ORIGINAL ARTICLE

Psychoactive substances and the provision of specialized care: the case of Espirito Santo

Substâncias psicoativas e a provisão de cuidados especializados: o caso do Espírito Santo

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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. Method: We used a snowball sampling technique to include all the treatment facilities in our State in which we employed a semi-structured interview instrument for 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 Central region (70.6%) and followed by the Northern (15.3%) and Southern (14.1%) regions. The majority of those that provide direct care are private nonprofit centers (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 give assistance to people in the 26-45 years age group (89.4%); with regard to gender, the institutions take care of: men (31.8%), women (5.9%), and both sexes (56.5%). The treatment models most used are psychosocial (58.8%), therapeutic community (47.1%) and biomedical (43.5%) and the 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 and the majority of all services are in the Central region. The populations in the mainland have 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 of specialized care for psychoactive substance users, with substantially more services directed to the Northern and Southern regions of the state. Moreover, the emphasis of these new institutions should be on outpatient care.

Descriptors: Psychoactive substances; Health, public; Healthcare surveys; Substance abuse; Health services evaluation

Resumo

Objetivo: Foi realizado um levantamento de todas as instituiçõesque proporcionam tratamento para dependência de substâncias psicoativas no Estado do Espírito Santo, Brasil, durante o período de 2004-2005. Método: Foi utilizado o método de amostragem bola-de-neve para incluir todos os estabelecimentos de tratamento no Estado e empregada uma entrevista semi-estruturada para informantes-chave em cada instituição. Os resultados descritivos foram apresentados e as diferenças testadas entre os grupos, utilizando o teste de qui-quadrado. Resultados: No Espírito Santo, 250 instituições proporcionam tratamento para dependência de substâncias psicoativas e se distribuem da seguinte forma: governamentais (17,6%), não-governamentais (22,8%) e grupos de auto-ajuda (59,6%). Destas 250 instituições, 85 proporcionam assistência direta e a maioria se encontra na região Central (70,6%), seguido pela região Norte (15,3%) e Sul (14,1%). A maioria daquelas que fazem o atendimento direto são instituições privadas e sem fins lucrativos (16,8%); as que possuem vínculos com organizações religiosas compõem quase um terço do total (30,6%) de prestadores de serviços diretos. As drogas mais consumidas pelos que buscaram atendimento são álcool (82,4%), tabaco (81,2%) e maconha *(68,2%). As instituições geralmente atendem pessoas na faixa etária entre 26 e 45 anos (89,4%); com relação ao sexo, as instituições que atendem somente homens perfazem 31,8%; as que só atendem mulheres, 5,9%; e ambos os sexos, 56,5%. Os modelos de tratamento mais utilizados são o psicossocial (58,8%), a comunidade terapêutica (47,1%) e o biomédico (43,5%), sendo o trabalho avaliado por meio da técnica de grupo (72,9%). Conclusões: No Estado do Espírito Santo, os serviços de atendimento indireto são muito maiores do que os que oferecem atendimento direto; a maioria dos serviços está na região central do Estado. As populações do interior do Estado estão em desvantagem quanto às opções de tratamento para o uso de substâncias psicoativas. Foi observado que um número significativo de instituições que provêem tratamento para o abuso de drogas tem apoio financeiro de organizações religiosas. A pesquisa no Estado do Espírito Santo demonstra a necessidade da descentralização do atendimento especializado para os usuários de substâncias e de consideravelmente mais serviços direcionados às regiões Norte e Sul do Estado. Além disso, a ênfase dessas novas instituições deve ser o tratamento ambulatorial.*

Descritores: Substâncias psicoativas; Saúde pública; Pesquisas sobre serviços de saúde; Abuso de substâncias; Avaliação de serviços de saúde

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Introduction

Psychoactive substance (PAS) consumption is present worldwide, 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 lives[2-3] and around one quarter smoked tobacco.[4] Illicit drugs reach 4.2% of the world's population.[5-6]

The social and health problems related to the consumption and dependence of legal and illicit drugs are currently 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.[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 focused on integrating several social sectors, such as education, health, social work, sports, justice, and public security.[7,9-11] The prime example of this approach is the National Antidrug Policy (*Política Nacional Antidrogas - PNAD*), whose objectives for the user are the reduction of the demand and supply of drugs and are focused on prevention, treatment, recovery, reintegration into society, damage reduction; 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), with the goal of providing specialized outpatient assistance, as well as articulating the network of services in this field.[7,12]

The development and implementation of treatment options are the result, in most 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.[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. Those services vary in terms of treatment team, physical resources, type of equipment available, and treatment models. According to several authors,[14-17] the services are organized with limited service potential and are not subordinated to local needs. Silveira & Moreira, in a recent publication, described the services of the Brazilian care system for PAS users as a decentralized network integrating services with diverse complexity and articulating them with already existing ones into a network of care for social and health issues.[13] 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 current network of care provision available to drug users in the state of Espirito Santo. According to IBGE data,[18] Espirito Santo has 3,399,255 inhabitants, with 1,901,577 (56%) in the Central region, 894,087 (26.3%) in the Northern and 603,591 (17.7%) in the Southern regions. Of this total, 48.9% of the population is male and 51.1% is female. Medical care is provided through 1,496 institutions (895 public and 596 private), 122 with inpatient care (25 public and 97 private), 1,036 with only outpatient care (859 public and 177 private) and 1,057 through services of the Unified Health System (*Sistema Único de Saúde* - SUS).

In addition, there are no specific epidemiological studies on use, abuse and dependence of psychoactive substances in Espirito Santo. The Southeastern Region of the First Household Survey on the Use of Psychotropic Drugs in Brazil,[19] can give us a closer view about 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 of Brazil, somewhat lower than the Brazilian mean of 19.4%. In the Southeast, the lifetime use of alcohol was 71.5% and alcohol-dependence was 9.2%, compared to the 68.7% and 11.2% Brazilian means, respectively. The Southeast of Brazil also has the highest lifetime use of cocaine (2.6%) and crack (0.4%). In addition, dependence of alcohol (9.2%) and tobacco (8.4%) is very significant, being more frequent in males (13.8% and 9.7%, respectively) than in females (4.7% and 4.3%, respectively).

The lack of national data about services that provide assistance to the problems stemming from psychoactive substance use,[20] as well as the scarcity of qualified information about the institutions of specialized attention in Espirito Santo, like coverage areas, institutional profile, client profile, who receives care, etc., all motivated this study. Our objective, therefore, was 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 care network in the state.

Method

We aimed 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 Health and Social agencies such 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 such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Families of Alcoholics Anonymous (AL-ANON) located in the mainland and 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 Universidade Federal de São Paulo (UNIFESP). We obtained the informed consent from all respondents, in accordance with Resolution 196/96 of the Brazilian National Health Council.[21] For data collection we used a semi-structured questionnaire composed of 40 questions distributed along the following three groups: 1) respondent background; 2) institutional organization; and 3) treatment. The five treatment models in the institutions chosen 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 uses spiritual activities and biblical study; and *self-help programs*, which employ the twelve-step approach, known as the Minnesota Model.[22-29] The instrument was initially tested in three institutions in the municipality of Vitoria, in the municipal, state and federal levels 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".[30] Next, using the snowball sampling technique,[31-32] we asked informants at the institutions visited to indicate new organizations in their city and/or another cities. In this way we added 127 new institutions that were not listed in the original Catalogue, totaling 250 institutions.

The interviews were accomplished by nursing and social work students from the Federal University of Espirito Santo, during the period between July 2004 and June 2005 under the supervision of the coordinator of the specific region. Visits to the institutions were divided into three administrative health zones - Northern, Central, and Southern (Figure 1) - and interviews were scheduled in advance by phone.

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

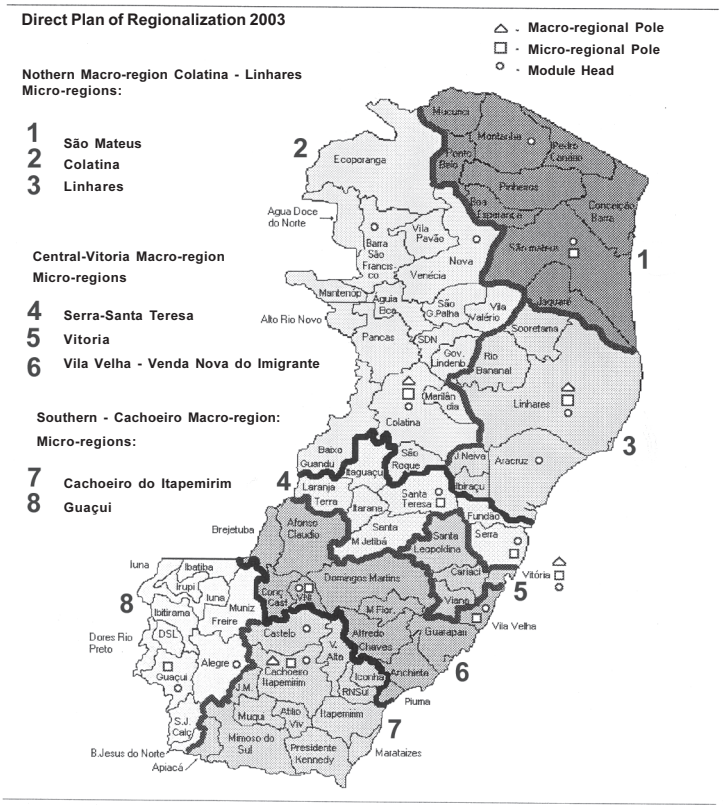

Figure 1 - Regional Distribution, Espirito Santo state

Source: SESA, 2005[33]

Results

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 17.6%) (n = 44) of the total, and non-governmental groups accounted for 22.8% (n = 57) while self-help groups made up the majority of services offered in the state, comprising 59.6% of the institutions (n = 149). Among the governmental institutions, three (1.2%) were federal, nine (3.6%) were state and 32 were (12.8%) municipal. Among the non-governmental institutions that offered services, 42 (16.8%) were nonprofit and 15 (6.0%) were for-profit 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 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. Although self-help groups provide services to PAS, we

Table 1 - Institutions that provide care for psychoactive substance users in Espirito Santo, Brazil

Types of institutions	n	%
Governmental	**44**	**17.6**
1) 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
2) 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
3) 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
TOTAL	**250**	**100.0**

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

Table 2 - Profile of institutions that provide direct care services for psychoactive substance treatment*

Variables	Frequency (n = 85)	Percentage (%)
Administrative region		
Central	62	70.6
Northern	13	15.3
Southern	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
Screening	5	5.9

** Excludes 165 institutions that provide indirect assistance*

excluded them for this analysis to focus on the institutions that provide clinical care either to inpatients, outpatients or by screening the population and referring the cases to proper services. The majority of the 85 institutions in Espirito Santo that provide direct services are concentrated in the Central region (70.6%), offer inpatient services (61.2%) and are registered in the city departments of health, SEMUS, (43.5%). There is a predominance of private nonprofit institutions (49.4%) and religious organizations (30.6%) among services that offer PAS abuse treatment in Espirito Santo. Moreover, 47.1% of the financial resources in the institutions come from the users and their families. Finally, there are psychologists on the staff in 64 out of the 85 institutions (75.3%), followed by medical doctors on 57 (67.1%) of the 85 institutions.

Table 3 shows the profile of the treatment of psychoactive substances in Espirito Santo. Thirty four percent of the cases treated in ambulatory care (clinical treatment) are less severe cases and 36.5% of the hospitalizations depends on how much severe the case is. The authorization of the hospital admission is given both by the user (52.4%) and the family (45.3%); the minimum duration of the treatment is $\leqslant$ 90 days (14.1%) and the maximum is $\geqslant$ 120 (27.1%). The most used substances among the users at the state's institutions are alcohol (82.4%) and tobacco (81.2%) followed by cannabis (68.2%). The age range reported by the institutions ranged 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%

Table 3 - Profile of the psychoactive substance treatment in Espirito Santo

Variables	Frequency (n = 80*)	Percentage (%)
Criteria for outpatient treatment		
Less serious cases	29	34.1
To believe to be optimum	25	29.4
Lack of option to admit	4	4.7
Criteria for 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 city	79	92.1
Other cities	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
Maintaining agency	17	20.0

** Excludes 5 institutions that do only triage*

only for females). In 92.1% of the cases, the patients are from the same city the institution is located. With regard to the treatment model, 58.8% of the institutions use the psychosocial model, followed by therapeutic community (47.1%) and biomedical (43.5%); Individualized care is the priority of treatment in 89.4% of institutions, as well as the psychical activity (85.9%), being the assessment of treatment performed together with the members of the technical team (21.2%).

In Table 4 we present the characteristics of the institutions in Espirito Santo classified by ownership status (private non-profit, private for-profit, and public). 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 in the subsequent table to more clearly show differences across the three ownership statuses. That is, rather than focusing on the differences *within* each ownership category (column percentages), we wish to compare these institutional characteristics 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 p-value ranging from $\leqslant 0.001$ to $p \leqslant 0.05$.

In Table 5 we present the patient characteristics (age range, sex, drug most consumed) classified by ownership status of the institution they attended. All variables of the treatment profile were statistically significant in the Chi-squared test, p-value ranging from $\leqslant 0.001$ to $p \leqslant 0.05$.

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 psychoactive substances related problems. Of these, 62 (70.6%) institutions are in the Central region, 13 (15.3%) in the Northern region and 12 (14.1%) in Southern region. The types of services offered by institutions are screening in five (5.9%), outpatient clinics in 28 (32.9%) and 52 which offer (61.2%) inpatient care. We found that only 32.9% of the institutions which offered outpatient services did not comply with the existing health policies in Brazil. These require a regionalized and hierarchical 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 to the social and familial environment of the user is less traumatic and less expensive than the inpatient care.[38-39] An emphasis on the tertiary sector is observed in Espirito Santo, which privileges inpatient services in hospitals, clinics, and therapeutic communities, instead of fomenting outpatient care in the same institutions. Federal and State governments, therefore, transfer their care responsibilities over psychoactive substance use and abuse related problems to services in the philanthropic or private sectors, as is the case of the therapeutic communities, despite the lack of supervision of those services.

Table 4 – Institutional characteristics, by ownership status

Treatment profile	Private non-profit		Private for profit		Public		Total	X^2 p value
	n	%	n	%	n	%	n	
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

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	
Tobacco	2	18.1	0	0.0	9	81.8	11	
Tranquilizers	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 the percent of total in that category
[a]Variable contains mutually exclusive categories

It is important to highlight that from the beginning of the 20th century up to the middle of 1980s inpatient care was the priority in terms of recommended treatment to any situation of abuse or dependence of a psychoactive substance. From the 1980s to the 1990s, this hospital-focused perspective gradually began to be replaced 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 risks. Meanwhile, outpatient treatment, which is closer to the daily reality of the user, became valued and stimulated.[12,39]

The vast majority of institutions 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 Espirito Santo with a small number registered with the State Social Work Department and with the State Antidrug Council, as well as with the National Antidrug Department.

Regarding the 85 studied institutions, 42 (49.4%) are private non-profit, 15 (17.6%) are for-profit and 28 (32.9%) are public institutions. That is, the largest group of institutions offering psychoactive substance treatment in Espirito Santo pertains to the private sector corroborating the findings of Schneider et al.[40] in the metropolitan area of Florianopolis. We consider that the lack of public funded services is a central aspect to be considered in the formulation of the State's health public policies, particularly in the field of drug abuse treatment.

The institutions are financially supported by churches (30.6%), donations from individuals and legal institutions (28.2%) and municipal governments (21.2%). The listed human resources available in the institutions are psychologists (75.3%), medical doctors (67.1%), social workers (50.6%), nurses (48.3%), and psychiatrists (41.2%). That is, the minimum team of mental health professionals, according to the Ministry of Health, is not present in the majority of these institutions. Psychiatrists are particularly absent from many of these institutional teams. This points out to the importance of an interdisciplinary team including specialists on different disciplines with expertise on drug use recovery.

We know one of the principles of SUS (the Brazilian Unified Health Care System) is its complementarity with the private sector; however, it is our opinion that the public manager should implement the public sector, to later complement its shortages with the private sector, preferentially with non-profit institutions (philanthropic).[41] In Espirito Santo the principle of complementarity of the private sector has not been followed due to the lack of public investments, 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 Health Organic Law Nº 8080 of 19/09/1990,[38] defines the criteria for organizations which provide health services as well as the central aspects in terms of human resources. RDC No 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 survey on the Espirito Santo state, 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, $\leqslant$ 90 days and the maximum $\geqslant$ 120 days. Gastfriend & McLellan in a review of the criteria guiding each type of service, described the factors (e.g., patient's demographics, type of drug, comorbidity, and social insertion) that must be taken into account when deciding between inpatient vs. outpatient treatment.[43] The American Association of Medicine of Dependencies (ASAM)[44] created criteria with the objective to meet the needs of the patients with comorbidity, adolescents, and to clarify the complexity level for inpatient services. This process is called *matching* by the Americans.[45] Finney et al. claimed that previous revisions, as well as that performed by them, do not provide evidence for the superiority of inpatient over clinical treatment.[46]

Age ranges of patients seen in the institutions surveyed are as follows: 10-15 years in 38.8% of the cases, 26-45 years in 89.4% of them 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[47] and national[13] literatures recommend that care resources should be differentiated by complexity, considering the age range attended by the services. The literature has shown that adolescents,[48] women[49] and the elderly[50] have more difficulties to comply with treatment.[51] In the state of Espirito Santo, however, a significant minority of the institutions attend men only. Moreover, there are few specialized services in the early and late stages of the life cycle, therefore, confirming the low efficacy of treatment.

Alcohol is the most used drug (82.4%) in this survey of Espirito Santo institutions, as it was also found in the national household study performed by CEBRID.[19] Alcohol is the licit drug responsible for increasing public expenses, being considered one of the main causes of accidents of diverse orders and for the increase of the load of illnesses in the population.[1,3,6]

Tobacco is in the second most used substance (81.2%) in the state survey, as a death cause in the world.[1,4,6] However, few institutions have specific services which give treatment for this dependence. In a greater part of them, rather, tobacco is accepted, and they also have spaces destined for smoking.

The other drugs used were, in descending order, marijuana, cocaine, crack and sedatives. Of note, the vertiginous growth in Espirito Santo of the dependence on crack, that until the year 2000 was not so significant, but in the last two years has had a significant growth. Crack has been responsible for an increasing number of hospital admissions, not only in the lower class as it is less expensive, but also reaching the middle and upper classes. The data of CEBRID[19] show that such situations are observed in the Southeastern region (0.4%), as well 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 spiritual (58.8%). It is known that substance use and human behavior are complex matters that require holistic approaches for understanding the "cause" of the problem as well as its application in the "treatment process". This is accomplished in an articulated way by the assistance modality used in the service and by the activities which use the therapeutic care.[22-29]

In Espirito Santo, we noticed a trend for the use of the psychosocial model, which involves social learning, the familial interaction and the personality characteristics of the individual,[22] as well as of the biomedical model, where the dependence is seen as a chronic and recurrent upheaval, with biological and genetic bases, having the goal of total abstinence.[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,[25-26] is currently the preponderant theoretician-methodological trend in the treatment. The technique most used by the institutions in the study and the most effective in recent years is relapse prevention.[27] The basic conception, in the social-cultural approach accomplished by the therapeutic communities, is utilization of group activities in order to establish a therapeutic social environment. There are variations on the application of this technique, as developed by Maxwell Jones[28] in England, among them, a care team coordination must be composed by former dependents; others can include some health professionals, with or without the participation of former-residents. The rationale 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.[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 about the existence of 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 to be compared.

Conclusion

The Espirito Santo State Survey demonstrates the need of a decentralized provision of specialized care for psychoactive substance users, and that services should be directed to the Northern and Southern regions of the state and with emphasis on outpatient care.

The majority of Espirito Santo institutions for treatment are placed in the Central region - mainly in the metropolitan region of Vitoria (the capital city); they are registered with the responsible agency for the municipal medical and sanitary assistance; they are private non-profit facilities whose main financial support come from the users and their families, and have psychologists as their main staff person.

Psychoactive substance treatment in Espirito Santo emphasizes tertiary- hospital care, treatment time ranges from $\leqslant$ 90 up to $\geqslant$ 120 days; the origin of the users is municipal, the age range is from 26 to 45 years, with attendance for both sexes, however services are not adequate to special populations such as the 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 reflecting the Brazilian reality,[40,52] especially of Espirito Santo are warranted. They should involve mental health assessment such[53] as psychoactive substances[54-55] use related problems in order to develop services especially designed to treat this population.

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[56-58] as a form of social control on the actual provision of health care in the country.

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