Psychoactive Substances and the Provision of Specialized Care: The Case of Espirito Santo[1]

Marluce Miguel de Siqueira[2], Dulce A. Barbosa[3], Ronaldo Laranjeira[4], Kristine Hopkins[5]

ABSTRACT

Objective: In this study, we conducted a survey of all the institutions that provide treatment for psychoactive substances in the state of Espirito Santo, Brazil during the period 2004-2005.

Methods: We used a snowball sampling technique to include all the state's treatment facilities in which we employed a semi-structured interview instrument to key informants at each institution. We present descriptive results and test differences between groups using the Chi-square test.

Results: In Espirito Santo, 250 institutions provide treatment for psychoactive substances and are distributed as follows: governmental (17.6%), nongovernmental (22.8%), and self-help groups (59.6%). Of these 250 institutions, 85 provide direct care, with the majority found in the Center region (70.6%), followed by the North (15.3%) and South (14.1%) regions. The majority of those that provide direct care are private nonprofits (16.8%). Institutions with ties to religious organizations make up nearly one-third (30.6%) of direct care providers. The drugs most consumed by those seeking care are alcohol (82.4%), tobacco (81.2%) and marijuana (68.2%). The institutions generally serve people in the 26-45 year age group (89.4%); with regard to the gender the institutions take care of only men (31.8%), only women (5.9%), and both (56.5%). The treatment models most used are psychosocial (58.8%), therapeutic community (47.1%) and biomedical (43.5%) and work is evaluated through the team technique (72.9 %).

Conclusions: In the state of Espirito Santo, indirect care services are many times greater than those that offer direct care; the majority of all services are in the Center region. The populations in the interior of the state are at a comparative disadvantage when it comes to treatment options for psychoactive substance use. We observed that a significant number of institutions that provide drug abuse treatment have financial support from religious organizations.

The Espirito Santo State survey demonstrates the necessity of a decentralized provision specialized care for psychoactive substance users, with substantially more services directed to the North and South regions of the state. Moreover, the emphasis of these new institutions should be on outpatient care.

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[1] The project received financial support from agencies CNPq and CAPES.

[2] PhD of Nursing School, NEAD coordinator of Federal University of Espirito Santo - UFES – Vitória (ES) – Brazil, Pos-Doctoral at Federal University of São Paulo – UNIFESP- São Paulo (SP) – Brazil and University of Texas at Austin (Tx) – EUA.

[3] PhD of Nursing School, PPGE coordinator of Federal University of São Paulo – UNIFESP- São Paulo (SP) – Brazil and co-supervisor of Pos-Doctoral.

[4] PhD of Medicine School, UNIAD coordinator of Federal University of São Paulo – UNIFESP- São Paulo (SP) – Brazil and supervisor of Pos-Doctoral.

[5] Research Associate, Population Research Center, Research Director, Vilmar Faria Fellowship in Quantitative Analysis and Public Policy, University of Texas at Austin (Tx) – EUA and supervisor of Pos-Doctoral.

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INTRODUCTION

Psychoactive substance (PAS) consumption is present throughout the world, unleashing diverse impacts on the individual, family and society. A 2002 World Health Organization[1] report indicated that 8.9% of the global load of illnesses result from the consumption of PAS, with tobacco accounting for 4.1%, alcohol for 4% and illicit drugs for 0.8% of the global disease load. In the Americas and Europe, more than half of the population had used alcohol some time in their life (NIAAA, 1998; and WHO, 1999)[2,3] and around a quarter smoke (WHO, 2000)[4]. Illicit drugs reach 4.2% of world's population (UNODCCP, 2000; WHO, 2004) [5,6]

The social and health problems related to the consumption and dependence of legal and illicit drugs currently are well known and considered a significant public health challenge. This challenge requires the attention of decision markers and the creation of appropriate public policies, as well as the involvement of representatives of all the segments of society: politicians, legislators, researchers, health professionals, and civil society groups (Sacardo, 2003; BRAZIL, 2003)[7,8].

In the last ten to fifteen years, the Brazilian government has attempted to implement strategies to reduce the demand and supply of drugs. These policies have centered on integrating several social sectors, such as education, health, social work, sports, justice, and public security (BRAZIL, 2001; 2003; 2004a, 2004b)[7,9-11]. The prime example of this approach is National Antidrug Policy (*Política Nacional Antidrogas* – PNAD), whose objectives are the reduction of the demand and supply of drugs and are focused on, for the user, prevention, treatment, recuperation, reintegration into society, reduction of damages; law enforcement; and support for research and evaluation of existing programs and treatment models.

In April of 2002, the Brazilian Ministry of Health launched the National Program of Integral Care for Alcohol and other Drugs Users (*Política de Atenção*

integral aos usuários Álcool e outras Drogas - PAIUAD) aiming to integrate federal, state and municipal actions, as well as organizing and implanting the network of care in this area. In 2003, the Health Ministry published norms for the Centers of Psychosocial Care for Alcohol and Drugs Users (*Centro de Atenção Psicossocial para Usuários de Álcool e Drogas* - CAPSad), which had as its goal to give specialized outpatient assistance, as well as articulating the network of services in this field (BRAZIL, 2003; 2004c)[7,12].

The development and implementation of treatment options are the result, in the majority of countries, of initiatives of private or nongovernmental organizations such as foundations, religious organizations and community organizations. In few cases, however, treatment programs are promoted by the government. Developing countries have imported and replicated the therapeutic experiences used by many developed countries (Silveira & Moreira, 2006)[13].

In Brazil, assistance for problems resulting from psychoactive substance use is currently provided in a wide variety of settings which include inpatient and outpatient services and whose characteristics can vary substantially. That is, these services vary in terms of treatment team, physical resources, equipment available, and treatment models. According to diverse authors (Laranjeira, 1996; Tancredi, 1998; Formigoni, 2001; Ribeiro, 2004)[14-17], the services are organized with limited service potential and are not subordinated to local needs. Silveira & Moreira, 2006[13], in a recent publication, describe the services of the Brazilian care system for PAS users from a decentralized vision integrating services with diverse complexity and articulating them with already existing ones into a network of care for social and health issues. This care is carried out inside and outside of hospitals, in private and public services, and nongovernmental organizations.

Hence, we were motivated to investigate the actual network of care provision available to drug users in the state of Espirito Santo. According to IBGE data (2005)[18], Espirito Santo totals 3,399,255 people, with 1,901,577 (56%) in the Center region, 894,087 (26.3%) in North and 603,591 (17.7%) in the South. Of this total, 48.9% of the population is male and 51.1% is female.

Medical care is provided through 1,496 establishments (895 public and 596 private), 122 with inpatient care (25 public and 97 private), 1,036 with outpatient care only (859 public and 177 private) and 1,057 through services of the Unified Health System (*Sistema Único de Saúde* - SUS).

In addition, Espirito Santo does not have specific epidemiological studies on use, abuse and dependence of psychoactive substances. Using the Southeastern Region of the First Household Survey on the Use of Psychotropic Drugs in Brazil (CEBRID, 2001)[19], can give us an approximation of the conditions present in the state of Espirito Santo. The survey found that lifetime use of any drug except alcohol and tobacco was 16.9% in the Southeast, somewhat lower than the Brazilian mean of 19.4%, while lifetime use of alcohol in the region was 71.5% and alcohol-dependence was 9.2%, compared to 68.7% and 11.2% in Brazil, respectively. The Southeast also has the highest lifetime use of cocaine 2.6% and crack 0.4% in Brazil. In addition, dependence on alcohol (9.2%) and tobacco (8.4%) is very significant, being more frequent in males (13.8% and 9.7%, respectively) than in female (4.7% and 4,3%, respectively).

The lack of national data about services that provide assistance to the problems resulting from psychoactive substance use (SENAD, 2006)[20], as well as the scarcity of qualified information about the institutions of specialized attention in Espirito Santo, like areas of coverage, institutional profile, client profile, who receives care, and so on, all motivate this study. Our objective, therefore, is to carry out a survey of the institutions that provide treatment for psychoactive substance use in the state of Espirito Santo. We provide an analysis of the network of care provision in the state.

METHODOLOGY

We sought to gather information on all the institutions in the state of Espirito Santo that provide direct and indirect services for the prevention or treatment of psychoactive substance use during the period of 2004 and 2005.

The research was developed on the governmental institutions including managing agencies of Health and Social as State and Municipal Departments of

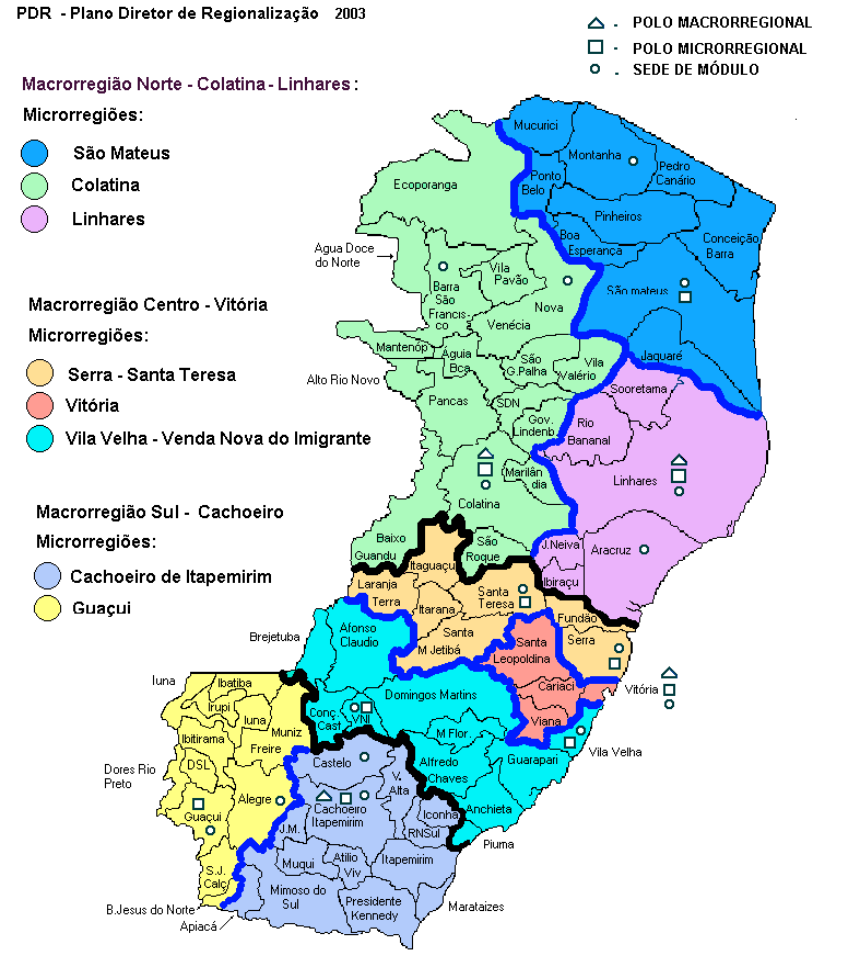
Health and Social Assistance; State and Municipal Anti-drug Councils and Study Groups and non governmental including self-help groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Families of Alcoholics Anonymous (AL-ANON) located in the country and on the capital of the State

The study was submitted to the Graduate Program in Psychiatry, and, after its approval, was sent to the Committee of Ethics in Research of the Federal University of São Paulo (UNIFESP). We obtained informed consent from all respondents, in accordance with Resolution 196/96 of the Brazil National Health Council[21]. In the collection of data we used a semi-structured questionnaire composed of 40 questions in the following three groups: (1) respondent background; (2) institutional organization; and (3) treatment. The five treatment models from which institutions chose were: *psychosocial*, which involves social learning, the familial interaction and personality characteristics; *therapeutic community*, which are long-term residential programs for drug abuse treatment; *biomedical*, where drug dependence is seen as a chronic and recurrent upheaval with a biological and genetic base, having as its goal total abstinence; *alternative*, which use spiritual activities and biblical study; and *self-help programs*, which employ the twelve-step approach, known as the Minnesota Model[22-29]. The instrument initially was tested in three institutions in the municipality of Vitória, one each at the municipal, state and federal level of care provision. After making adjustments, such as adding a more complete categorization of registry types and the elimination of repetitive questions, the survey was put into the field.

Institutions were identified using the following two techniques. We first took a survey with 123 institutions noted in the "Catalogue of Institutions Specialized in Chemical Dependence" (Garcia & Siqueira, 2003)[30]. Next, using the snowball sampling technique (Coleman, 1958; Dunn & Ferri, 1999)[31-32], we asked informants at the visited institutions to indicate new organizations in their city and/or another city. In this way we added 127 new listings that were not in the original Catalogue, for a total of 250 institutions.

The interviews were carried out by nursing and social work students from the Federal University of Espirito Santo, during the period from July 2004 to June 2005 under the supervision of the coordinator of the specific region. Visits to the institutions were divided into three administrative health zones – North, Center, and South (Map 1) – and interviews were scheduled ahead of time by telephone.

Map 1 - Regional Distribution, Espirito Santo state



Source: SESA, 2005 [33]

Data were analyzed with the Statistical Package for Social Sciences - SPSS for Windows, version 14 SPSS, 2005[34], using tabulations and Chi-square test for difference between groups.

RESULTS

Table 1. Institutions that Provide Care for the Psychoactive Substance Users in Espirito Santo, Brazil

Types of Institutions	N	%
Governmental:	**44**	**17.6**
Federal	3	1.2
Direct Assistance		
Alcohol Program	1	0.4
Indirect Assistance		
Nucleus of Studies on the Alcohol and other Drugs NEAD	1	0.4
Repression Department	1	0.4
State	9	3.6
Direct Assistance		
Clinics	5	2.0
Tobacco Program	1	0.4
Indirect Assistance		
State Antidrug Council COESAD	1	0.4
State Coordination of Mental Health CORSAM	1	0.4
State Coordination of Tobacco COETAP	1	0.4
Municipal	32	12.8
Direct Assistance		
Clinics	9	3.6
Center for Psychosocial Care CAPS	3	1.2
Center for Psychosocial Care CAPSad	3	1.2
Tobacco Program	6	2.4
Indirect Assistance		
Municipal Antidrug Council COMAD[1]	10	4.0
Municipal Coordination of Tobacco COMTAP	1	0.4
Non-Governmental[2]	**57**	**22.8**
Non-profit clinics	42	16.8
For profit clinics	15	6.0
Self-Help Groups	**149**	**59.6**
Alcoholics Anonymous AA[3]	108	43.2
Anonymous narcotics NA[3]	24	9.6
Families of Alcoholics Anonymous AL-ANON[3]	10	4.0
Demanding Love[4]	7	2.8
T O T A L	**250**	**100.0**

[1] COESAD, 2005[35]
[2] All non-governmental institutions provide direct assistance.
[3] Alcoholics Anonymous 2006[36]; all group provide indirect assistance.
[4] Brazilian Confederacy of Demanding Love, 2005[37]; all groups provide indirect assistance.

In table 1 we see selected characteristics of the institutions that provide care for the psychoactive substance users in the state of Espirito Santo, and we can observe that in the period studied, 250 institutions or groups offered some sort of care. Governmental institutions accounted for 44 (17.6%) of the total and non-governmental groups accounted for 57 (22.8%), while self-help groups made up the majority of services offered in the state, at 149 (59.6%) institutions. Among the governmental institutions, three (1.2%) were federal, nine (3.6%) were state and 32 (12.8%) municipal. Among the non-governmental institutions that offer services, 42 (16.8%) were nonprofits and 15 (6.0%) were profit-making enterprises. The self-help group that predominates in Espirito Santo is Alcoholics Anonymous with 108 groups, or 43.2% of the total. Finally, of the 13 Centers of Psychosocial Care (CAPSad or CAPS) in Espirito Santo state, only six (2.4%) offered direct assistance for the drug users.

In Table 2, we restrict our sample to the 85 institutions that provided direct inpatient or outpatient services. Therefore, we excluded 165 institutions that provide indirect assistance, such as all self-help groups, municipal or state antidrug councils, and municipal or state tobacco programs. While self-help groups provide services to PAS, we exclude them here to focus on the institutions that provide clinical care either through inpatient, outpatient or triage services. The majority of the 85 institutions in Espirito Santo that provide direct services are concentrated in the Center region (70.6%), offer inpatient services (61.2%) and are registered in the city departments of health, SEMUS, (43.5%). In the offer of psychoactive substance abuse treatment in the Espirito Santo market, we can see a predominance of private nonprofit institutions (49.4%) and religious organizations (30.6%). Moreover, 47.1% of the financial resources in the institutions come from the users and their families. Finally, psychologists there are on staff in 64 of 85 institutions (75.3%), followed by medical doctors on 57 (67.1%) of the institutions' staffs.

Table 2 - Profile of Institutions that Provide Direct Care Services for Psychoactive Substance Treatment*

Variables	Frequency N=85	Percentage %
Administrative region		
Center	62	70.6
North	13	15.3
South	12	14.1
Registered		
Yes	80	94.1
No	5	5.9
Registering Agency		
SEMUS Municipal Health Department	37	43.5
SESA State Health Department	31	36.5
SEAS State Social Work Department	9	10.6
COESAD State Antidrug Council	8	9.4
SENAD National Antidrug Department	3	3.5
Institutional characteristic		
Private non-profit	42	49.4
Private for profit	15	17.6
Public	28	32.9
Financial support agency		
Church Religious organizations	26	30.6
Donations	24	28.2
Own resources	16	18.8
Municipal government	18	21.2
State government	10	11.8
Federal government	2	2.4
Financial resources		
Users and family	40	47.1
Donations	37	43.5
Municipal/State/Federal Treasury	32	37.6
Private institutions	22	25.9
Product Sales	16	18.8
Accords public institutions	11	12.9
Human resources		
Psychologist	64	75.3
Medical doctor	57	67.1
Social worker	43	50.6
Nurse	41	48.2
Nurse assistant	36	42.4
Psychiatrist	35	41.2
Volunteer	29	34.1
Member of GAM	27	31.8
Consultant	18	21.2
Priest	18	21.2
Health agent	12	14.1
Trainee	4	4.7
Type of Service		
Inpatient	52	61.2
Outpatient	28	32.9
Triage	5	5.9

* Excludes 165 institutions that provide indirect assistance.

Table 3 shows the profile of the psychoactive substances treatment in Espirito Santo, where we observe that the choice of 34.1% of clinical treatment is less serious cases and 36.5% of the hospitalizations are due to how much serious the case is. The responsibility of authorizing admittance to the hospital is dominated by the user (52.4%), followed by the family (45.3%); the minimum time in treatment is ≤ 90 days (14.1%) and the maximum is ≥ 120 (27.1%). The most used drugs are alcohol (82.4%) and tobacco (81.2%) among the users from followed by marijuana (68.2%). The age range reported by the institutions is placed between 26 and 45 years (89.4%); 56.5% of the institutions offer care for both sexes (31.8% only for males and 5.9% only for females). In 92.1% of the cases, the patients are from the same municipality as where the institution is located. With regard to the treatment model, 58.8% of the institutions use the psychosocial model, followed by the use of a therapeutic community (47.1%) and biomedical (43.5%); Individualized care is the priority in treatment in 89.4% of institutions, with group therapy following closely behind in 84.7% of institutions. Psychological activities make up the majority (85.9%) of activities offered and, in the majority of institutions (72.9%), the evaluation of the treatment technique is carried out by the members of the team.

Table 3. Profile of the Psychoactive Substance Treatment in Espirito Santo

Variables	Frequency N=80*	Percentage %
Criterion of Outpatient Treatment		
Less serious cases	29	34.1
To believe to be optimum	25	29.4
Lack of option to admit	4	4.7
Criterion of Inpatient Treatment		
Equal for all	24	28.2
It varies with the severity of the case	31	36.5
Time of Internment		
Minimum	≤ 90 days	14.1
Maximum	≥ 120 days	27.1
Age		
10 to 15 years	33	38.8
26 to 45 years	76	89.4
66 years or +	51	60.0
Sex		
Only males	27	31.8
Only females	5	5.9
Both sexes	48	56.5
Origin of Patients		
Same municipality	79	92.1
Other municipalities	70	82.4
Other states	37	43.5
Most consumed drug		
Alcohol	70	82.4
Tobacco	69	81.2
Marijuana	58	68.2
Cocaine	57	67.2
Crack	54	63.5
Tranquilizers	42	49.4
Multiple drugs	52	61.2
Developed activities		
Psychological	73	85.9
Physical	69	81.2
Recreational	61	71.8
Occupational	57	67.1
Spiritual	50	58.8
Type of Assistance		
Individual	76	89.4
Group	72	84.7
Community	33	38.8
Treatment models		
Psychosocial	50	58.8
Therapeutic community	40	47.1
Biomedical	37	43.5
Alternative	33	38.8
Self-help	9	10.6
Treatment Evaluation		
Team	62	72.9
Users	15	17.6
Mantaining agency	17	20.0

* Excludes 5 institutions that do only triage.

In table 4 we present crosstabs of the variables that comprise the **institutional characteristics** (registry, program and therapy type, financial and human resources) **by ownership status** (private non-profit, private for–profit, and public) in Espirito Santo. The numbers presented are row totals; that is, all numbers across the row sum to 100% of the institutions in that sub-category. We present row totals in this and the subsequent table to more clearly show differences *across* the three ownership statuses. That is, rather than focus on the differences *within* each ownership category (column percentages), we wish to show how these institutional characteristics compare based on whether they are publicly or privately held, and for profit or not for profit. All variables presented were statistically significant in the Chi-squared test, with a value of ***p*** varying of ***p*** ≤ 0.001 until ***p*** ≤ 0.05. Some characteristics are more heavily weighted toward private non-profits e.g., 35 private non-profit institutions (66.1%) offer inpatient programs (p ≤ 0.001), 24 (92.3%) treat with biblical study (p ≤ 0.001), 35 (87.5%) treat with therapeutic model community (p ≤ 0.001) and 17 (94.4%) have a shepherd on their human resources team (p ≤ 0.001); compared to private for-profits in which 12 (28.5%) offer outpatient programs (p ≤ 0.001), 5 (31.2%) offer familiar therapy (p ≤ 0.05), 11 (22%) treat with the psychosocial model (p ≤ 0.001) and 10 (55.5%) have consultants on their human resources team (p ≤ 0.001). Finally, public institutions show that 22 (71%) are registry at SESA (p ≤ 0.001), 18 (50%) offer prevention programs (p ≤ 0.05), 8 (50%) offer familiar therapy (p ≤ 0.05), 25 (67.5%) treat with the biomedical model (p ≤ 0.001) and 24 (58.5%) have nurses predominating their human resources team (p ≤ 0.001).

Table 4 – Institutional Characteristics, by Ownership Status

Treatment Profile	Private non-profit N	%	Private for profit N	%	Public N	%	Total N	X^2 p value
Registry								
SEMUS[1]	10	27.0	9	24.3	18	48.6	37	0.001
SESA[2]	4	12.9	5	16.1	22	71.0	31	0.001
SEAS[3]	8	88.9	0	0.0	1	11.1	9	0.041
Program type								
Prevention	14	38.8	4	11.1	18	50.0	36	0.015
Outpatient	8	19.1	12	28.5	22	52.4	42	0.001
Inpatient	35	66.1	10	18.7	8	15.1	53	0.001
Therapy type								
Family	3	18.7	5	31.2	8	50.0	16	0.023
Occupational	34	64.1	8	15.1	11	20.8	53	0.001
Biblical study	24	92.3	0	0.0	2	7.7	26	0.001
Treatment model								0.001[a]
Biomedical	4	10.8	8	21.6	25	67.5	37	
Therapeutic community	35	87.5	4	10.0	1	2.5	40	
Psychosocial	14	28.0	11	22.0	25	5.0	50	
Alternative	28	84.8	3	9.1	2	6.1	33	
Human resources								
Medicine	20	35.1	14	24.6	23	40.3	57	0.001
Social work	14	32.5	6	13.9	23	53.4	43	0.001
Psychology	25	39.0	14	21.9	25	39.0	64	0.001
Nursing	7	17.0	10	24.3	24	58.5	41	0.001
Nursing assistant	9	25.0	9	25.0	18	50.0	36	0.001
Consultant	7	38.8	10	55.5	1	5.5	18	0.001
Member GAM	12	44.4	9	38.3	6	22.2	27	0.029
Shepherd	17	94.4	0	0.0	1	5.5	18	0.001
Volunteers	27	93.1	0	0.0	2	6.9	29	0.001
Financial resources								
Users / Family	27	67.5	13	32.5	0	0.0	40	0.001
Treasury[4]	6	18.7	1	0.03	25	78.1	32	0.001
Private health insurance	14	63.6	7	31.8	1	4.5	22	0.003
Donations	32	86.4	1	2.7	4	10.8	37	0.001
Product sales	15	93.7	1	6.2	0	0.0	16	0.001

Note: Totals are the number of institutions in the sample for which the condition is true. Percentages are percent of total in that category (row percentages).

[1] Municipal Health Department.

[2] State Health Department.

[3] State Social Work Department.

[4] Municipal, State and Federal.

[a] Variable contains mutually exclusive categories.

In table 5 we present the patient characteristics (age range, sex, drug most consumed) by ownership status (private non-profit and private for-profits and public institutions) in Espirito Santo. All variables of the treatment profile were statistically significant in the Chi-squared test, with a value of ***p*** varying of ***p*** ≤ 0.001 until ***p*** ≤ 0,05. Some treatment profiles are more heavily weighted

toward private non-profits, e.g., in 38 (58.4%) the treatment age ranged from 16 to 20 years ($p \leq 0.001$); 26 (96.2%) institutions offer treatment for males only ($p \leq 0.001$) and 13 (86.6%) in which crack is the most consumed drug ($p \leq 0.001$). Private for profits, on the other hand, show that in 11 (16.9%) the treatment age ranges from 16 to 20 years ($p \leq 0.001$), 15 (31.2%) offer treatment for both sexes ($p \leq 0.001$) and 8 (21.6%) in which alcohol is the drug most consumed ($p \leq 0.001$). Finally, in the public sector, 22 (43.1%) offer treatment to the age range of 66 years or more ($p \leq 0.331$), 25 (52.1%) offer treatment for both sexes ($p \leq 0.001$) and 9 (81.8%) in which tobacco is drug most consumed.

Table 5 - Patient Characteristics, by Ownership Status

Treatment Profile	Private non-profit		Private for profit		Public		Total	X^2 p value
	N	%	N	%	N	%	N	
Age								
16 to 20 years	38	58.4	11	16.9	16	24.6	65	0.001
66 years or more	21	41.1	8	15.6	22	43.1	51	0.097
Sex								0.001[a]
Only male	26	96.2	0	0.0	1	3.7	27	
Only female	4	80.0	0	0.0	1	20.0	5	
Both sexes	8	16.6	15	31.2	25	52.1	48	
Drug Most Consumed								0.001[a]
Alcohol	12	32.4	8	21.6	17	45.9	37	
Tabacco	2	18.1	0	0.0	9	81.8	11	
Tranquilizantes	0	0.0	1	100.0	0	0.0	1	
Marijuana	7	87.5	2	25.0	1	12.5	8	
Cocaine	2	40.0	2	40.0	1	20.0	5	
Crack	13	86.6	2	13.3	0	0.0	15	
Multiple	2	66.6	1	33.3	0	0.0	3	

Note: Totals are the number of institutions in the sample for which the condition is true. Percentages are percent of total in that category.

[a] Variable contains mutually exclusive categories.

DISCUSSION

1. Profile of Institutions that Provide Direct Care Services for Psychoactive Substance Treatment

In Espirito Santo we have 85 institutions for the treatment of problems with psychoactive substances. Of these, 62 (70.6%) institutions are in the Center region, 13 (15.3%) in the North region and 12 (14.1%) in South region. The types of services offered by institutions are triage in 5 (5.9%), clinic outpatient

services in 28 (32.9%) and 52 which offer (61.2%) inpatient care. The finding that only 32.9% of the institutions offer outpatient services does not jibe with existing health policies that require the regionalization and hierarchical nature of the system, with emphasis in the primary and secondary care. Depending on the level of clinical damage of the psychoactive substance user, the preferential treatment option is outpatient care, because being closer the social and familiar environment of the user is less traumatic and less expensive than inpatient care (BRAZIL, 1991; 2004d)[38,39]. An emphasis on the tertiary sector is observed in the Espirito Santo, which privileges inpatient services in hospitals, clinics, and therapeutic communities, to the detriment of the outpatient care in the same institutions. Federal and state governments, therefore, transfer their care responsibilities of the problems resulting from psychoactive substance use and abuse to services in the philanthropic or private sectors, as is the case of the therapeutic communities, despite lack of oversight for those services.

It is important to highlight that from the beginning of 20th century to the middle of 1980s inpatient care was the priority recommended treatment to any situation of abuse or dependence of substance psychoactive. From the 1980s to 1990s, this hospital-focused perspective gradually began to be substituted by the new model promoted by the Center of Psychosocial Care for Alcohol and other Drugs (CAPSad), in that inpatient care is recommended only in cases of more serious physical, social or family risk. Outpatient treatment, meanwhile, which is closer to the daily reality of the user, became valued and stimulated (BRAZIL, 2004c; 2004d)[12,39].

The vast majority of institutions, 80 or 94.1%, are registered with a government agency in Espirito Santo. The study detected that the registrations are with the city and state departments of Health of the Espirito Santo with a small number registered with the State Social Work Department and State Antidrug Council, as well as in the National Antidrug Department.

Regarding the 85 studied institutions, 42 (49.4%) are private non-profits, 15 (17.6%) are for-profits and 28 (32.9%) are public institutions. That is, the largest group of institutions offering psychoactive substance treatment in Espirito

Santo are in the private sector corroborating the findings of Schneider et al. (2004)[40] in the metropolitan region of the Florianopolis. We consider that the lack of publicly funded services is a central aspect to be considered in the formularization of public policies of health for the state, particularly in the area of drug abuse treatment.

The institutions are financially supported by churches (30.6%), personal and legal institutions donations (28.2%) and municipal governments (21.2%). The listed human resources available in the institutions are psychologists (75.3%), medical doctors (67.1%), social worker (50.6%), nurses (48.3%) and psychiatrists (41.2%). That is, the minimum team of mental health professionals, according to Ministry of Health, is not present in the majority of these institutions. Psychiatrists are particularly glaring omission from many of these institutional teams. This points to the importance of an interdisciplinary team with specialists in different disciplines, including the users in recovery so that with their rich experiences can assist the patients in treatment.

We know one of the principles of SUS is the complementarity with the private sector, however, the public manager needs to implement the planning of the public sector, to later complement “what it lacks” with the private sector, preferentially with no profit making institutions (philanthropy) (BRAZIL, 2001)[41]. However, the reality in Espirito Santo has shown problems with the principle of the complementarity of the private sector due no priority of public investment, demonstrated by the low proportion of public institutions, which represent just 32.9% of all institutions that offer direct psychoactive care in the state.

The Organic Law of the Health Nº 8080 of 19/09/1990[38], defines the criteria for health services organizations as well as central aspects of human resources. RDC N^{o} 101/01-ANVISA[42] states that the Therapeutic Communities have to offer a minimum team composed by one health care professional, an administrative coordinator and three community agents. However, this composition was not found in this Espirito Santo state survey, although therapeutic communities do represent the majority (49.4%) of care service offered to the psychoactive substance users in the state.

2. Profile of the Psychoactive Substance Treatment in Espirito Santo

The clinical treatment in the institutions of this study is defined by the following criteria: less serious cases (34.1%) and the belief that clinical modality is the best intervention (29.4%), inpatient care, ≤ 90 days and the maximum ≥ 120 days. Gastfriend & McLellan (1997)[43] in a revision of the criteria guiding each type of service, described the factors of the patient demographics, type of drug, comorbidity, and social insertion that must be taken in consideration for the inpatient vs. outpatient treatment decision. The American Association of Medicine of Dependencies (ASAM)[44] created criteria with the objective to reach necessity of the patients with comorbidity, adolescents, and for clarification of the complexity level for inpatient services. This process is called *matching* by the North Americans (Rychtarik et al., 2000)[45]. Finney et al. (1996)[46] designated that previous revisions, as well as the carried through them, they had concluded that it does not have evidences of the superiority of the treatment with internment on the clinical.

The institutions in this study attend patients in the age ranges 10-15 years in 38.8% of the cases, 26-45 years in 89.4% and 66 years or more in 60%, with 27 (31.8%) institutions exclusively serving males, 5 (5.9%) exclusively serving females and 48 (56.5%) serving both genders. Regarding the origin of the users, 92.1% are from the same municipality, 82.4% from other cities of ES and 43.5% from other Brazilian states. The international (Kaminer et al., 1998)[47] and national (Silveira & Moreira, 2006)[13] literatures recommend the necessity of care resources differentiated by complexity, considering the age range attended by the services. The literature has shown that adolescents (Weiner et al., 2001)[48], women (Magalhães, 1991)[49] and the elderly (Brennan et al., 2001)[50] have more difficulties adhering treatment (Blume Zilberman, 2004)[51]. In the state of Espirito Santo, however, a significant minority of the institutions attend men only. Moreover, there is little existence of specialized services in the early and late

stages of the life cycle, therefore, corroborating with the low efficacy of treatment.

Alcohol is the most used drug (82.4%) in this survey of Espirito Santo institutions, as was also found in the national household carried out by CEBRID (2002)[19]. Alcohol is the licit drug responsible for raised public expenses, being considered one of the main causes of accidents of diverse orders and of the increase of the load of illnesses in the population (WHO, 1999; 2002; OMS, 2004)[1,3,6].

Tobacco is in the second most used substance (81.2%) in the state survey, as death cause in the world (WHO, 2000; 2002; OMS, 2004)[1,4,6]. However, few services have specific services for this dependence. In a greater part of them, rather, tobacco is accepted, having spaces also reserved for smoking.

The other drugs used were, in descending order, marijuana, cocaine, crack and sedatives. Drawing our attention is the vertiginous growth in Espirito Santo of the dependence on crack, that until year 2000 was not so significant, but in the last two years has had significant growth, being responsible for an increasing number of hospital admissions, not only in lower class due to it being a cheaper drug, but also reaching the middle and upper classes as well. The data of CEBRID (2002)[19] show that such situations are observed in the Southeastern region (0.4%), as in Brazil (2,3%).

The effective models of treatment in Espirito Santo institutions are the psychosocial (58.8)% model, the biomedical (43.5%) model, the therapeutic community (47.1%) model, alternative (47.1%) and of self-help (10.6%); with emphasis on individual therapy (89.4%) and group therapy (84.7%) to the detriment of community therapy (38.8%). The activities are: psychological (85.9%), physical (81.2%), recreational (71.8%), occupational (67.1%) and spirituals (58.8%). It is known that substance use and human behavior are complex questions that require holistic approaches for understanding the “cause” of the problem as well as the application of this in the “assistance process”. This

happens through an articulated way by the assistance modality used in the service and by the activities using in therapeutic care[22-29].

In Espirito Santo, we observe a trend of the psychosocial model, which involves social learning, the familial interaction and the personality characteristics of the individual (Nathan, 1983)[22], as well as of the biomedical model, where the dependence is seen as a chronic and recurrent upheaval, with a biological and genetic base, having the goal of total abstinence (Cloninger, 1987; Vaillant, 1983)[23-24]. In this model, psychotherapies are used as auxiliary techniques, such as individual therapy and familial and group therapy. Among these, the Cognitive-Behavioral approach (Miller & Rollnick, 1991; Beck et al., 1993)[25-26], actually is the preponderant theoretician-methodological trend in the treatment. The technique most used by the institutions in the study and the most effectiveness in recent years is of prevention to relapse (Marlatt & Gordon, 1993)[27]. The basic conception, in the social-cultural approach carried through by the therapeutic communities, is utilization of group activities in order to establish a therapeutic environment social therapy. There are variations on this technique application, developed by Maxwell Jones (1943)[28] in England, among them, a coordinator care team must be composed by former-dependents; others can include some health professionals, with or without the participation of former-residents. The rationality horizon that guides them is the religious and moral, and the majority of the therapeutic communities are services developed by some religious organization - Catholic, Christian, Protestant, Spiritual community, among others (Leon, 2003)[29].

This study has some potential limitations. First, the primary informant was typically the administrator of the institution who may not have given completely accurate information about the institution. In addition, the instrument only asked for the existence certain treatment models, but not about the actual intervention techniques used at the institution. Finally, our study's results are limited by the lack of other Brazilian studies with which to compare it.

CONCLUSION

The Espirito Santo State Survey demonstrates the necessity of a decentralized provision of specialized care for psychoactive substance users, with services directed to the North and South regions of the state and with emphasis on outpatient care.

The majority of Espirito Santo institutions of treatment are placed in the region's center – mainly in the metropolitan region of Vitoria; they are registered with the responsible agency for the municipal medical and sanitary assistance; they are private non-profit establishments that have the user/family as main source of financial support, and the psychologist as main staff person.

Psychoactive substance treatment in Espirito Santo emphasizes tertiary-hospital care with minimum time of internment of ≤ 90 days and a maximum of ≥ 120 days; the origin of the users is municipal, the age range is from 26 to 45 years, with attendance for both sexes, however without adequacy of the services to special populations as adolescent, the elderly and women. The most used drug is alcohol followed by tobacco. The predominant model is psychosocial with individualized therapy and the institutional evaluation of the treatment technique is carried out internally.

New studies that reflect the Brazilian reality (Burcher, 1992; Schneider et al., 2004)[40,52], especially of Espirito Santo, involving in such a way the mental health (Ferreira, 2005)[53] as psychoactive substances (Garcia, 2005; Garcia & Siqueira, 2005)[54-55], are necessary so that it extends the knowledge on the pointers aiming at one better matting user-service. Among the factors to be studied are the characteristics of the users and the services that are responsible for the effectiveness of the treatment.

This study demonstrates that public policies for psychoactive substance use must prioritize the evaluation of services (Rodrigues, 2004; Laranjeira, 2005; Siqueira et al., 2006)[56-58] as a form of social control on the actual provision of health care in the country.

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REFERENCES

1. World Health Organization WHO. The World health report 2002. Geneva: WHO; 2002.

2. National Institute on Alcohol Abuse and Alcoholism NIAAA. Drinking in the United States: main finds from the 1992 National Longitudinal Alcohol Epidemiologic Survey NLAES. Bethesda: National Institute of Health; 1998. Available from: http://www.niaa.nih.gov/publications/Nlaesdrm.pdf

3. World Health Organization WHO. Global Status Report on alcohol [text on the Internet]. Geneva: WHO, 1999. Available from: http://www.who.int/substance_abuse/pubs_alcohol.htm

4. World Health Organization WHO. Tobacco Free Initiative. Tobacco control country profiles [text on the Internet]. Geneva: WHO, 2000. Available from: http://www5.who.int/tobacco/page.cfm?sid=57#European

5. United Nations Office for Drug Control and Crime Prevention UNODCCP. World drug report 2000 [text on the Internet]. New York: Oxford Press, 2000. Available from: http://www.undcp.org/adhoc world_drug_report_2000/report.html

6. Organização Mundial da Saúde OMS. Neurociências: consumo e dependência de substâncias psicoativas. Genebra: OMS, 2004.

7. Brasil. Ministério da Saúde. Secretaria Executiva. Secretaria de Atenção a Saúde. Coordenação Nacional DST/AIDS. A Política do Ministério da Saúde para Atenção Integral a Usuários de Álcool e Outras Drogas. 1ª ed. Brasília: Ministério da Saúde, 2003.

8. Sacardo DP. Das políticas públicas às políticas públicas saudáveis: contribuições para a promoção da saúde. Mundo Saúde. 2003; 28 1:5-13.

9. Brasil. Presidência da República. Secretaria Nacional Antidrogas. Política Nacional Antidrogas. Brasília: Presidência da República, Gabinete de Segurança Institucional, Secretaria Nacional Antidrogas, 2001.

10. Brasil. Presidência da República. Secretaria Nacional Antidrogas. In: Seminário Internacional sobre Políticas Públicas sobre Drogas. Brasília: SENAD, 2004_a.

11. Brasil. Presidência da República. Secretaria Nacional Antidrogas. In: Fórum Nacional sobre Drogas. Brasília: SENAD, 2004_b.

12. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Saúde mental no SUS: os centros de atenção psicossocial. Brasília: Ministério da Saúde, 2004_c.

13. Silveira, DX; Moreira, FG. Panorama atual de drogas e dependências. Org. Dartiu X. Silveira, Fernanda G. Moreira. 1ª ed., São Paulo: Ed. Atheneu, 2006.

14. Laranjeira R. Bases para uma política de tratamento dos problemas relacionados ao álcool e outras drogas no Estado de São Paulo. J Bras Psiquiatr 1996; 454:191-9.

15.Tancredi, FB., Barrios, SRL. Ferreira, JHG. Planejamento em Saúde. São Paulo: IDS-USP-Itaú; 1998. Disponível on-line: URL: http://ids-saude.uol.com.br/SaudeCidadania/ed_02/index.html

16. Formigoni MLOS. Organização e avaliação de serviços de tratamento a usuários de drogas. In: Seibel SD, Toscano-Júnior A. Dependência de drogas.São Paulo: Atheneu; 2001.

17. Ribeiro, M. Organização de serviços para o tratamento da dependência do álcool. Rev Bras Psiquiatr 2004; 26Supl I:59-62.

18. Instituto Brasileiro de Geografia e Estatística. Censo Brasileiro de 2002. Disponível em: http://www.ibge.gov.br Acesso em: 20 jun. 2006.

19. Centro Brasileiro de Informações Sobre Drogas Psicoativas CEBRID. I Levantamento Domiciliar Sobre o Uso de Drogas Psicotrópicas no Brasil – 2001. São Paulo, 2002.

20. Secretaria Nacional Antidrogas SENAD. Disponível em: www.senad.gov.br/mapeamento.htm Acesso em: 08 jul. 2006.

21. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Normas de pesquisa envolvendo seres humanos. Res. CNS 196/96. Bioética 1996; 4 Suppl:15-25.

22. Nathan PE. Behaviour theory and behavioural theories of alcoholics. In: Galenter Recent Development in Alcoholism. New York: Plenum; 1983.

23. Cloninger CR. Neurogenetic adaptative mechanism in alcoholism. Science 1987; 236:410-5.

24. Vaillant GE. The natural history of alcoholism. Cambridge: Harvard University Press; 1983.

25. Miller WR, Rollnick S. Motivational Interviewing: preparing people to change. New York: Guilford Press; 1991.

26. Beck AT, Wright F, Newmann C, Liese B. Cognitive therapy of substance abuse. New York: Guilford Press; 1993.

27. Marlatt, G. & Gordon, J. Prevenção de Recaída: estratégias de manutenção no tratamento de comportamentos adictivos. Porto alegre: Artes Médicas, 1993.

28. Maxwell, J. Available in: http://www.sanctuaryweb.com/main/maxwell_jones.htm. 30 jun. 2006.

29. De Leon, G. Comunidades Terapêuticas: teoria, modelo e método. São Paulo: Loyola, 2003.

30. Garcia, MLT; Siqueira, MM. Catálogo das instituições especializadas em dependência química no Estado do Espírito Santo. Vitória: UFES, 2003.

31. Coleman, J. Relational Analyzes: the study of social organization with silvery methods**.** Human Organization spring; 1958.

32. Dunn J., Ferri, CP. Epidemiological methods for research with drug misusers Rev. Saúde Pública. 1999; 33 2: 206-15.

33. Secretaria Estadual de Saúde. Plano Regional de Desenvolvimento. Vitória: SESA, 2003.

34. Statistical Package Social Science – SPSS for Windows versão 2005. Chicago: SPSS Inc., 2005.

35. Secretaria Estadual de Justiça. COESAD. http://www.sejus.es.gov.br/default.asp#ProjetosdoConselho

36. Alcoólicos Anônimos.Disponível em: http://www.alcoolicosanonimos.org.br Acesso em 20 jun. 2006.

37. Amor Exigente. Disponível em: http://www.amorexigente.cjb.net Acesso em: 20 jun. 2006.

38. Brasil. Ministério da Saúde. Lei Orgânica da Saúde. 2ª ed. Brasília: Assessoria de Comunicação Social, 1991.

39. Brasil. Secretaria Nacional Antidrogas SENAD. Atualização de Conhecimentos sobre Redução da Demanda de Drogas. Brasília, 2004_d.

40. Schneider, DR.; Spohr, B.; Accorsi, M.; Leitão, C.; Scatamburlo, N. Caracterização dos Serviços de Atenção à Dependência Química da Região da Grande Florianópolis. Relatório de Pesquisa submetido a Funpesquisa. Florianópolis: UFSC, 2004.

41. Brasil. Ministério da Saúde. Sistema Único de Saúde SUS: princípios e conquistas. Brasília: 2001.

42. Agência Nacional de Vigilância Sanitária. Resolução RDC nº 101, de 30 de maio de 2001. Disponível em: http://e-legis.anvisa.gov.br/leisref/public/showAct.php?id=1188#' Acesso em 25 jun. 2006.

43. Gastfriend, DR; McLellan, T. Individualização do tratamento: bases teóricas e implicações práticas. In: Samet, JH; Stein, MD; O'Connor, P org. Clinicas Médicas da América do Norte. Abuso de Álcool e Outras Drogas. Interlivros Edições Ltda, Rio de Janeiro, 921-944, 1997.

44. American Society Of Addiction Medicine. Disponível em: http://www.asam.org/ Available from: 30 jun. 2006.

45. Rychtarik,RG; Connors, GJ.; Whitney, RB.; McGillicuddy, NB.; Fitterling, JM.; Wirtz, PW. Treatment settings for persons with alcoholism: evidence for matching clients to impatient versus outpatient care. J Consult Clin Psychol. 2000; 682:277-89.

46. Finney,JW.; Hahn, AC.; Moss, RH. The effectiveness of inpatient and out patient treatment for alcohol abuse: the need to focus on mediators and moderators of setting effects. Addiction 1996; 9112:1773-76.

47. Kaminer, Y; Blitz, C; Burleson, JA; Sussman, J. The teen treatment services review T-TSR. Journal Substance Abuse Treatment. 1998; 154:291-330.

48. Weiner, DA; Abraham, ME; Lyons, J. Clinical characteristics of youths with substance use problems and implications for residential treatment. Psychiatric Services 2001; 526: 793-799.

49. Magalhães, MP. O sistema francês de atendimento à toxicomania. Revista ABP-APAL 1991; 132:59-62.

50. Brennan P; Kagay CR; Geppert JJ; Moss RH. Predictors and outcomes of outpatient mental health care. A 4-year prospective study of elderly Medicare patients with substance use disorders. Medical Care 2001; 39(1):39-49.

51. Blume SB, Zilberman ML. Women: clinical aspects.In: Lowison J, Ruiz P, Millman RB, Langrod JG, eds.Substance abuse : a comprehensive textbook, 4ºth edition.Lippincott Willians & Wilkins 2004:1049-64.

52. Burcher, Richard. Drogas e drogadição no Brasil. Porto Alegre: Artes Médicas, 1992.

53. FERREIRA, Lilia Emília Almeida. Análise de Política Pública de Saúde Mental: o caso do Estado do Espírito Santo. Dissertação de Mestrado Programa de Pós-Gradução em Psiquiatria e Saúde Mental, Universidade Faderal do Rio de Janeiro, Rio de Janeiro, 2005.

54. Garcia, MLT. Política de atenção ao dependente químico no Espírito Santo. Relatório de pesquisa submetido ao CNPq. Vitória: UFES, 2005.

55. Gracia, MLT.; Siqueira, MM. Instituições especializadas no tratamento de dependência química no estado do Espírito Santo. Jornal Brasileiro de Psiquiatria. 2005; 543192-196,.

56. Rodrigues, T. Política e drogas nas Américas. São Paulo:EDUC:FAPESP, 2004.

57. Laranjeira, R e Romano, M. Consenso Brasileiro sobre Políticas Públicas do Álcool. Rev Bras Psiquiatr. 2004; 26 1:63-67.

58. Siqueira, M.M.; Barbosa, D.A.; Laranjeira, R. Políticas públicas relacionadas às substâncias psicoativas e o papel do estado. Cadernos de Saúde Pública. submetido em maio/2006.