

In some cases, it was observed that the tenets of the hospital-centric model prevailed to the detriment of the psychosocial model[20,21] and the majority of investment focussed on admissions to psychiatric hospitals which adopt a passive approach to the drug user and isolate patients from society by confining them in inadequate conditions which often aggravate their health[17].

With respect to the distribution of services, the literature indicates the under participation of the state in the implementation of policies to address this issue[22-25]. Studies undertaken in the State of Espírito Santo, Florianópolis and the Centre-West Region verified that most of the support services were provided by the private sector[22-24]. These findings corroborate the results of a national study undertaken between 2006 and 2007 which showed that only 31% of organisations surveyed (389 out of a total of 1256) were from the public sector[25].

These findings show that the implementation of the care system is contrary to public policies that highlight the need for a private health network to complement public services, and not *vice versa*. There is therefore a gap between policy and practice. One possible explanation for this situation is the recent nature of the public policies to address treatment of drug users. However, the effective transfer of a constitutional responsibil-

ity to the civil society by the government still remains a major cause for concern[22].

Pitta[26] highlights two *civil society initiatives that emerged* within this "dearth of government support network initiatives": Therapeutic Communities (TCs) and self-help groups. Although beliefs and approaches are considerably heterogeneous, TCs are growing in number in Brazil and are playing an ever greater role in the political arena. According to Machado and Miranda[27], the level of organisation of these groups, their links with religious organisations and their ability to pressure government agencies has meant that many of these initiatives have become a model of care for substance use disorders, thus reinforcing the misconceived notion that support for illicit drug users falls outside the scope of the public sector.

A number of TCs receive government funding for treatment of substance use disorders. However, according to the Brazilian Federal Court of Accounts (TCU, acronym in Portuguese)[14], the majority of TCs that receive funds do not have appropriate licences and their facilities and activities are not adequately inspected, monitored and controlled.

The self-help groups Alcoholics Anonymous and Narcotics Anonymous are another example of civil society participation in the drug support network. There is a lack of concrete data regarding these groups and studies provide divergent interpretations regarding their effectiveness[28]. Given the multifaceted nature of drug related harm and the need to improve the effectiveness of care, it is important to consider the multiplicity, not only of these types of initiatives, but also of hospital support for disintoxication and low-intensity and high-intensity outpatient and residential services[29].

The role played by civil society in easing social ills is fruit of a neoliberal agenda which has dominated political and economic spheres in Brazil since the end of the 1970s[30]. Furthermore, the treatment of substance use disorders is permeated by religious, moralising and legal discourses focussed on cure or abstinence-based approaches[27]. Exclusion and isolation in TCs therefore continue to be seen as viable alternatives, while the voice of illicit drug users continues to be silenced and debate regarding other care methods such as harm reduction is severely limited.

A strange paradox emerges from this melting pot: the mobilisation of society through the formation of associations and nongovernmental organisations was made possible by the same democratic government processes that have resulted in this transfer of responsabilities[31]. The ideology of public participation or taking "ownership" of a social problem such as illicit drug use is set to create alternatives that, instead of rethinking the problem, contribute to the individualisation of drug treatment and adoption of models that are distant from the approach put forward by the SUS and RP. A strategy to provide adequate care for drug users based on the transfer of government responsibility and increased investment in private sector care, thus weakening public services, is therefore questionable; what is really needed is an increase in investment in public services.

Within this perspective, general hospitals should be viewed as components of hospital care within the RAPS and drug support network. One of the focuses of the PIEC is to increase the number of hospital beds in general hospitals to provide comprehensive care for illicit drug users[12]. However, there has been a low adherence rate of hospitals to this program and only 179 beds had been provided by June 2011, which is equivalent to only 5% of the original target of 3,492[14]. As a result, many illicit drug users in need of detoxification and treatment are still admitted to psychiatric hospitals, private clinics or TCs[32].

General hospitals do not have the capacity or available beds to meet demand and provide adequate care for illicit drug users. The TCU suggests the following factors as possible causes of this situation: lack or absence of trained health professionals; prejudice and stigmas among health professionals, and difficulties in dealing with patient behaviour; poor healthcare facilities; funding provided by the SUS does not cover the real cost of admission and treatment[14]. Furthermore, general hospitals are commonly work in isolation from the RAPS and drug support network[32]. As a result, it is necessary to tackle the causes of the lack of hospital beds and strengthen the role of general hospitals within the network.

With respect to particularly affected and *socially vulnerable* drug users, it is recommended that healthcare services should approach this sector of the population in an attempt to facilitate access[33]. In this respect, the Harm Reduction Programme and Street Clinics Programme are important strategies of the RAPS and drugs support network which, based on a harm-reduction approach, focus on *in situ* treatment of people with mental disorders and illicit drug users that live on the streets thus bringing services and community closer[33,34]. These initiatives represent

a new approach to reducing the gap in care provision for socially vulnerable illicit drug users and strengthen the support network.

The majority of the literature analysed by this study portray networks as *an organizational structure for health services which is seen as an end in itself*, as a ready-made template. This means that networks are seen as a 'saviour', without problematising underlying principles and the adoption of this mode of organisation as opposed to other alternatives. Emphasis is generally given to structural aspects of networks without questioning the composition of the networks and the mode of participation of the different actors and organisations involved in the process. Therefore, policy makers, managers and health professionals lose sight of coordination, communication and relationships between that groups and individuals that shape and are shaped by the network[19].

The Role of CAPSad in the Network

As seen above, national drug policies based on RP are a major advance in the treatment of illicit drug users. The APS presents a unique opportunity for creating a new approach to care based on CAPSs[10]. However, the integration and organisational capacity of CAPSs and CAPSads within the mental health and drugs networks remains limited[35]. According to the TCU, despite the expansion of the CAPS system which started in 2002, coverage is still lacking, especially when it comes to CAPSads: at the end of 2010, there were 1,620 CAPSs in Brazil, of which only 258 were CAPSads[14].

The coordinating capacity of CAPSads is also questionable, since these units are generally isolated from other fundamentally important RAS and RAPS services and from the drug support network itself, including APS services, social and community care centres and other even other CAPSs and CAPSads[36]. CAPSads, therefore still lack the necessary planning and organisational ability to accomplish the objective of being a coordinating centre of the general drug support network. This in turn compromises the continuity of treatment at all levels of the health system and the ability to provide comprehensive care[37].

CAPSads have a number of other common shortcomings such as: shortcomings of e*ducation of healthcare professionals* based on the biomedical model[20,21,38]; lack of effective evidence-based therapy plans[37]; poor facilities, lack of funding and lack of human resources[14]; hierarchies in decision-making dominated by medical professionals[38]. The predominant mode of ambulatory care in CAPSs perpetuates the simplistic approach to the treatment of illicit drug users which fosters an increase in fragmentation of the care network[18]. These combined factors significantly compromise the CAPSad system's ability to provide adequate care and highlight the need to create policies to overcome these problems.

The social reintegration of illicit drug users is another major obstacle to achieving comprehensive care, since the CAPSad system faces difficulties in implementing effective reintegration strategies[37,39]. Care practices that contradict the principles of RP lead to the 'risk of asylumisation' within these initiatives, given that social reintegration should only be promoted within the sphere of the CAPS system[40]. As Campos and Furtado[35] assert, if this situation "is not backed up by a group of measures to combat and overcome the problem, the services may risk losing social legitimacy without identifying and removing impasses". Given the above, the authors defend serious consideration of the CAPSad system and its role in the RAPS and drug support network and the introduction of measures to strengthen and expand the system, improve facilities and adopt best practices.

Coordination with health and social service networks

The main instruments of the drug support network are apparently isolated from the RAS, particularly from primary health care, resulting in a lack of access to comprehensive care among illicit drug users[21,36,37]. Referrals are often used as a way of strengthening the integration of the health services[41], but are often made within an already ineffective referral system and can therefore lead to a lack of continuity in treatment and evasion of responsibilities among health professionals[42].

Therefore, the decentralisation of mental health services and treatment of illicit drug users within primary health care should be problematised, questioning whether this really represents a shared approach to care or a transfer of responsibilities[42]. Coordination between the instruments of the support network – that also include the RAS and RAPS – should be based on a multidisciplinary, integrated and intersectoral approach and greater involvement of the health care professionals[19].

Another important issue is the extent of responsibility of primary health care professionals

when it comes to the treatment of illicit drug users. Studies point to the importance of capacity building, given the shortcomings of e*ducation of healthcare professionals*. However, training alone is not sufficient[43] to assure adequate care without overcoming obstacles such as lack of technical and operational resources, and weak planning and organisational support provided by the CAPSads[36,44,45]. The role of primary health care professionals cannot therefore be analysed in isolation from other factors, given that the weaknesses of the network have a significant impact on care at this level.

Another important requirement for the effective treatment is that the approach should be comprehensive at all levels of care (primary, secondary and tertiary), thus allowing greater flexibility and coordination of wider actions, and organisation of care based on the needs and conditions of illicit drug uses rather than the type of treatment offered by the health services[46]. In addition to problems relating to the fragmentation of the drug support network and lack of management capacity of the CAPSads, the absence of coordination of the activities between the different levels of care contributes even further to the lack of comprehensiveness of the drug support network. To achieve the desired impact in the population in question, the entire system should be prepared to receive, assess and refer illicit drug users at the level of care which is most appropriate to each specific case[29].

The actions of the drug support network and social services network also appear to be isolated. According to the TCU[14], the majority of social service managers believed that the coordination of services within the CAPS system was very important or extremely important to the success of the social reintegration process. However, the majority of managers and social service professionals believed that coordination between the social services network and CAPSad system was lacking: 55% of CRAS and 45% of CREAS professionals that participated in the survey said that coordination was inexistent or extremely lacking[15].

The use of illicit drugs is a multifaceted problem with a number of determining factors. Social service initiatives offer a wider perspective on care and should not be seen merely as referral centres. The coordination of care activities with these services must be planned by the organisations involved and should not be limited to isolated individual cases[14,41].

It is also evident that the organisation of the majority of care services for illicit drug users in Brazil is based on the personal opinion and experiences of professionals[47] and often disregards specific contexts and information highlighted by previous systematic reviews and assessments, therefore contributing to inadequate care which detached from the needs of the target population[47,48].

The problems outlined above show that there is a continual process of erosion of health services for illicit drug users within the network and a resulting dependency on specific treatment procedures[35]. As Dimenstein and Liberato[49] highlight, the incapacity of the public health service to meet demands, together with the lack of comprehensiveness and intersectorality within the system, lead to the overburdening of health professionals, the bureaucratization of medical care, and a limited self-feeding network that causes stagnation of patient flow.

The Transposition of Decontextualised Models?

Another pertinent issue is the lack of a more detailed analysis of what the authors call 'transposition of the mental health care model' to illicit drug user care. Much is said regarding the heterogeneous nature of projects and professional practices based on personal conceptions which disregard the guiding principles of national policies addressing substance abuse[50]. However, few studies question the processes involving the creation of care models in the public sector, particularly the adequacy of the CAPSad system.

It is important to consider that traditional service provision models are generally based on historic and political factors, rather than the real needs of the target population[51]. In Brazil, the creation of drug policies originated with mental health policies whose main focus was the anti-asylum movement[30]. As a result, the implementation of drug policies in the country was characterised by an approach that treated drug abuse as a growing marginal problem, repeating the perspectives on mental health[52].

The design of actions and creation of a drug support network focussed on out-of-hospital services for patients suffering from the chronic long term effects of drug abuse, such as serious schizophrenia, who were previously admitted to psychiatric hospitals. It must therefore be asked whether the CAPSad system adequately meets the needs of illicit drug users, or if they simply represent a replication of the traditional CAPS model, and thus a mere continuation of the men-

tal health model without the adequate structure for dealing with the clinical specificity of drug abuse[52].

It is important to highlight the need to understand, first and foremost, *who* is the illicit drug user in the CAPSad system, to be able to propose an appropriate mode of treatment. This is a fundamental requirement for designing a care network that encompasses prevention, treatment and social reintegration.

The determining factors of drug abuse are different to those of mental health disorders. Therefore, services which are designed based on academic findings are inadequate since a number of surveys and practices related to drug abuse are based on a mental health perspective, and lack a more detailed analysis of the fundamental differences between mental health disorders and drug abuse disorders.

The characteristics of groups that seek drug abuse treatment services, particularly those treated at CAPSads, are different to those of CAPS patients[53]. CAPSads patients are predominantly male (approximately 90%) and the majority have only completed primary education. Despite differences between study findings, evidence suggests a generally high treatment adherence rate among illicit drug users[33,53-55].

It is therefore important to be open to a range of approaches to be able to provide the appropriate treatment for each specific case. The current modes of treatment adopted by the CAPSad system are a result of a generalised and abstract view of the illicit drug user which disregards the determining factors of each particular case and the care initiatives present in a given society at a given moment in history. Is it acceptable to use a mode of treatment within the CAPSad system that does not analyse or accurately understand the target of its interventions? Should our understanding of the patient be based on a theoreticomethodological, ahistoric and *a priori* notion of the drug user? The result of the above is a conception of the individual that does not take into account the multiple social, psychological, and biological factors that determine the level of mental health.

Apart from understanding the factors that determine illicit drug use, it is important to identify how to strengthen the CAPSad system and other initiatives in order to tackle the structural causes of the problem. Such a discussion may contribute to advances in social integration proposals which are currently thwarted by the issues raised above.

We by no means intend to delegitimise the RP movement or take away its accomplishments, but rather question why the motives behind the transfer of approaches from mental health to the treatment of substance abuse are not problematised with the same intensity as the structural components of the health service (coverage, funding, etc..). We believe that the CAPS and the modes of treatment therein must be open to constructive criticism and constant review and that practices that disregard the local context and specific determining factors of drug abuse should be avoided. Interventions involving the CAPSad system and other initiatives to provide care services for people with substance use disorders should be constantly assessed. These considerations are fundamentally important for addressing the particularities of specific drug problems and creating effective public policies and practices which meet the needs of the target population and reflect the realities of drug abuse[24].

The lack of connection between policies and academic literature

The issue of drug abuse is fertile ground for researchers. However, despite the emphasis on networks in national policies, studies that specifically address drug support networks remain scarce, even when compared to the scientific literature on mental health. This raises the following questions: 1) is there a general lack interest in this topic among researchers? 2) Is this topic difficult to address or analyse?

The authors suggest two causing factors that may lead to the lack of literature on this topic: a) networks were reintroduced to the debate on the organisation of health services only in the last decade; and b) public policies that address drug abuse in Brazil are recent.

As Kuschnir & Chorny[56] note, although the heart of the discussion regarding the reorganisation of Brazil's health system is service integration through the construction of networks, this topic was ignored in the 1990s due to political reasons and the direction taken by the decentralisation process, and discussion of the matter only regained impetus in the 2000s. Furthermore, public policies for the treatment of drug abuse were basically limited to the admission of patients to psychiatric hospitals up to the 1990s and beginning of the 2000s[30].

The study also observed the underuse of scientific evidence in the design of drug policies. The public debate of this topic is apparently based on political demands and ideological conceptions, rather than on sound scientific evidence which,

although scarce, is an important input for decision-making and the creation of effective health policies[51,57]. The investment in quality research on this topic would therefore make a significant contribution to the design, implementation and evaluation of public policies in this country.

The Health Work Education Programme (*PET-Saúde*, acronym in Portuguese), or more specifically, the PET Health/Mental Health – Crack, Alcohol and other Drugs Programme (PET-AD, acronym in Portuguese) is good example. This programme aims to provide practical training to health students and promote integration between academia, the health services that comprise the support network, and the community[58].

The PET-AD enables an interface between public policies and scientific research regarding support networks that encompasses teaching, research and outreach activities[59]. The relationship between graduate students and health professionals enables exchange of experiences and vertical integration, stimulates reflection and contributes to the reorientation of health services[60]. The inclusion of graduate students in the public system also provides future professionals with a wider academic background and experience of the realities of the treatment of drug abuse disorders, and may lead to an increase in the number of professionals working in this area in the future[60].

However, it is important to note that the actions of the PET-AD lack continuity. Given the lack of specialised professionals and researchers in this area, major investment is necessary in initiatives such as the PET-AD that promote dialogue between academia and the health services and ensure a continued impact in the support network.

Final considerations

The objective of this article was to carry out a critical analysis of the academic literature on drug support networks. The study does not purport to provide a conclusive answer, but rather generate a discussion which is particularly important given the recent nature of public policies and the current debate on the topic. Furthermore, this study did not aim to delegitimise this perspective of the organisation of health systems, services and modes of care, but rather problematise these aspects of health care. We believe that an in-depth reflection of such a complex issue can catalyse knowledge and best practices.

It is evident that further studies are required to obtain a deeper understanding of the real situation of care services and the drug support network in order to structure and strengthen the system. This in turn should also contribute to improving connections between services, academia and public policies which result in the creation and implementation of effective projects and actions that are adapted to specific contexts.

As Strang et al.[57] state, it does not matter how effective a treatment is; it will produce few benefits for the individual and society if it is inaccessible. Well organized programs, wider service coverage and willing professionals provide much better results. In other words, a key differentiating factor for effective treatment is the availability of health services and willingness of health professionals to treat illicit drug users. This is a problem in Brazil, due to the lack of coverage and fragmented nature of services, shortcomings in the education of service providers and overburdening of these professionals.

It is important to note that only a relatively small proportion of people with drug abuse disorders seek specialist care, thus generating a 'gap in care'. To achieve the desired impact, wide-scale implementation of interventions in this area is necessary, through a system of integrated services, as opposed to exclusive emphasis on specialised services. For this to occur, an intersectoral approach must be adopted that encompasses a wide range of services and contexts[28,51].

Although advances in the approach and treatment of illicit drug users have been made by the CAPS and CAPSad systems, it is also imperative to rethink their role within the support network. Despite an expansion in the number of centres and in coverage, in terms of number and countrywide distribution of these care units, the system is still limited if the centres are to be considered the central pillars of an entire support network.

The ambulatory care model still pervades the system. This issue should be problematised, especially given the psychosocial aspects of drug abuse treatment.

However, the criticism regarding open treatment models should be treated with caution. The authors defend the need for increased coverage, improved therapeutic planning and qualified professionals with specific competence in this area.

Given the current interests at stake in this area, weakening the principal drug support ser-

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vices offered by the public sector is out of the question. This study therefore proposes an expansion and adaption of the CAPSad system as opposed to its dislegitimisation.

Despite its inherent contradictions and conflicts, Brazil's RP had an inevitable influence on the analysis of the drug problem and interventions, which is reflected in the design of care models. In this respect, it is important to analyse the specificity of these areas and consider the following questions: 1) is the CAPS care model appropriate for the CAPSad system?; and 2) given that the integration of the support network is centred on the CAPS system, what is the difference between the coordination of a mental health network and the coordination of a drug support network? Furthermore, given the interface between these two areas and the comorbidity of drug use disorders and other mental illnesses, improved coordination of actions of these two fields, without causing an overlap in care ideologies, is vital.

Finally, considering the role of the public sector in care provision, the government must assume its responsibility to improve the current drug support scenario, giving priority to expanding care coverage, improving care services within the public system, and developing clear guidelines based on sound evidence. However, it is important to bear in mind that the expansion of the service network alone is not enough to ensure comprehensive care for illicit drug users[21]. This also requires advances in strengthening intersectoral actions, coordination of care through the Health Care and Pschycosocial Support Networks, changes in the e*ducation of healthcare professionals* and improvements in working conditions.

Collaborations

PHA Costa participated in the conception of this study, data collection and analysis, and drafting the final version of this article. DCB Mota, FS Paiva and TM Ronzani participated in data analysis and drafting and revising this article.

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