DOI: 10.1590/1413-81232015211.13752014

Access to treatment for those with alcohol, crack or other drug dependency problems - a case study in the municipality of Rio de Janeiro, Brazil

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Abstract *Changes in psychiatric policies has meant more emphasis on the protection of the individual's rights, tougher regulations and disincentives regarding involuntary patient admissions, and the creation of a community network to support individuals needing help. The differing socioeconomic status of those requiring treatment coupled with guidelines issued by the Health Ministry has meant that more support and care is now being directed towards individuals and families. The rise in public awareness of the problems in these areas has aided in the changes that have taken place. Due to a lack of community public services, this has led to the proliferation of different types of services all with differing standards of care and has fueled the public debate surrounding involuntary patient admissions. Our analysis in relation to treatment for those with alcohol, crack and other drugs problems in the municipality of Rio de Janeiro, states that there are gaps related to access for all-day public services and a lack of psychiatrists in multi-disciplinary teams. There are many new and untried serviced offered by the private sector, religious bodies and public shelters which have arisen in the wake of the rise in people that need help. We took note of the development and progress of these new projects as well as the policy recommendations from the Government*
Key words *Mental Health, Health Policies, Alcohol and drugs*

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Introduction

Policies on mental health have shown the continuous influence of the Brazilian Psychiatric Reforms (RPB) and a concerted effort to be more in line with other international models concerning psychiatric treatment in mental health hospitals. With the RPB came more focus on the poor treatment given to psychiatric patients and this led to wholesale changes in the mental care system in 1987. At that time there was a strong movement against mental "asylums"[1]. Benefits were observed in treatments given in local areas and in trying other innovative methods. As a result these alternatives were backed, against being placed in psychiatric hospitals. These changes came at a time when democracy was being introduced in Brazil as well as the introduction of reforms in the Health System. The innovative measures that were implemented have been widely analyzed with reference to the setting up of a community network of services[2]. This move away from psychiatric admissions towards treatments to taking place in the community was based on the Italian experience that was driven by the Caracas Declaration in 1990. From then on these ideas spread throughout Brazil[3]. While the above may be true, what has also been noted are the limits on the services on offer due to: having to depend on the Brazilian National Health System (SUS), the levels of finance earmark for these services and restrictions in the services that are being offered[4].

The passing of Legislation 10.216 (the Paulo Delgado Act) of 2001 signaled the start of the changes in this area which meant: guarantying the rights of individuals and the curtailment in involuntary patient admissions. The law also reinforced one of the main objectives of SUS being universal health care access for all and the right for those with dependency problems to obtain assistance and mental health care. With the above changes came rises in different people in need coming from various socioeconomic backgrounds. This reinforced the idea in community treatment. Recent policies that have received media attention have prioritized treatment for drug addicts as well as children and teenagers with mental disorders. This process, which has been driven by financial incentives and has been backed by the Health Ministry (MS), has resulted in the gradual opening of more Psychosocial Centers (CAPS). It has also brought about more financial and social support mechanisms for patients and families. We noted that from the beginning of the 2000s more attention was given to drug addicts due to specific MS policies. Then from 2010 this attention was intensified on account of the RPB when various policies were made into regulations. Also at this time the Government produced a paper in this area called "the Integrated Plan for Dealing with Crack and other Drug Abuse"[5]. The importance of this issue has remained in the eye public and many controversial pieces of legislation have been making there way through the National Congress. The impact of this crack problem has been noted and studied. By way of example, in 2012 crack users on the streets were the focus of a major study. The study showed that crack is widely distributed throughout the country in the different capitals and the users are mainly young males with little schooling. They are also associated with alcohol and other drugs[6].

The urgency for actions to be taken has resulted in the rise of different available services which adhere to the guidelines from the MS. A philanthropic network has arisen focusing on Community Therapy (CT) but it has not been shown to be following any official clinical protocols. The expansion in these types of services and their ability to obtain finances offered by the Government in support of their projects has given rise to discontentment amongst health care professional and leaders in this area who are linked to the RPB. Aside from the above, other government-linked sectors have also been asked to fill the spaces left where needs exist and specifically to provide assistance to drug abusers. This is illustrated through the increase in new social assistance centers and shelters.

The current scene is one where there are many new, untried and untested innovative projects which are connected to the Government. From these the following are being evaluated: (i) registering community therapies and social assistance on SUS; (ii) discussing compulsory, voluntary and involuntary admissions; (iii) Government finances being earmarked for specific groups that are in need; and (iv) the opening of more shelters and similar governmental services in the area of social assistance.

In particular, the pressing issue of alcohol and drug abusers in an environment where there are few outpatient public services for serious cases, has also brought to light questions related to involuntary psychiatric admissions and the revisiting the primary objectives of the RPB. The surge in the number unofficial service providers not having officially recognized practices in mental health has occurred in part, due to the lack of official service providers from the RPB.

The aim of this paper is to analyze governmental policies in relation to mental health, alcohol and drug abuse (SMAD) in light of the current heightened public attention towards drug abusers. In this paper we considered the progresses that have occurred in the different services offered by the social services and those by the health system. We noted that a process exists that allows for these services to adapt to demands but which also promotes normative conflicts with the conventional RPB's agenda.

In relation to our methodology, we used the municipality of Rio de Janeiro as our case study which allowed us to analyze the workings of the public health service and social assistance projects that were there. As a secondary objective we analyzed the actual treatment coverage for mental health as a response to the growing urgency to deal with alcohol problems and other problems related to the abuse of drugs. The data that we gleaned from specialist gave us information about the public system's capacity to provide services to the population. Consideration concerning the quality of networks was not overly analyzed.

A general analysis of the processes associated with policies on mental health was conducted in the given municipality because of the large concentration of public health services and social services in the region. Many of them were associated with experimental initiatives. For the basis of our theory, we utilized common categories covering incrementalism, which is outlined below. We took into account the ideas surrounding innovation and experimentalism. Our procedural methods principally involved researching documents and going through administrative data bases from the MS. Using both the experience of all those that co-authored this paper plus input from outside specialists, we were able to paint an analytic picture of the current situation.

Recent developments concerning policies in mental health care and both alcohol and drugs abuse

As has been mentioned, the RPB was influenced by the Italian experience. The meant a move towards treatment being given away from hospitals and the creation of community care networks. These were all models used to provide solutions to problems in specific areas. Specific characteristics regarding the organized networks in Italy were important particularly in relation to service coverage. Girolamo et al.[7] noted that an Italian psychiatrist conducted an inquiry into their system in 1978 which resulted in the gradual closure of all of the psychiatric hospitals. Their national network offers both in hospital and outpatient care and it manages residential semi-residential services (2.9 beds per 10,000 inhabitants). Hospital care is given through small psychiatric units (with no more than 15 beds). Considering what is offered in both the public and private sectors, the number of beds for serious cases is 1.7 per 10,000 inhabitants.

The World Health Organization[8] highlighted that the number of health professionals working in mental health in countries where the standard income is equivalent to or below the national average, is not enough. Almost half the world's population lives in countries where, on average, there is only one psychiatrist to treat 200,000 people or more. Other trained mental health professionals undertaking psychosocial interventions are even lesser in number. This lack of professionals is reflected in the access that people have to services.

The treatment given to those with alcohol and drug problems was analyzed in conjunction with: accompanying mental health policies, relevant regulations and administrative services. The specifics of the help, assistance and care given to drug addicts were dealt with here in terms of analyzing the wider demands placed on public services and the spread of support given. We analyzed this based of being admitted to a psychiatric hospital on a permanent basis.

With reference to illicit drugs, according to the World Drug Report[9], in Latin America and the Caribbean it is estimated that 5.7 million people have been affected by disorders related to the use of drugs at some point in their lives. In Brazil one study[10] concluded that a high number of neuropsychiatric disorders come about due to depression, psychosis and order disorders related to the consumption of alcohol. The use of crack started in the late 1980's in São Paulo and coupled with cocaine, it became the main drug of choice. In the middle of the following decade it moved to being the choice of drug[11] for more affluent young people and this started to define the urban crack scene. The associations between the use of drugs, violence and social vulnerability have been analyzed for a long time in specialist national journals and case studies[12] have been conducted in order to understand the challenges for public health and social care systems.

In terms of public services, the MS[13] allowed for the expansion of non-hospital services throughout the last decade. National coverage of

the CAPS in 2012 was 72% of the population, according to the parameters (1/100,000 inhabitants). However for treatment in serious cases, in 2011, there were only 68 specialist services given by the CAPS. Another modality for the process of treating patients outside of hospitals known as Residential Therapy, catered for 3,470 residents and in 2010, 92 street medical consultations were done in the country. Specialists have noted that the small amount of 24 hour community care services and the predominance of beds in psychiatric hospitals at the detriment of general hospitals goes against the anti-asylum model that was successful in Italy[3,7].

In relation to treatment for dependency, its success seems to depend on controlling the compulsive behavior in the cycles of use and abstinence[14]. There is no evidence showing that drugs used to control dependency and non-drug therapies have been used in serious cases[15]. This gives weight to solutions based on long term admissions and being subject to CT[16]. Apart from this, in the specific case of crack consumption, the usual scene of it being openly used on the street, has affected the traditional models for therapy[17]. This change in relation to the use of drugs and the speed in which the theme has taken center stage in Brazil, has put a lot of pressure on existing services. The issuing of directives by the MS to deal with problem areas in mental health reflects this assertion.

The regulatory framework, which encompasses acts, decrees and regulations, can be described as piecemeal. This is in accordance with studies on policies conducted by Lindblom[18], upon analyzing the decision-making process in the legislative branch of Government. Here policies are developed through having to choose between limited options. This results in incremental changes. This is particularly the case in the health sector when what is being discussed is not considered to be a major change (i.e. big-bang) as defined by Klein[19].

The damage limitation policies, which have been mentioned many time in official documents, have not been successful due to legal restrictions in the use of substitutive drugs. The specifics of this topic have been well debated and takes into account international experiences and what has been taking place in Brazil[20]. The creation of the National System for Public Policies on Drugs (SISNAD), in 2006 with emphasis on inter-sectoral actions was followed by Legislation 6.117 in 2007 which codified drug policies into laws and placed them under the Justice Ministry's jurisdiction. It covers: drug abuse, violence and criminality. Then in 2010 the Federal Government put together the Crack Plan, which was a consolidation of both the alcohol and drug's agenda in the political sector.

From 2011 we noted concerns with community care services. This showed the willingness on the part of specialists and mental health care managers to reaffirm the excellent CAPS models and the need to expand them at a faster rate. There was a drive to associate these policies with the Psychosocial Health Care Network (RAPS) which would place more priority on crack, alcohol and other drugs in SUS. Drop-in care centers for crack addicts and other drug abusers were created as residential services. At the same time on the street drug treatment centers were directed to help drug users on the street which included crack addicts.

As mentioned, the aim of this study was to analyze the mental health policies that have come to the fore on account of the increasing media and public attention on alcohol and drug problems. The proposals from the last Health Ministry directives on the scope of the RAP, which involved primary health care associated with hospitals, illustrates this adaptive process that exists. We did not have any independent studies that covered, in a definitive way, the balance between the services on offer, those requiring help and the possible lack in resources. However the way in which the Government has responded in an almost emergency like way to drug dependency, the high levels of mental health hospital admissions and to the woeful lack of effective community services, shows that the system is in dire need of reform.

A case study in the municipality of Rio de Janeiro

According to the Demographic Census for 2010[21] the municipality has 6,320,446 inhabitants. Its Human Development Index in 2011 was 0.799 which put it in the 45th position in the country and 9th amongst the country's capital cities. As it used to be the capital of the country, it retains a high number of federal health institutions. As regards the abuse of drugs, the city has a number of major urban areas where crack is openly consumed. We also observed in this municipality differing approaches, solutions, social experiments and many public debates on the issue of drug use.

We analyzed in Rio de Janeiro the health and social services and other services that sit outside

of the official health care public system in SMAD. During the period of our study there was a reduction in psychiatric admissions and the setting up of a community health care network in the municipality. Table 1 shows what occurred in relation to psychiatric admissions in the municipality with the reduction in psychiatric beds in the public sector in 1992 (this was at a time when other methods were en vogue) to 2012. The number of available psychiatric beds taking into account the total number of beds available for mental health patients on SUS fell from 21% (1992) to 8% (2012). There was, therefore, an overall reductions in the number of SUS beds during this period as specialist treatments were beginning to be used[22]. However, measurements based on the total of AIH paid to SUS, indicate that the intensity of the reduction was higher than the total reduction of beds on SUS in the country. In the case of mental health, the continuous reduction in admissions - from 97,598 in 1992 to 20,404 in 2012 - reflect the persuasive influence of RPB in terms of advocating for treatment outside of hospitals and an important series of innovative programs developed by the MS to incentivize community care.

The removal of treatment and care of psychiatric patients from hospitals (contrary to other tendencies) is aligned with policy objectives even though the resources are not always available. The out-patients regime is minimal and the Therapeutic Residential treatments still have some connection with hospitals. Community services show clinical and social responsibility through their mental health care services. New demands on the system, due to population increases and the public spotlight on these issues, have meant greater outpatient care and more pressure placed on the CAPS. The scarcity of these services, with reference to CAPS III, led to these services being provided by providers outside of the formal health care system, as can be seen in Table 1.

According to the MS data[14], the CAPS coverage in the state of Rio de Janeiro in 2011 was 59% (lower than the national average of 72%) with only CAPS III and CAPS ad III being registered to provide services. The RTs, where individuals are sent to after leaving specialist hospitals, were

Table 1. Hospital Admissions from SUS (AIH paid) based on the hospital departments/specialisms in the Municipality of Rio de Janeiro, 1992-2012.

Year	Psychiatry	Surgical Clinic	Obstetrics	Medical Clinic	Long-term Care	Pediatrics	Others*	Total
1992	97,598	93,744	90,823	83,661	61,210	32,999	1,263	461,298
1993	75,863	96,485	91,482	87,542	65,953	38,461	1,685	457,471
1994	50,382	78,884	81,036	77,166	64,383	33,719	1,649	387,219
1995	49,495	78,779	74,640	70,571	66,234	28,190	1,299	369,208
1996	47,910	87,712	81,622	72,985	57,785	33,181	2,899	384,094
1997	45,102	93,244	82,652	82,652	47,908	36,329	3,536	391,423
1998	39,669	93,838	65,979	83,451	27,934	33,324	4,980	349,175
1999	45,159	106,846	82,347	79,109	13,100	31,182	6,101	363,844
2000	50,118	109,463	81,289	76,351	14,039	28,890	4,451	364,601
2001	46,252	96,865	73,648	71,228	13,872	27,151	3,586	332,602
2002	42,762	84,878	71,065	64,543	13,691	22,969	3,288	303,196
2003	41,103	88,435	71,738	62.901	13,688	22,918	3,084	303,867
2004	38,594	92,131	71,376	65,314	13,109	23,893	3,785	308,202
2005	36,982	87,229	63,110	63,812	13,023	24,148	3,428	291,732
2006	32,937	85,135	52,416	61,566	11,473	23,293	3,486	270.306
2007	31,635	96,079	53,959	67,656	10,728	24,278	3,637	287,972
2008	28,013	73,250	41,302	59,214	10.505	23,394	4,699	240,377
2009	26,475	85,393	44,913	61,292	10,585	23,131	3,897	255,686
2010	23,433	84,376	47,293	63,546	10,145	22.701	2,923	254,417
2011	22,910	88,995	50,622	66,271	10,199	25.119	3,527	267,643
2012	20,404	93,734	48,418	64,142	10,182	24,482	3,750	265,112

* Includes Rehabilitation Dept, Pulmonology services, day surgery, mental health, AIDs, pos-transplant care. Source: Health Ministry - The Information System for Hospitals that make up SUS (SIH/SUS).

made up of 106 units with 593 residents. The is a lower number when compared with the numbers obtained in the process of de-hospitalization. In terms of treatment given at street units, there were only eight such units in the state, amongst 92 in the whole country.

To get a better understanding of the overall public services for those with mental health problems in Rio de Janeiro we looked at the number of officially contracted hours that psychiatrist worked. This information did not guarantee that these professionals actually fulfilled these hours, it was just an indication of what they could potentially do. The identifications of these hours was done through the National Registration for Health Bodies (CNES), as this database represents the official register for all health bodies in the country. In practice there is a greater amount of available information from SUS registered service providers than those in the private sector that are not registered.

In relation to the criteria used to select bodies, we used the presence of at least one registered psychiatric doctor and we excluded isolated medical centers. The potential service here that was identified was far more all-encompassing than that which was recommended in the guidelines from the MS for RAPS. This occurred because the selection based on the presence of psychiatrists brought together data on services that were not formally identified at the RAPS. In this way professional resources can be made available for professionals. On the other hand, the bias due to this type of selection, is inevitable in so much as a formal register of the confirmation to practice for RAPS in the municipality of Rio de Janeiro did not exist.

Nevertheless a number of things ought to be borne in mind with respect to this type of procedure. One of them relates to bodies that use trained mental health care professionals with the presence of a psychiatrist. It is evident that with the beginning of the RPB and the directives from the MS, incentives have existed for multi-professional and inter-disciplinary teams in basic mental health care and in the CAPS. There are also incentives connected to the work of psychiatrists and psychologists which makes the teams dynamic. The health bodies can choose whether to track and monitor patients through their psychiatrists covering diagnosis, medical prescriptions and the decisions on whether someone should be transferred to another unit or admitted. Specialists[23] have recommended that adequate treatment in mental health ought to consist of a combination of drug therapy and psychotherapy. If this occurs the presence of a medical psychiatrist will be essential in mental health services dealing with complex cases. In this way our selection criteria does not conflict with the policy that covers the inter-disciplinary fundamentals.

The tracking and monitoring that took place based on the aforementioned criteria showed the existence of 171 bodies in the municipality of Rio de Janeiro in May 2013. Of these, 109 (63.7%) exclusively provide services to SUS and 10 (5.9%) combine providing services to SUS and to private clients. The remaining 52 services (30.4%) deal exclusively with private clients. The exclusive provision of outpatient care occurs in relation to 95 services (55.6%) and in another 69 (40.4%) there are combined services which include emergency treatment and admissions. 7 services (4.1%) just deal with admissions.

In Table 2, the services are classified based on the type of treatment and service given. Irrespective of whether the service is provided on SUS or not, the majority of psychiatrists provide services in hospitals. The data shows that 40% of these services are covered by general and specialist hospitals. Within that number psychiatrists provide services in 70.4% of these cases and that amounts to 74.0% of their time when working. The CAPS are responsible for only 7.8% of contracted hours. Aside from this the Psychosocial Centers that cover alcohol and drug problems (CAPS-AD) and they represent only a small part of those that were counted. There are also other (available or not to individuals on SUS) outpatient services where psychiatrists are available such as: health centers, basic health units, policlinics and specialist centers. They only, however, represent 18.2% of the overall services that are offered.

One point should be noted. The MS directives, as mentioned, envisage the use of psychologists and other health care professionals in the treatment of individuals and this is seen as a positive attribute of the multi-professional model. The dearth in psychiatrists limits the creation of complete teams when services are needed to deal with complex or emergency cases as is often the case in the CAPS III. The difficulty in defining which health care professionals belong to which teams means that it is not possible to say with accuracy the scope and nature of the services on offer. However in the CAPS all of the highly trained professionals are available to practice.

According to the data in Table 3, the public health services have 77.6% of the psychiatrists and they cover 84.0% of their working hours fulfilling

their roles. In relation to access mechanism, we noted that services exclusively for SUS (80.5%) account for the majority of the treatment given. There are 25 CAPS which provide services under SUS. Of these, 23 provide outpatient care and only two combine this care with admissions or emergency treatment. All of the CAPS fall under the auspices of the public administration. These 25 CAPS have 60 psychiatrists who provide a total of 1,370 working hours per week. When one considers the estimated demand for services, this availability of professionals seems insufficient to sustain the policy on a larger scale.

The social assistance services are geared towards the most vulnerable in the population. Different to the health sector, in the case of social assistance, information on practices and conduct was not available in administrative databases. It needs to be directly obtained from the managers. The information that we have came from state and municipal organs of Rio de Janeiro particularly from the State Secretary for Social Assistance and Human Rights (SEASDH) and the Municipal Secretary for Social Development (SMDS). The terms of reference, powers and obligations between the state and municipal organs are not clearly defined. SEASDH mainly manages the principal state services and there is often an overlap of competencies in relation to the SMDS.

The state government adheres to the Confronting Crack Plan that came from the Federal Government. Through financial resources that came from the plan, SEASDH signed contracts with private institutions that manage Help and Care for Alcohol and Drugs Abusers Centers (CARE-AD). These services are a part of the public health and social care network. There are six of these units in the whole of the state of Rio de Janeiro that take patients sent by the CAPS and in 2013 they had 230 places available for patients in the whole of RJ. Two of these services are located in the capital. The main work that the SEASDH does in Rio de Janeiro is providing health treatment on the streets.

With reference to the SMDS, the CREAS (the Specialist Reference Center for Social Assistance) work in roughly the same way as the street clinics in although in some ways they are different. The CREAS do the following: make contact with crack addicts, they then register them, they provide them with advice and finally they are re-

Table 3. The total amount of psychiatrists and the number of weekly contracted working hours based on the selected characteristics of the service in the Municipality of Rio de Janeiro, 2013.

Characteristics	Psychiatrists		Weekly Hours	
	n	%	n	%
Administration				
Adm. Public	558	77.6	14796	84
Private Company	105	14.6	1766	10
Philanthropic	56	7.8	1053	6
Total	719	100	17615	100
Access				
Private	123	17.1	2400	13.6
SUS	543	75.5	14186	80.5
SUS + Private	53	7.4	1029	5.8
Total	719	100	17615	100

Source: CNES/MS.

Table 2. The total amount of services, psychiatrists and the number of contracted working hours based on the type of service in the Municipality of Rio de Janeiro, 2013.

	Services		Psychiatrists		Weekly Hours	
	n	%	n	%	n	%
General Hospital	40	23.4	149	20.7	3,571	20.3
Health Center/Basic Health Unit	35	20.5	67	9.3	1,642	9.3
Specialist Hospital	30	17.5	357	49.7	9466	53.7
Psychosocial Care Center	25	14.6	60	8.3	1,370	7.8
Specialist Clinc/Center	24	14	31	4.3	472	2.7
Policlinic	17	9.9	55	7.6	1,094	6.2
Total	171	100	719	100.0	17.615	100.0

Source: CNES/MS.

ferred to the CAPS network in the municipality. When drug users voluntarily accept some form of treatment, according to reports from teams, they are then sent to the Patience Shelter (in the center of the borough). These services can cater for 400 people, but this is not specifically for drug users. In general individuals are seen to whilst on the street. They are backed up by multi-professional and outpatient teams that are capable of dealing with less serious drug problems. The shelters also send individuals to the CAPS.

Children and young adults are sent to the reception part of the Children and Young Persons Court and Social Services are notified. The young people that have been using drugs are sent to the Living House (Casa Viva) project or another specialist treatment unit. If such treatment is not necessary they are sent to the CAPS. There are six specialist care centers that have contracts with the SMDS. Each of these units have the capacity to deal with up to 20 teenagers, which adds up to 120 spaces for the whole of the Rio de Janeiro municipality. Another way to receive help from these units is through the criminal justice system. Many of these young people that are dealt with by the system do not present any signs of substance abuse and the often come from different districts.

SEASDH has more organized information on the attention given to people in need which comes from the Observatory Information on Drugs. This information is held in partnership with the State University of Rio de Janeiro (UERJ). According to the data from the Observatory for January to October 2012, 714 cases were treated in relation to drug abuse where the individual had been a street user and the drug in question was either cocaine, crack or the case involved the use of alcohol. There were cases where all of the above was being used by the individual. The target audience for these services is individuals over the age of 18 that have been sent to care shelters from the mental care networks due to their compulsion for drug misuse or mental health risks. The more serious clinical conditions, abstinence syndromes or psychotic crisis are sent with urgency to psychiatric services, general hospitals or Accident and Emergency units (UPA). In this way the CARE-AD are not recommended for serious cases of drug misuse and they only have 90 spaces for patients. The average waiting time was between 30 to 60 days.

In relation to services and actions outside of the public health and social assistance system, we obtained information from the Brazilian Federation for Therapeutic Communities (FEBRACT), which is the traditional body that acts in this sector. Searches via the internet were important to identify other services and organizations acting in this area, particularly in the archdiocese of Rio de Janeiro.

In the case of CT, the information available was neither complete nor consistent, which hampered any form of analysis on the quality of the services. On the FEBRACT site (www.febract.org.br) there was no information on the nature of the services. Information from managers showed that 1,000 CTs are in the country. The service given is free and it is for individuals that are 15 years old or over. They do not follow any official clinical protocols nor do they have minimum number of professionals in their teams to meet service demands. Financing comes from voluntary donations and access to their services is on a drop-in basis. They also accept judicial referrals.

With reference to FEBRACT, it was possible to observe that they were not restricted to a specific denomination or a particular religious entity. They have a list of service given in a cooperative network and their governance framework is not clearly defined. Aside from this the network is not well publicized and accounts for only 20.1% of the services that were registered on CNES.

In order to analyze the geographical reach of the services characterized as CT, we looked at a map showing where all of the health institutions were since 2007, which was obtained from the National Secretary for Drugs. In the area of social assistance, we looked at documents from the Ministry of Social Development (MDS) which had a list of services as CREAS and Specialist Shelters for caring for drug users. Amongst the services from the Municipal Council for Policies on Drugs (COMAD) there was a list of various outpatient public services. There was also information on: private services, not-for-profit bodies, general hospitals and specialist hospitals. The majority of the aforementioned were public. What was common on the list was a combination of well-known public institutions and various philanthropic associations.

The religious organization, the National Confederation for Bishops in Brazil (Pastoral Sobriety) coordinated the integrated network for therapeutic communities, recuperation centers and mutual help groups. Their services aim to rehabilitate drug user and provide help for their families. This religious body kept records on all of the treatment and services given according to country, state and municipality.

From this we were able to utilize criteria that were far more all-encompassing from the list of services including public bodies. We put together a database covering the municipality of Rio de Janeiro which covered 227 registered services such as mental care treatment. From these 46.7% were SUS service providers.

In the specific case of FEBRACT, which is a very politically active body, we observed 46 services in the municipality of Rio de Janeiro. In this network we observed the presence of some establishments that provided private services to other clients or which have contracts with SUS. The governance framework for this network showed weaknesses in the procedures for sending drug users to the public network. Amongst the services listed, some were connected to well-known public institutions as UERJ and the Oswaldo Cruz Foundation (Fiocruz). Others represent non-governmental organizations (ONG) acting in health care. The majority of these are connected to religions namely Catholicism or Evangelicalism.

There are also four CTs listed by the Evangelical Federation of Therapeutical Communities in Brazil and, according to COMAD, these self-proclaimed institutions provide social care and assistance. Just as was the case with the CT, we were not able to obtain public records or additional data in order to do a preliminary evaluation of their capacity to provide services in these areas.

In relation to the mutual help groups the aforementioned Pastoral Sobriety body told us of their work in providing training for their agents and facilitating mutual help in the country. Where individuals participate in the groups, they are considered to have received treatment which is evaluated by trained agents on the course. According to the data in the municipality of Rio de Janeiro between 2002-2012, 414 agents were trained, 18 courses were carried out and there were 73,389 cases where treatment was given (on average 9.3 participants per group meeting). The breakdown in the number of drug and alcohol users needing help was the following according to the agents: 21.5% for alcohol, 15.5% nicotine, 11.7% marijuana, 11.0% cocaine and 5.9% crack (the others were 34.4%). Not all of the treatment data was available including patients clinical conditions and procedures/therapies that were used.

These bodies have developed outside of the mainstream public health and social care system. They are not necessarily transparent with reference to their clinical practices and therapies used. Their judicial status is not clear particularly in relation to the treatment they are giving. Recent regulations from the MS have tried to impose more rigid measures which deal with the make-up of their teams and protocols for treatment. It has also tried to enforce service provider registration where payment is given by the public.

Final Considerations

In this paper we analyzed the responses from governmental sectors and policy development managers in the area of mental health care after the implementation of reform measures when the Paulo Delgado Law was passed. We considered that the challenges for different governments, in relation to implementing community networks, were also necessities that would arise from de-hospitalizations. The challenge would be to deal with the pressing issues of alcohol and drugs problems in the light of growing public interest.

Through an analysis of directives from the MS we found that they were at best piecemeal. Their aims were to strength: the CAPS, the mental health care networks as a response to the complex political process and to meet the new demands that came from the reforms. Admissions to general hospitals for mental health patients and the creation of agile street care teams to provide treatment on the road, show the incremental responses that the Government has given to tackle these problems. This can be said for residential therapy programs and benefits given to support families. The knee jerk actions in the creation of CAPS III show the necessity to have responses that are more objective. This is particularly the case for the current situation where there is lack of primary health care service providers for serious cases.

On the other hand, as we showed when monitoring and analyzing the availability of specialists, the offer of community services (CAP and other primary health care services) is evidently inadequate, especially for supporting those in critical situations.

In the middle of the Government responding to the needs in the health sector through the provision of psychiatric reforms, two types of (public social services and philanthropic/religious services) have become more visible and are aimed at filling the health gaps. These services work through providing shelter for those in need in public units. The service providers are often philanthropic or religious in nature and the

treatment may go on for a long period of time. This reminds us of the debate surrounding the institutionalization of mental health sufferers and for those with drug dependency problems. These groups are aided by social services in the form of shelters which have generally been set up by social care secretaries and therapeutic communities or similar communities which are philanthropic or religious in nature. The social care services tend to follow protocols and guideline from SUS. These communities, which offer therapeutic treatment, are often independent and do not have systems where they make records of their practices. They often reject governmental interference and control in their organizations.

This case study in the municipality of Rio de Janeiro has brought to light many different models and practices that are in both the public and private sector and the initiatives in civil entities. Our finding represent important challenges for public policy which are: (i) the need to avoid at all costs compulsory admissions to mental health hospitals akin to the asylums of the past; (ii) to define at what level the return in the use of aspect of the asylum model can weaken the exiting mental health care community network; (iii) to define mechanisms to adjust alternative community therapies so that they act as part of the mainstream health service; (iv) to develop more effective policies involved in implementing services such as those provide by CAPS III for serious cases; (v) to speed up the integration of services that are different in one network for the provision of psychosocial care and (vi) to promote adequate incentives and innovative solutions for the current lack of psychiatrists in the public sector.

These challenges can also be viewed as policy recommendations that are aligned to local and international trends in health care. This is the case, for example, regarding dehospitalization, outpatient and community treatment and the regulation of the decision-making process for professionals and service providers. There also needs to be changes in the training of professionals in this area and interdisciplinary teams.

The success of the mental health policies is strongly dependent on the structure and the quality of the services given by SUS. The public health system is hampered by inadequate financing and increases in spending. The above means that leaders and managers in this sector must be committed to psychiatric care reforms, to invest in innovation and to take advantage of the existing care units. The above needs to be done in order to avoid lengthy psychiatric admissions (some of which are compulsory) and the feelings that some families have of being abandoned by the state. The current health situation needs to be change starting off with policy reforms.

Collaborations

JM Ribeiro, MR Moreira, FIPM Bastos, A Inglez-Dias and FMB Fernandes participated in: the idea for this paper, the development of the research methodology used and drafting of this study. JM Ribeiro also drafted the final version.

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Article submitted 10/09/2014
Approved 06/05/2015
Final version submitted 08/05/2015