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A regionalização da atenção psicossocial em álcool e outras drogas no Brasil

Regionalization of psychosocial care of alcohol and other drug addiction in Brazil

La regionalización de atencón psicosocial en alcohol y otras drogas en Brasil

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RESUMO: Esse trabalho objetiva discutir o processo de regionalização da RAPS no âmbito da atenção às pessoas com necessidades decorrentes ao uso de álcool, crack e outras drogas. Especificamente, pretende dimensionar os pontos de atenção da RAPS voltados para essa problemática, além de apontar os desafios quanto ao processo de expansão e de interiorização da atenção psicossocial no Brasil. É um estudo transversal, delineado a partir da elaboração de um banco de dados com base nas informações disponibilizadas pela Coordenação Nacional de Saúde Mental e pela plataforma "Observatório Crack é possível vencer". As informações foram reconstruídas a partir do banco de indicadores da plataforma Regiões e Redes de modo a relacionar os 5.570 municípios, organizados em 438 regiões de saúde. As unidades de análise foram, no caso o mapeamento dos serviços da RAPS, a estratificação por estado e porte dos municípios, e no que diz respeito ao processo de Regionalização da Atenção ao álcool e outras drogas no Brasil, as próprias regiões de saúde (CIR). Esse dimensionamento incluiu a rede intersetorial (CRAS, CREAS, Centro Pop e CRR). Observou-se uma rede de serviços insuficiente e pouco organizada. Há uma "expansão errante" que não considera o planejamento e a pactuação regional necessários para a sustentabilidade do sistema. Há vazios assistenciais em todo o país em relação à atenção ao usuário de álcool, crack e outras drogas, fato que vem provocando o incremento desenfreado das comunidades terapêuticas. Há uma desigualdade evidente na distribuição dos serviços nos municípios de grande e de pequeno portes.
Palavras-chave: regionalização, RAPS, atenção psicossocial, álcool e outras drogas.

ABSTRACT: This work aims to discuss the RAPS regionalization process in regard to the care of people with needs from alcohol, crack and other drug use. Specifically, it intends to give dimension to the care points of the RAPS dedicated to this issue, and point out the challenges of the expansion and interiorization processes in psychosocial care in Brazil. It's a cross-study, defined from the elaboration of a database which uses the info made available by the Coordenação Nacional de Saúde Mental (National Coordination of Mental Health) and the "Observatório Crack é possível vencer"

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("Crack Watch: A win is possible") platform. The pieces of information were reconstructed from the indicators database of the Regions and Networks platform as to relate the 5.570 municipalities, organized in 438 health regions. The unity analysis was, in the case of mapping RAPS services, the state by state stratification and municipalities size, as well as to what concerns the regionalization of alcohol and other drugs care policy in Brazil, the very regions of health (CIR). This dimension included the intersectional network (CRAS, CREAS, Centro Pop e CRR). An insufficient and not very organized network of services was found. There is a wandering expansion that does not consider the necessary planning and the regional pact for the sustainability of the system. There are assistential gaps all over the country in relation to care of alcohol, crack and other drugs, a fact that has caused the uncontrolled growth of therapeutic communities. There is an evident inequality in the distribution of services in municipalities of large and smaller size.
Keywords: regionalization, RAPS, psychosocial attention, alcohol and drugs.

RESUMEN: Este trabajo pretende discutir el proceso de regionalización de la RAPS —*Red de atención psicosocial*— en el ámbito de atención a las personas con necesidades decurrentes al uso del alcohol, craque y otras drogas. Específicamente, pretende dimensionar los puntos de atención de la RAPS volcados para esta problemática, además de señalar los desafíos en lo que concierne al proceso de la expansión y de la interiorización de la atención psicosocial en Brasil. Este es un estudio transversal, delineado a partir de la elaboración de un banco de datos con base en las informaciones disponibles por la Coordinación Nacional de Salud Mental y por la plataforma "*Observatório Crack é possível vencer*". Las informaciones fueron reconstruidas a partir del banco de indicadores de la plataforma "*Regiões e Redes*" en la que se articulan los 5.570 municipios brasileños, organizados en 438 regionales de salud. Las unidades de análisis fueron, específicamente, el mapeamiento de los servicios de la RAPS, la estratificación por estado y el tamaño de los municipios, y en lo que se refiere, particularmente, al proceso de la Regionalización de la Atención en alcohol y otras drogas en Brasil, las propias regionales de salud (CIR —Comisiones Integrales Regionales). Este dimensionamiento incluye la red intersectorial (CRAS — Centros de referencias de la Asistencia Social, CREAS — Centros de Referencia Especializados de Asistencia Social, Centro Pop — Centro de Referencia para Población en Situación Ambulante, y el CRR — Centro de Referencia Especializado en Craque y Alcohol). Se observó una red de servicios insuficiente y poco organizada. Hay una "expansión errante" que no considera la planeación y el pacto regional necesario para la sostenibilidad del sistema. Hay vacíos asistenciales en todo el país en relación con la atención del usuario de alcohol, craque y otras drogas, hecho que ha provocado el incremento desenfrenado de las comunidades terapéuticas. Hay una desigualdad evidente en la distribución de los servicios en los municipios, sean estos grandes o pequeños.
Palabras-clave: regionalización, RAPS, atención psicosocial, alcohol y otras drogas.

INTRODUCTION

The theme of alcohol and other drugs is considered today a public health issue on a world wide scale, since abusive use and addiction to psychoactive substances cause serious damage, not just to the user, but also to those around them (family, neighbours, friends, etc). Despite the many advances, whether in understanding the problem or in healthcare strategies, especially under the point of view of the Harm Reduction paradigm, Brazil unfortunately has disjointed public policies and many obstacles in the access to them, that increase the inequality among extremely socially vulnerable people with needs that come from issues caused by abusive use of alcohol and other drugs.

After the law of Brazilian Psychiatric Reform (Law nº 10,216/2001), the Ministry of Health established a National Integral Care Policy of Alcohol and Other Use (PNS-AD), which represents a step in the right direction in the debate. PNS-AD deals with the paradigms, strategies and care models based on the Harm Reduction proposal, which is based in autonomy and freedom, recognizing the subject in their singularity and as co-responsible in their treatment[2]. This perspective aims to deconstruct and substitute the concerning stigma of psychoactive substances such as "ill" and "marginal", seeing them as rightful citizens.

Among the many advances caused by the new legislation, we can highlight universal and integral care to those who suffer from needs from the use of alcohol and other drugs. Furthermore, a service network was structured that tries to emphasize the social interaction among users, values the decentralization of care and tries to adjust its actions to the real needs of the population in a democratic[2] way. In this way, implementation of the mental health services has significantly grown through the whole country since the approval of the Law nº 1,216/2011. 2015 registred the quantitative number of 1,135 Psychosocial Care Centers (CAPS) of the I kind, 488 of the II kind, 92 of the 24h kind and 210 CAPS of the juvenile kind. Specifically there were 315 CAPS of the 315 alcohol and drug use kind, and 88 of the Alcohol and Drug use 24hours care, totaling 2,328 services, 119 more than the last quantitative report by the Mental Health in Data report[4].

CAPS Ad is a specialized community based service, funded in the principles of Harm Reduction. As a principle, it is an open service that imposes no access limitations, receiving cases with no prior notice or users under the effect of psychoactive substances. Its acting must be interdisciplinary as to favor the user's protagonism and prioritize group actions. Its activities include: individual consultations, group psychotherapy, assisted medication, group psychotherapy, home care, therapeutic workshops, family care, psychosocial rehabilitation and providing daily meals5. Besides the aspects related to the field of care, CAPS Ad is also responsible for organizing the local network of services that can attend to the needs of psychoactive substances users in the territory where they act, once it coordinates supervision activities and the matrix-based of other services and programmes involving mental health and basic care groups2.

To try to strengthen mental health actions, Decree nº 3.088/2011 was created, which instituted the Psychosocial Care Networks (RAPS) and established the organization and implementation criteria for the whole country, integrating mental health in all levels and the attention points of the health of System Unified Health System (SUS). The RAPS reaffirm the autonomy principles, the respect to human rights, and the exercise of citizenship by people with mental suffering and needs from crack, alcohol and other drug use, something that has long been defended by the Movement for the Anti-asylum Struggle and by the Psychiatric Reform. To this end, it aims to promote equality and recognize the social determinants of the health-illness-suffering-care processes and ensures the access to quality integral care, with an emphasis on territorial based and community services, with the establishment of intersectoral actions in an articulated network[6].

The RAPS law matches two other instruments which aim to strengthen the SUS's institutionalization, the Decree nº 4.279/2010 and the Decree nº 7.508/2011. These instruments open a new perspective for the health regionalization process with the Redes de Atenção à Saúde (RAS) and the Health Regions. The Regionalization of Public Health in Brazil is a strategy to overcome the fragmentation of the health care services offer through cooperative action between municipalities in an integrated and continuous way, increasing way, improving access and the system's efficacy[7].

The Network of Health Care (RAS), created by the Decree nº 4,279/2010, was defined as a group of health based organizational arrangement and actions, structured by different technological densities and complexities levels, which were integrated by technical, logistic and management support that seek to assure the integrality of care[8]. With the purpose of overcoming the historical fragmentation of care and management of the health system, this scheme allows for the offer of a continuous and integral care of certain segments of the population, coordinated by primary care, a key component for the organization of the RAS and the reorientation of techno-assistential model of health[8,9]. To make the RAS operational all over the country, the definition of health regions were used, established by the Decree nº 7,508/2011, from the territorial cut off constituted by neighbouring municipalities groupings with similar cultural, economical and social characteristics, and composed by shared communication and transport infrastructure networks. Each Health Region has the aim to integrate organization, planning and execution of health actions and services, involving different levels and care points (primary care; urgency and emergency, psychosocial care, specialized ambulatory and hospital care)[6]

In practice, the ordering of the RAPS in every Health Region would include the offer of psychosocial care in at least seven points of the SUS network: 1) Primary Care 2) Psychosocial Specialized Care, 3) Care to urgency and emergency, 4) Residential transitory care; 5) Hospital care; 6) Deinstitutionalization strategy; 7) Psychosocial Rehabilitation. Doing so has broadened, overall, the access points and psychosocial care to a population that now counts with more variety of services implemented in the country's regions.

There's a tendency toward the interiorization of care for medium and small size municipalities, followed by a growing participation in basic care network and decentralization of the psychosocial care beds and residential therapeutic services. This is made possible because of changes to financing in prioritizing extra-hospital actions with a territorial and communitary base, beyond the pacts of government spheres and regional levels of government, through the Regional Management Commissions-CIR and the elaboration of Regional Action Plans (PAR) of RAPS in Health Regions. it is worth bringing up then, that the regionalization of health policy in Brazil has been a fundamental strategy to ensure the organization and service offers, as well as access, efficiency, cutting costs, increasing the user's satisfaction, as well as diminishing inequalities as to produce positive impact on the sanitary and livelihood conditions of populations[3]. However this

public policy has been seriously threatened by the recent political changes in the country.

In face of that, we aim to discuss, from the regionalization of SUS, like it has taken place on the RAPS, specifically in the regard of care to people with needs from alcohol and other drug use. This study is justified by the possibility to contribute with the literature that deals with the Brazilian Psychiatric Reform and the debate of Health Regionalization after the creation of RAPS. In this way, we aim to analyze the process of regionalization in course in one of the most tense fields of the reformist process, which is care to people with needs from alcohol, crack and other drug users. In a specific way, we intent to dimension RAPS on their work with alcohol and other drug use, and point to the challenges of that field in expansion and interiorization to psychosocial care in Brazil.

DEVELOPMENT

This is a cross-sectional study, drawn from the creation of a data bank based on the information made available by the National Mental Health Coordination and by the platform "Observatório Crack é possível vencer" ("Crackwatch: A Win is possible"). Via these sources, we accessed the service information that integrate the main care points in the RAPS in the SUS, focused in psychosocial care in alcohol and drugs: basic care (Community Health Agents-ACS, Family Strategy Health teams-ESF, Core Family Health Support-NASF and Street Practice Teams), specialized care (CAPS Ad e CAPS Ad 24h), residential care of a transitory character (Adult Beds Unity and Therapeutic Community Services), hospital care (psychosocial beds in general hospitals), as well as the Intersectorial Network: Reference Centers in Social Work-CRAS, Specialized Social Work Reference Centers-CREAS, Reference Centers for Homelessness/ Popular Center and Regional Reference Center in Crack, Alcohol and Other Drugs Use/CRR.

Next, the information was reconstructed through a data bank of indicators of the platform Regiões e Redes - Regions and Networks (http://www.resbr.net.br/), relating the 5,570 Brazilian municipalities organized in 438 health (Regional Management Commissions - CIR). Thus it was possible to see the quantitative and modalities of services as far as national coverage goes, which are able to be broken down in municipal levels, including by population size and the respective health regions of every integrated municipality. The resulting basis for the data was analyzed in a descriptive manner using the software Statistical Package for the Social Sciences (SPSS) for Windows, 20 version. Unity analysis were, like in the case of mapping RAPS services, stratified by state and size of municipalities, and by the very same health regions (CIR) as far as the process of Regionalization of Care to Alcohol and Other drugs go.

To give dimension to the network of psychosocial care on alcohol and other drugs in Brazil, in at least four care points in the RAPS acting through SUS, which also includes the intersectional network (CRAS, CREAS, Centro Pop and CRR), we present the following tables:

Table 1. Service quantitative which compose the psychosocial network of alcohol and other drug care in Brazil.

Network components	Care points	N
Primary Health Care	ACS ESF Team NASF (I, II and III)	332.289 48.410 5.067
Psychosocial Specialized Care	Team CR	135
	CAPS Ad	315
	CAPS Ad 24h	88
Residential care of a transitory character	Adult Fostering Unity (UAA))	38
	Therapeutic Communities (CT)	1.863
Hospital Care	Beds in general hospital	997
Intersectional Servicess	CRAS CREAS Center POP CRR	8.155 2.435 235 36

SOURCE: National Mental Health Coordination (Jan/2016). Census of the Single Social Work System (Brasil, 2015).

Table 2. Dimension of services that compose the RAPS, focused in alcohol and other drug use care by Brazilian Region

	NASF	CAPS AD	CAPS AD 24h	UAA	ECR	Beds	Center POP	CT
N	385	9	7	2	8	5	11	136
NE	1.996	84	25	10	29	15	59	315
CO	368	20	6	1	11	4	12	159
SE	1.454	135	29	16	71	72	107	777
S	864	67	21	9	16	97	46	476
BRAZIL	**5.067**	**315**	**88**	**38**	**135**	**193**	**235**	**1.863**

SOURCE: National Mental Health Coordination (Jan/2016) .Census of the Single Social Work System (Brasil, 2015).

Table 3. Dimension of the services that compose the RAPS, focused in alcohol and other drug use care by location and population size

		NASF	CAPS AD	CAPS AD 24h	UAA	ECR	Leitos	Center POP	CT
CAPITAL		594	61	31	16	66	9	45	306
	PQ	3.430	30	15	2	1	121	1	471
	MPQ	418	74	11	6	4	34	20	365
RURAL	**MP**	396	109	10	9	31	21	11	470
	MGR	101	24	13	1	18	4	36	171
	GR	128	17	8	4	15	4	22	80
Total		**5067**	**315**	**88**	**38**	**135**	**193**	**235**	**1.863**

SOURCE: National Mental Health Coordination (Jan/2016). Census of the Single Social Work System (Brasil, 2015).

The data presented in the tables 1, 2 and 3 show how much was done in the county until the moment of the structuring of a diversified network of services which looks to the care of people with needs from use of alcohol and other drugs. However, it is necessary to look carefully at the distribution of these services to see the several pitfalls and challenges of the regionalization process of the RAPS across the country.

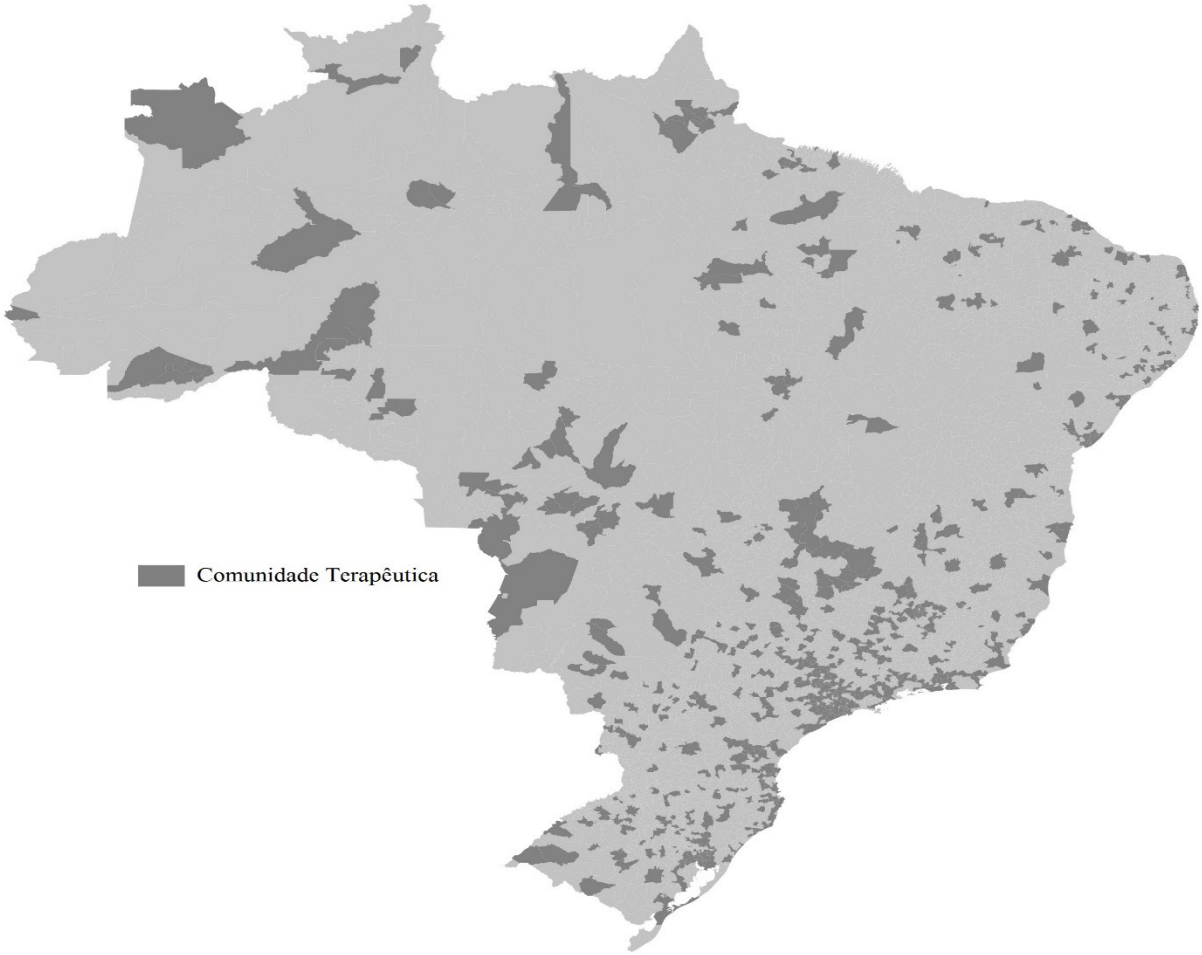
In what concerns hospital care, which is a crucial network point in the handling of acute cases and clinical cases from abusive use of substances, of breakdown crisis situations and/or abstinence cases that demand psychiatric urgence, the network only has 997 psychosocial beds distributed across 193 municipalities, which indicate coverage of only 3.5% municipalities in the whole country. They are mostly in the South (39.4%) and Southeast (35.9%) regions. There are many challenges in implementing psychosocial beds in Brazil, such as financing, as well as resistance from managers and workers anchored in an asylum culture and the stigma connected to the image of drugs and alcohol users. On the other hand, we can register a larger number of beds in countryside municipalities (77.83%), specially in small (35.1%), medium small (18%) and medium size (14.14%), which is an important advance and indicates that smaller municipalities have faced less resistance by managers in bringing this service, especially because of costs and possible encouragements for creating or maintaining these beds.

As for Residential Care of a Transitory Character, there are 38 UAA registred, all of which offer transitory fostering. They work as houses where people with needs from alcohol, crack and other drug use who are being treated in CAPS have profissional support and can live in for a certain period of time. More incentives and sensitivity from management is needed to implement these services, considering the need for fostering for a longer period than users appear to have. Despite being in small number, services are more present in the Southeast region (42.1%), followed by Northeast (26.3%), notably in capitals. From the 133 municipalities which meet the implementation criteria (200 thousand hab.), only 9.7% count with the service, demanding a larger need for investment in this type of device.

As for the Therapeutic Communities, despite adopting an inverse proposal from the Harm Reduction and the Anti-Asylum struggle movement, since generally they are oriented by the mindset of abstinence as the only "treatment", as well as using discipline and being oriented by the framework of religious moral10, these services, contradictory compose the RAPS, from Residential Care of a Transitory Character. The inclusion of Therapeutic Communities in the RAPS generated countless tensions and discontentments among users, family members and works in mental health services. However, they end up answering the pleas of larger society, religious entities, social workers and even some professionals in health.

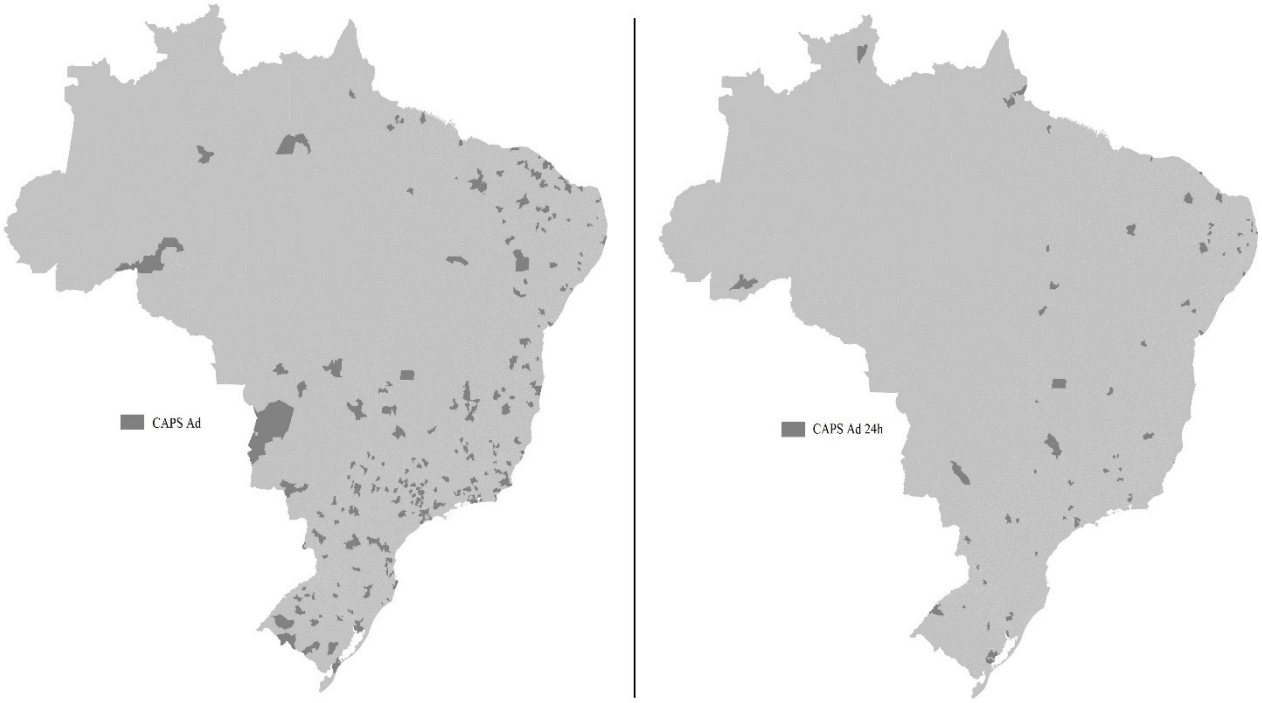
Overall there are over 1,863 Therapeutic Communities distributed in 713 municipalities, located, predominantly in the Southeast (41.7%) and South (25.6%) regions, in the municipalities of small (25.3%) and average size (25.2%), as shown in image 1. From the existing number, according with the Mental Health Technical Area/DAPES/SAS/MS, none of the services, until this point, had presented a proposal that matches a Decree nº 131, of January 26, 2012, which regulates the permission for fostering people under the suffering caused by use of alcohol and other drugs. The funding has been given by the National Secretary of Drug Policy (SENAD) from the Ministry of Justice, via public notices.

Image 1. Distribution of Therapeutic Community by municipalities in Brazil.



In relation to Specialized Psychosocial Care, for their specificity, CAPS Ad ended up historically, having the function of central device, reference, and "a gateway" for this type of care in SUS. In function of that, many network points, particularly in basic care and intersectoral network (social work and education, for example), refer cases to services of the CAPS kind of services. When we give dimension to specialized psychosocial care which focuses to alcohol and drug use care, we can observe is composed by 315 CAPS Ad and 88 CAPS Ad 24h, distributed as followed in Brazil:

Image 2. Distribution of CAPS Ad and Ad 24h, by municipalities, in Brazil



These services are in larger number in the Southern region, with 42.9% and 32.9%, respectively. The Northern region is the one with the smallest number of CAPS Ad (n=9) and the Center West has the smallest number of Caps 24h (n=6). The state of São Paulo concentrates the largest number of services in the country, 24.7% CAPS Ad and 17.04% CAPS Ad 24h. Considering the location of services, among the municipalities that meet the criteria for implementation, 80.63% of CAPS Ad and 64.78% of CAPS Ad 24h are situated in the countryside. CAPS Ad are emphasized for their concentration in medium size municipalities (34.6%) and small size (23.49%), while the CAPS Ad 24h are present in larger quantities in capitals (35.22%) and small size municipalities (17%), considering the regional service character of these cases.

It is clear that there is a picture of expansion of the network of the country. The number of 268 municipalities that count with CAPS Ad and 68 which count with CAPS Ad 24h, making it possible for a larger offering of care actions for people with needs from using psychoactive substances in Brazil. However, if we consider only the places that meet the criteria for CAPS Ad implementation (70 thousand pop) and CAPS Ad 24h (150 thousand pop.), there's still a meaningful

number of municipalities which do not count with these services: 214 places (50.6%) which do not count with CAPS Ad and 140 (79.1%) which do not count with CAPS Ad 24h.

The worst scenario can be seen in 183 municipalities which don't count with either services (CAPS Ad and CAPS Ad 24h). About these, most of these municipalities are located in São Paulo (n=48), Minas Gerais (n=25), Rio de Janeiro (n=16) and Pará (n=15). They are located mostly in the rural area, with emphasis for mid-small sized locations (n=90) and average medium size (n=86). In this carelessness scenario, Therapeutic Communities end up taking over the spotlight and covering the gap caused by the lack of CAPS Ad and CAPS AD 24h coverage across national territory.

Among the locations which count on their networks with both Therapeutic Communities and other types of CAPS (except of the alcohol and drugs kind), the number of 713 municipalities is registered, distributed in the Southern (42.9%), South (25.5%), Northeast (18.6%), North (6.8%) and Center West (6%). Furthermore, we draw attention to the locals which count on Therapeutic Communities and of which there is no register, at the moment, of any CAPS equipment. That means 195 municipalities distributed in the following regions: Southeast (n=94), South (n=55), Northeast (n=18), North (n=14) and Center West (n=14), highlighting all of them are located in rural areas, with the following sizes: small(n=175), medium small size (n=12), medium (=7) and medium large (n=1). Only in 16 Brazilian municipalities can we register the presence of CAPS Ad, Ad 24h and CTs in its territories, distributed as following in the country's regions: Southeast (n=5), Northeast (n=5), South (n=4), North (n=1) and Center West (n=1), with nine being located in capitals and seven in rural areas. The larger presence of Therapeutic Communities in smaller municipalities, in populational terms, and the smaller presence of the CAPS network in these locals results in a picture that gives this service a wider legitimacy so it can make itself the main access for the population and the answer to the social panic generated by the so called "crack epidemic" throughout the country.

Primary Care, under the RAPS, includes four components, with 332,289 Community Health Agents, 48,410 Family Health Teams, 5,067 Family Health Support Core and 135 Street Practice Teams. In the three first cases, the largest numbers are placed in small size towns (46.2%, 47.2% and 67.7%) and in the Northeast (35.3%, 36.4% and 39.4%). The Street Practice Team is made by mobile full care teams to rough sleepers, with 52.6% focused in the Southeast region, which has a larger quantitative number of rough sleepers in the country[9,11], notably in capitals and mid size municipalities. However, 98.4% of municipalities do not have a homelessness care unity, especially in the Northeast region (32.4%).

Primary care is one of the network points where investment in permanent education actions is needed, as well as matrix-based mental health, in a systematic and continuous way, with the aim to deinstitutionalize practices and, most of all, the culture of fear and prejudice which floats around

professionals who work with people with needs from psychoactive use Historically, the services offer for primary care were very reticent regarding mental health actions on territories. The lack of education of professionals, families and communities in dealing with psychic suffering and the effects from abusive and addiction to substances has become increasingly clear[12].

Studies shown lack of preparation from health professionals to meet and care for such demands which get between access and care of these demands, with the difficulties between access and care for the suffering manifestations that appear during primary care being of different origins: lack understanding of different cultural codes in expressing suffering; absence of adequate framework for the teams; professionals and services still locked in the individual and fragmented model of practice; priority to mental health policy for cases considered serious; absence of care technology and access for patients with confusing complaints[13]. Currently its possible to observe that the largest part of treatment proposals aimed at abusive consumption of alcohol and other drugs proposes institutionalizing people, through medical-pharmaceutical interventions, as well as psychosocial, sociocultural and religious ones. The subject is left between asylums and therapeutic communities, taking on the role of the mad man as a degenerate subject and/or with no morals - a law breaker, excluded by society and labeled ill and/or a delinquent/criminal[14].

In this sense, there are many challenges made to professionals in family health teams (ESF) in what concerns alcohol and other drugs: working in a perspective different from what is learned in academia (prescriptive and centered in illness); facing one's own anxiety, insecurity, prejudice and even incapacity of dealing with the alcohol and drugs user; supporting with matrix-based mental health actions with specialized teams; programming activities based in ministerial policies which are not even consolidated in most regions of the country, nor are they valued by local management; create protocols of care which allow for monitoring and evaluation of actions developed alongside drugs and alcohol users in the region; and, at last, working as a team and as a network to ensure the wholeness of care[15]. it is common for family health professionals to be sought after to solve other issues which might be related to abusive use of alcohol and other drugs, and so it is important that professionals are prepared and able to draw preventive, promotion, treatment and rehabilitation actions for these patients[16].

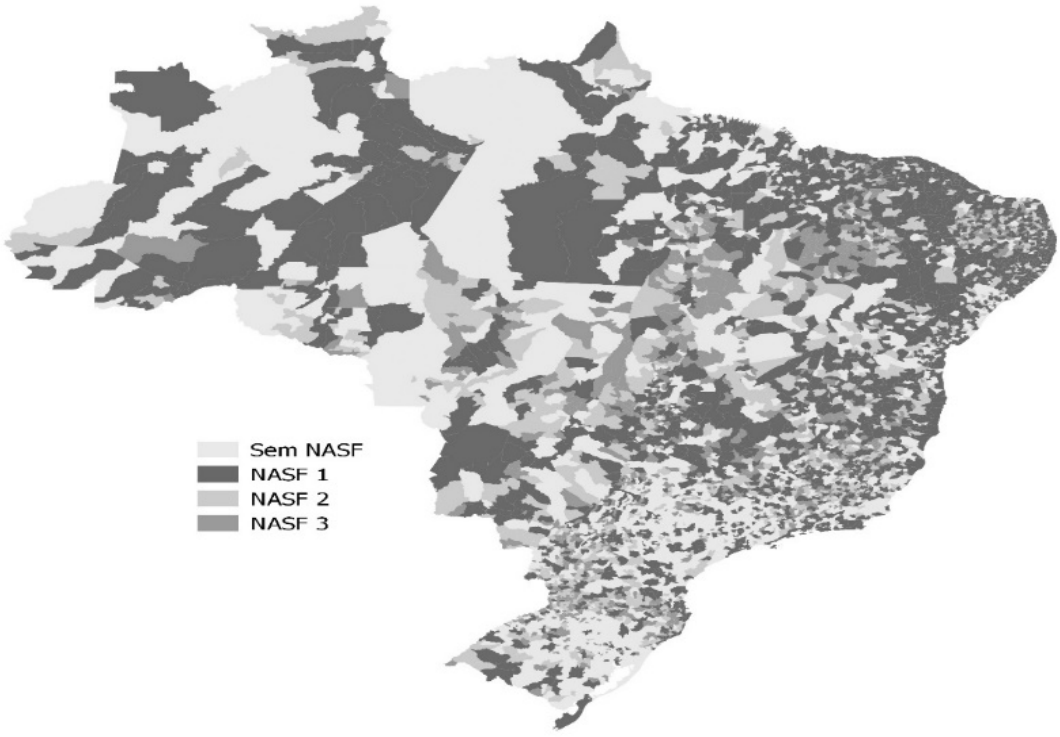
Such challenges are made harder in the places where only primary care teams are present (ACS, ESF or some kind of NASF team) to deal with psychosocial care of alcohol and other drugs users, like it happens in at least 3,006 municipalities, which makes for 54% of Brazilian towns. Such locations are distributed as such: 31% in the Southeast, 28.4% in the Northeast, 25.15% in the South, 8.15% in the Center West and 7.18% in the North. In regard to ESF, 31 municipalities do not count with these teams and 13 municipalities only have assistance from the RAPS in the from of Community Health Agents, which compromises and weakens deeply the access and the capcity to meet the demands from users and families in the field of psychosocial care of alcohol and other drugs.

Specifically on the NASF teams, which were created as a strategy to broaden diversity and actions made by ESF, it is necessary to situate some positive aspects and others which we consider as obstacle and stops that are important for the process of expansion and interiorization of RAPS in the country. Such teams have as an aim to develop matrix based actions, support primary care teams in discussing cases, in shared care and construction of joint unique therapeutic cases, aiming to coordinate and continuate care.

According to the Ministry for Health, there are three types of NASF: A) type 1 - composed of at least five professionals who must assist at least eight family health teams; B) type 2 -focused with municipalities with less than 10 people per square mile, which must include at least three higher education professionals of non coinciding occupations who must develop actions with three family health teams; c) type 3 - created by Decree nº 3,124/2012 for full care to crack, alcohol and other drug users in municipalities with less than 20,000 inhabitants [17].

From the 5,067 NASF teams through the country until now, 2,962 are of the NASF1 kind, 976 of the NASF2 kind and 1,129 of the NASF3 kind. Differently from the NASF1 teams, 20% located in the capitals and 80% in rural municipalities with an emphasis in small size towns (45.23%), the NASF3 teams are all in rural municipalities and 99.8% in small size towns. This last data is an excellent indicator considering that 54% of Brazilian municipalities in what concerns care to alcohol and other drugs use only count with primary care.

Image 3. Distribution of the kinds of NASF, by municipalities, in Brazil



There are 1,798 local that have no kinds of NASF, a condition that weakens RAPS in small municipalities. Despite advances in coverage of these services, in the handling of drugs and alcohol users, it is noticeable the small involvement from professionals, both from family health teams and NASF on the issue[18]. Prejudice, lack of experience, distancing from the area, attachment to the biomedical model are all factors that make the involvement of these professionals still tentative[19]. As a consequence, the population and the very services that make primary care in these places end up going to Therapeutic Communities in the region as their sole resource of care.

Besides the SUS network, the protection, attention and care field for people with needs from psychoactive substances use is composed of services of the intersectorial network, which involves education, welfare, justice and rights. In what concerns this study, we subscribe the data around the equipaments of the Social Work and Regional Reference Centers in Crack, Alcohol and Other Drugs/CRR.

In what concerns the Single Social Work System, there are 8,155 CRAS, 2,435 CREAS, 36 CRR and 235 Center POP. CRAS is a service characterized as an entryway for social work. It is found in areas of higher social vulnerability, with the goal of strengthening family life and community. It aims to ensure populational access to services, benefits and social work projects; it acts alongside the community facing social issues such as lack of access, transport, leisure spaces as well as culture, low quality in service offer, local violence, child labour, among others. This service is distributed noticeably in the Southeast region (34.4%) and the Northeast one (32.1%), in capitals (1.75%), and small (49.1%), mid small (17.5%) and large size (18.7%) municipalities.

CREAS offers a service specialized in a continuous way to families and individuals (children, teens, young adults, adults, aging, women) which find themselves in threatening situations or in situations where their rights are breached, such as physical, psychological and sexual violence, people trafficking, community service, personal and social risk situations caused by drug use, etc. The Northeast region (38.1%), followed by the Southeast (28.4%) show a larger number of services, noticeably, the small and mid small size municipalities. However it is worth pointing out that 60.6% of Brazilian municipalities are not assisted by this type of service, being as a whole rural and small size municipalities.

Center POP is a reference space and a specialized service for homeless populations which promotes group, social living and the development of relationships based in solidarity, affection and respect. It is based on the Southeast (45.5%), mainly in capitals and mid to large municipalities. Only 60 municipalities count with two services focused on homeless populations in their networks (ECR and Center Pop), distributed as such: Southeast (n=25), Northeast (n=14), South (n=10), North (n=6) and Center West (n=5). The capital to rural ratio is 21 to 39.

CRR is focused on the permanent present professional formation of healthcare, welfare and

public safety workers, as well of those who act in the Public Prosecution, the judiciary and entities which help juvenile offenders in institutions. It acts in places with a population equal or superior to 500 thousand inhabitants or in smaller size municipalities when partnerships are established to help similar sized populations. Thus this service focused on the Southeast (44.4%) and Northeast (27.7%) regions, in capitals, medium size and mid to large size municipalities.

To summarize it, there is no doubt about the advancement of the structuring terms of psychosocial services dedicated to alcohol and other drugs user in Brazil, especially after the implementation of the RAPS. Actions of an intersectoral and regionalized character were strengthened, despite the gaps and the recurring challenges that this field imposes to the opening of services specialized in locations with unbalanced regional development and low territorial concentration, which count, for the majority of cases, only with the basics of primary care. It is self-evident that deepening educational actions is needed, aiming to strengthen networking between services and other actors-organizations present in the everyday life of users. Dealing with a continent sized country, these fragilities in terms of coverage and specialized services offer brings a profound hopelessness among users, their families and mental health workers. This is made worse by the basic care problems and the historical fragmentation of healthcare and intersectoral networks in the country.

In function of that, the regionalization of health debate in Brazil, which has been proposed since SUS' creation, gained more strength from the 2000s, whose biggest innovation was in the year of 2006, caused by the Health Pact. Regionalization is seen as a proposal to overcome systemic fragmentation of the service offering, via cooperative action between municipalities in an integrated and continuous way, increasing access and system efficacy[20], strengthening regional answers to local problems[21] and reducing inequalities of an inter and intra regional character as to amplify full access for the local population.

Many advancements have been made in health regionalization, with the institutionalization of interfederative spaces to build regionalization in a cooperative manner, negotiation mechanisms and a pact of regional commitments and tools for health regions evaluations, especially with the introduction of the Organizational Public Action Contract - COAP, a joining instrument among managers to build welfare networks to integrate care and tend to the needs of the population's health in their territories[22]. Thus, the regionalization policy is divided in two moments: a) the Pact and the establishing of COAP, with intense discussions around the theme of regionalization and first responses in the managing and assistential sphere of decentralized networks of health care; b) the following moment, of institutional emptying and absence of innovation in the regionalization theme, in function of economic stagnation, strong fiscal destructuring of government agents and a democratic breakdown with president Dilma Rousseff's impeachment after her 2014 election.

Currently, we are in one of our history's most delicate points since the return of democracy

in 1988, where the illegitimate mandate of vice-president Michel Temer since 2016 established a New Fiscal Regimen (NRF) for the country, followed by a series of counter-reformations which struck directly the sector of health, with systematic actions of dismantling the SUS, life for instance the changes to National Basic Care Policy with a clear indication of changes to the mental health policy. Which means we can see a change of directions with the government's plans aligned to an agenda of austerity and conservative political bargaining.

In this confusing scenario it's possible to detect advances in relation to health regionalization. However, we can not say the same for RAPS regionalization in Brazil. There are pitfalls which represent big problems for psychosocial care3. There are currently 438 health regions, which group the 5,570 municipalities existing in the country. Despite 95.43% (n=418) of health regions being covered by RAPS, if we considered at least two care points (APS and ACS, ESF and NASF teams and CAPS network of any type) there are completely unassisted areas. Thus:

> In the regions with a CAPS I (between 15 and 70 thousand people), we identified 19 CIR which should have been built between these points of care (APS and CAPS I), however, in at least four regions (21.05%) there is no register of any type of service of the CAPS kind for back-up, only primary care services. In the regions with CAPS II implementation criteria (between 70 and 150 thousand people), we identified 7 CIR which should count with the same two care points (APS and CAPS II), with at least 58 regions (75.32%) with no registry of that specific service, despite counting with other CAPS modalities, especially of type I. In those with the implementation criteria for CAPS III (above 150 thousand peoples), we identified 342 CIR which should have been built in at least two care points(APS and CAPS III), however 296 regions (86.55%) do not count with this specific service, despite registries showing other types of CAPS in territories[3].

Besides that, 13 health regions still count only with ACS, ESF or NASF as the single point of access to mental health in their territories[3], being a very serious point of lack of assistance and inequality in psychosocial network access, because users don't even count with back-up services made in their municipalities which compose the same health region, having to recur to more distant municipalities to obtain some kind of more specialized care.

In the case of CAPS Ad and Ad 24h, there are 200 health regions in the country (45.16%) without access to these services, even with the implementation of programme Crack, a win is possible. It's an extremely concerning picture which reveals the fragility of regionalized care to people with needs from alcohol and other drug use. This situation has been stimulating the increase of therapeutic communities, which have no state regulation nor commitment to the psychosocial care directives and to psychiatric reform.

In the management report done in the National Mental Health Coordination for the Ministry of Health which refers to the period of 2011-2015, only 169 Plans of Regional Action (PAR) of the RAPS, or about cerca 35%, had been done in the whole country. The levels of government, joint

financing and legitimacy referred in regional plans as an instrument of interfederal management in every CIR presented themselves as the the great challenges to advance further the effectiveness of RAPS in a regionalized manner through the country[23]. This data reinforces even more the understanding that we live at risk of permanent stagnation and obstacles to regionalization policy or of reducing it the merely rational-instrumental aspect, aiming for administrative efficiency and cost reduction, being operated by protocol bureaucratic regulations, with no commitment with effectively put to practice SUS's principles[22].

CONCLUSION

This work has as a focus the psychosocial care of people with needs from alcohol, crack and other drug use. Despite the efforts for an effective National Full Care To Users of Alcohol and Other Drug Policy, alongside the Brazilian Psychiatric Reform Law (Nº 10,216/2001), we point, through our methodology of data crossing about the services used by this population and the health regions data, to important gaps as far as structuring a network with regionalized character across the country. We also highlight the need for articulation between the many levels that compose mental health care in RAPS, as well as other devices of territory in the intersectorial perspective with education, social work, justice/rights networks.

In regards to RAPS regionalization, there still not a consolidated institutional culture in Brazil, as well as in the sphere of public health policies focused on regional planning processes as SUS' defining and ordering instrument[24]. As a result, all that we see is an insufficient services network with bad organization. There is "a wandering expansion' which does not consider planning and regional pacts, necessary so the system can sustain itself"[25]. In this way it is necessary to overcome bureaucracy and the hardening of CIR and RAPS conductive groups, with Regional Action Plans that aim for planning regional systems in the average and long run.

At last, we draw attention that the debate about RAPS regionalization is inserted in the debate between workers and managements of mental health as to strengthen every health region to the change to the techno-assistant model of health, particularly in regards of care to alcohol and drugs.

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