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Original Article

Reference Center for Alcohol, Tobacco and Other Drugs: Six years of intervention*

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Objective: to describe the evolution of the intervention and treatment models of the Reference Center for Alcohol, Tobacco and Other Drugs in the State of São Paulo, submitting production data for the last 6 years. **Method**: a cross-sectional and retrospective study, with data and records of the consultations carried out between 2013 and 2018 in different CRATOD sectors. **Results**: the service counted 204,933 service records in the last six years, 31,807 of which were new cases, 12,318 rapid tests for HIV, Syphilis, and Hepatitis B and C and served 69 patients in the Monitored Housing. **Conclusion**: the service's line of care encompasses three premises: reception with qualified listening, outpatient/hospital treatment and social reintegration, in this context, the nursing professional appears as a fundamental part during all treatment phases. The consistency of this work in conjunction with the multi-professional team resulted in the consolidation and structuring of a service flow aimed at the constant motivation and care of the drug addict.

Descriptors: Substance-Related Disorders; Crack Cocaine; Public Policy; Harm Reduction.

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Centro de Referência de Álcool Tabaco e Outras Drogas: Seis anos de uma intervenção

Objetivo: descrever a evolução dos modelos de intervenção e tratamento do Centro de Referência de Álcool, Tabaco e Outras Drogas do Estado de São Paulo, apresentando dados de produção dos últimos 6 anos. **Método**: estudo transversal, retrospectivo, com dados e registros dos atendimentos realizados entre 2013 e 2018 em diversos setores do CRATOD. **Resultados**: o serviço contabilizou nos últimos seis anos 204.933 registros de atendimentos sendo 31.807 de casos novos, 12.318 testes rápidos para HIV, Sífilis, Hepatite B e C e atendeu 69 pacientes na Moradia Monitorada. **Conclusão**: a linha de cuidados do serviço engloba três premissas: acolhimento com escuta qualificada, tratamento ambulatorial/hospitalar e reinserção social, nesse contexto, o profissional de enfermagem aparece como peça fundamental durante todas as fases do tratamento. A consistência desse trabalho em conjunto com a equipe multiprofissional resultou na consolidação e estruturação de um fluxo de atendimento que visa a constante motivação e cuidado do dependente químico.

Descritores: Transtornos Relacionados ao Uso de Substâncias; Cocaína Crack; Política Pública; Redução do Dano.

Centro de Referencia en el tratamiento de Alcohol, Tabaco y Otras Drogas: Seis años de intervención

Objetivo: describir la evolución de los modelos de intervención y tratamiento del Centro de Referencia en el tratamiento de Alcohol, Tabaco y Otras Drogas en el Estado de São Paulo, presentando datos registrados en los últimos 6 años. **Método**: estudio transversal, retrospectivo, con datos y registros de las consultas realizadas entre 2013 y 2018 en diferentes sectores de CRATOD. **Resultados**: se computaron 204,933 registros de servicio en los últimos seis años, 31,807 de los cuales referían a casos nuevos, 12,318 pruebas rápidas para VIH, Sífilis, Hepatitis B y C y fueron atendidos 69 pacientes en la Vivienda Monitoreada. **Conclusión**: la línea de atención del servicio abarca tres premisas: admisión con escucha calificada, tratamiento ambulatorio/hospitalario y reintegración social, en este contexto, el profesional de enfermería surge como parte fundamental en todas las fases del tratamiento. La coherencia de este trabajo junto con el equipo multiprofesional dio como resultado la consolidación y estructuración de un flujo de servicio dirigido a la motivación y el cuidado constante del adicto.

Descriptores: Trastornos Relacionados con Sustancias; Crack de Cocaína; Política Pública; Reducción de Daños.

Introduction

The contemporary consumption of psychoactive substances has become a public health issue of enormous diversity and complexity[1]. Currently, 1 in 200 people between 15 and 64 years old has some kind of complication related to the consumption of some psychoactive substance[2], with significant harms to the individual, their family and their social groups – including loss of productivity, worsening of health standards, social non-adaptation, and greater involvement with crime[2].

Until a little over half a century ago, the consumption of psychoactive substances was little understood and problematized from the scientific point of view, now being seen as a sign of moral degradation and as Police case, or as a harmless way to achieve a high and peaceful way of living individual freedom and self-knowledge.

In the transition of 1980, both neurobiology and clinical epidemiology demonstrated, in addition to Manichean dualities, that the consumption of psychoactive substances and their associated problems are multifaceted and vary over time[3]. This same body of knowledge led to the development of a treatment system that gradually became more comprehensive and effective.

Thus, at the same time that it acts to normalize the brain functioning of the affected user and to offer psychosocial support for their behavioral change, the negative consequences of drug use, such as health problems arising from dependence, social harms, mortality/suicide, infectious diseases, psychiatric comorbidities, and social exclusion began to be seen as part of the process of social reintegration and rescue of citizenship for these individuals[3].

Currently, the treatment applied correctly and at the appropriate time can make a difference in the quality of life and recovery process of individuals with problems related to the consumption of psychoactive substances[4], decisively contributing so that they return to participate socially as members of their communities[3].

Although treatment is increasingly related to improved consumption patterns, only 1 in 11 users who need care in Latin America have access to specialized treatment programs[2]. In Latin American countries, the main barriers reported for access to treatment are the following: inappropriate services and/or facilities; insufficient treatment or medication options; lack of qualified professionals; long waiting times or limited opening hours; geographical distance of services or lack of transport options, and stigma[5-7].

In Brazil, the services aimed at drug users were substantially expanded throughout the first decade of the 2000s[8], primarily with the implementation of Psychosocial Care Centers – Alcohol and Drugs (*Centros de Atenção Psicossocial – Álcool e Drogas*, CAPS-AD) (2002) - which consists of a multidisciplinary model of treatment for addicts structured in the community - together with the definition of the comprehensive care network for users of psychoactive substances assisted in the Unified Health System (*Sistema Único de Saúde*, SUS)[9]. Subsequently, through the publication of Ordinance 2,197, the Ministry of Health (2004) consolidated the Psychosocial Care Network for people with mental distress or disorders resulting from the use of crack, alcohol, and other drugs[10].

In São Paulo, the State Government created in June 2002 the Reference Center for Alcohol, Tobacco and Other Drugs (*Centro de Referência de Álcool, Tabaco e Outras Drogas*, CRATOD), in order to be constituted as a reference for the definition of public policies for health promotion, prevention, and treatment of disorders related to the use of alcohol, tobacco, and other drugs. In November 2002, it was enabled as a CAPS-AD, thus adding other care-related characteristics to its initial purposes. Already in 2004, the State Department of Health took over the State Coordination of the National Program for Tobacco Control (*Programa Nacional de Controle do Tabagismo*, PNCT), with the mission of empowering, organizing, and maintaining the Program with the municipalities of São Paulo, thus the CRATOD being responsible for the organization of the Smoking Treatment Network.

In 2013, the CRATOD began to be classified as a Psychosocial Care Center for Alcohol and Drugs III – Qualified (*Centro de Atenção Psicossocial de Álcool e Drogas III*, CAPS-AD III) increasing its scope and complexity of treatment. Still in 2013, with the creation of the State Program to Combat Crack, referred to as *Programa Recomeço* (New Start Program), once again expanded its activities, becoming the joint service and initial formation of *Rede Recomeço* (New Start Network) for the state of São Paulo, together with the Secretariats of Social Development and Justice and Defense of Citizenship, adding to the treatment offered in the CAPS the referential offer of beds for detoxification through the regulation system being referred to as the Central for the Regulation of the Health Services Offer (*Central de Regulação de Oferta de Serviços de Saúde*, CROSS) and the possibility of social reception in accredited and accredited Therapeutic Communities.

Regarding *Programa Recomeço*, its basic premise is to help the user of psychoactive substances along the various stages of their psychosocial reinsertion process. For this, the Program has been providing a Line of Care that includes actions of prevention, treatment, social reintegration, and access to justice and citizenship, in addition to reducing situations of social and health vulnerability[11].

However, the CRATOD has been contributing as a complex and unprecedented multidisciplinary care model in the country that has managed, over the last few years, to include a range of services in a coordinated

and integrated manner that has been the basis for the implementation of new public policies in Brazil.

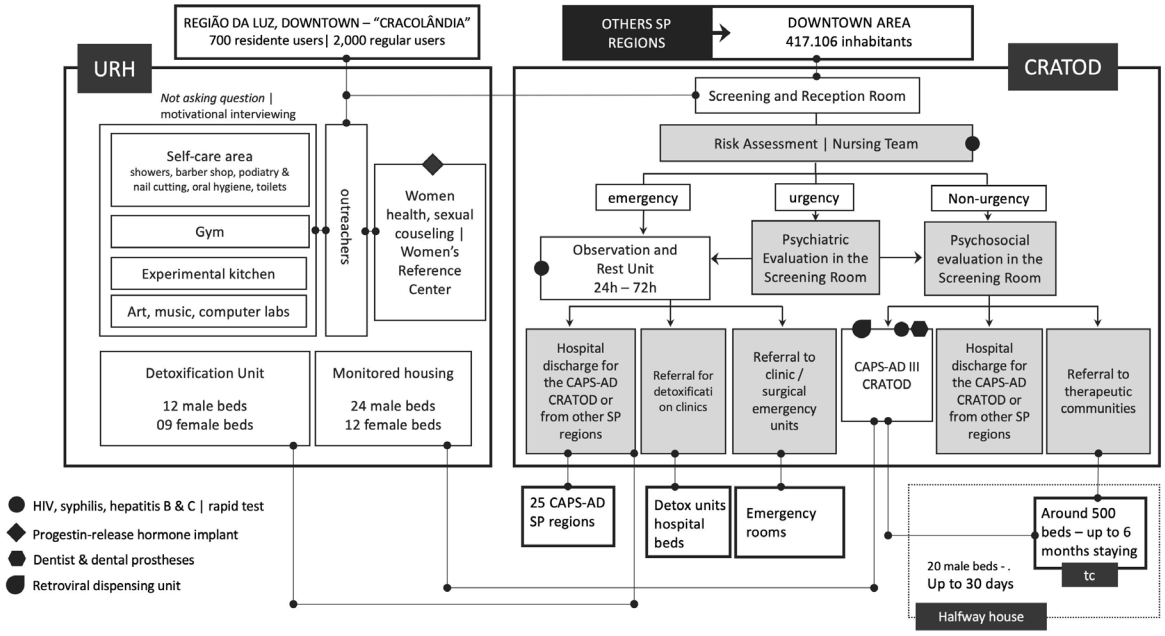
Thus, the aim of this article was to describe the evolution of intervention and treatment models and their respective production data, carried out in the last 6 years of activity.

Method

This is a cross-sectional and retrospective study that used data and records of care conducted between 2013 and 2018 in the diverse CRATOD sectors. The care model has been fully developed in the service only from 2016. Thus, for comparison purposes, the data were divided into two three-year periods: 2013 to 2015 and 2016 to 2018. The local Ethics Committee approved this study (CAAE 68624617.5.0000.5505). For statistical analysis purposes, percentages and means of the three-year period were calculated.

Locus: The CRATOD has as reference the central region of the city of São Paulo, which comprises a population of 431,106 inhabitants, distributed in eight districts: Santa Cecilia, Bela Vista, Liberdade, Consolação, República, Cambuci, Bom Retiro and Sé. The service is located in the region of Estação da Luz (Bom Retiro), in which there is also the largest area of open air crack consumption in the country, referred to as "*cracolândia*"[12].

The service's line of care encompasses three basic premises: reception with qualified listening, outpatient/hospital treatment, and social reintegration. After implementing *Programa Recomeço* in 2013, in order to support the approach, treatment, and social reintegration actions developed by the CRATOD, especially in the scene of using "*cracolândia*", the Secretariat of Health created the Helvetia New Start Unit (*Unidade Recomeço Helvetia*, URH), which is concentrated in an eleven-story building and offers a space for hygiene and self-care actions, workshops and physical activity, wards for detox, and monitored housing. The main service strategies of these two services are described in Figure 1.



*URH = Helvetia New Start Unit; †CRATOD = Reference Center for Alcohol Tobacco and Other Drugs; ‡CAPS-AD = Psychosocial Care Center Alcohol and Drugs; §TC = Therapeutic Community

Figure 1 – Service flowchart

Phase I – Reception of the users:

Street approach: conducted by counselors trained in addiction to chemical substances, it aims to welcome, clarify, and advise drug addicts and their families, encouraging spontaneous demand for treatment.

Recreational, educational, and self-care activities: coordinated by technical professionals with the objective of advising users in terms of harm reduction and in building experiences that can improve motivation, seeking to increase acceptance and adherence to treatment. These are short-term actions that take place in the Community Center of the Helvétia New Start Unit (URH), based on a grid of activities that contemplate: hygiene and self-care (such as: bath, haircut, chiropody, and barbershop), physical education (fitness center), gastronomy (experimental *cuisine*), and arts and music (drums, theater and *soiree*), among others.

Family planning – Gravius Project: supervised by the CRATOD and the Women's Reference Center Nursing teams at the Pérola Byington Hospital. It aims to prevent unplanned pregnancies in women who use drugs previously selected in the scenes of use of "*cracolândia*" by active search done by health agents, from the CRATOD or from the URH, in order to reduce social and family harms, even generating lower costs for the public service[13]. After providing clarifications on women's health, which also includes all the contraceptive methods, a subdermal etonogestrel implant is proposed at the Pérola Byington Hospital.

Phase II - Hospital and outpatient treatment

Psychosocial Care Center Alcohol and Drugs (CAPS-AD): a model carried out by a multidisciplinary team with the objective of assisting users who need comprehensive treatment. The CAPS-AD III CRATOD operates 24 hours a day and has observation and rest beds for up to 14 days. The treatment is structured in 3 stages (Intensive, Semi-intensive, and Non-intensive) according to the severity and individual need of the patient, thus initiating the so-called Singular Therapeutic Project (*Projeto Terapêutico Singular*, PTS) which consists of adapting the activities to the user's profile, which may include occupational, sports, and citizenship development activities, among others. After strengthening the bonds and adhering to the treatment, the final phase of the program will aim at social reintegration. From 2007, the CAPS has been offering dental care to patients assisted in the CRATOD, providing functional and aesthetic rehabilitation, for a better social reintegration of these individuals.

Detoxification Ward: they are hospital beds for short-stay hospitalization (from 15 to 30 days), purposing to offer diagnosis, detoxification, and psychiatric treatment. There are nearly 400 vacancies in nine hospitals, the URH has 21 of these beds, regulated by the Central for the Regulation of the Health Services Offer (CROSS).

Screening and Risk Assessment: screening is the reception of all the spontaneous demands on the part of the Unified Health System (SUS). Risk assessment is managed by the nursing team of the service and was based on the reception protocol with Risk Classification of the SUS adapted for psychiatric symptoms. Thus, upon arriving at the CRATOD and after being evaluated, the patients receive labels with colors that reveal the severity of their case. Thus, in the case of a psychiatric emergency in need for an immediate evaluation, the patient will receive a red label with a waiting time of zero to five minutes, or a yellow label in case of an emergency and the patient will wait for a maximum of 60 minutes. The green label will be provided in cases where an emergency has not been identified and can wait up to 120 minutes[14].

Rapid tests for Sexually Transmitted Infections (STIs) and Retroviral Therapy: after the screening, a nursing team trained by the CRT-AIDS Reference and Treatment Center offers the patient the possibility of a rapid testing for HIV, Syphilis, Hepatitis B and C, in a consented and voluntary manner. From May 2017, the CRATOD became an integral part of the logistics of distribution and dispensing of the list of antiretroviral drugs provided by the Ministry of Health, thus becoming a Drug Dispensing Unit (DDU).

Observation and Rest Unit: in the cases of a medical indication, the patients assisted can be observed in the CRATOD for up to 72 hours; the service has 35 beds (female and male), 02 isolation beds, and 01 emergency room. At first, everyone receives at least one social and psychological evaluation and can then be referred to short detox beds, to the CAPS-AD of the service itself or to the reference service, or to Therapeutic Communities.

Phase III - Social reintegration

Therapeutic Communities (TC): it is a model of assistance and care, focused towards abstinence and directed to those in social vulnerability and who wish to treat themselves voluntarily. Through *Programa Recomeço*, the Government of the State of São Paulo has established a partnership with the Brazilian Federation of Therapeutic Communities (*Federação Brasileira das Comunidades Terapêuticas*, FEBRACT), which allowed the CAPS AD III CRATOD to screen patients who need this type of service. This type of hospitalization is indicated for cases that require a prolonged stay favoring voluntary contact among peers. Nearly 500 vacancies are offered and the reception time is up to six months, after which an articulated and planned action between the TCs and the reference CAPS-AD of the patient will continue the treatment.

Partnership with mutual-help groups: invited members of the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, as well as from *Grupo de Amor Exigente* (Demanding Love Group) offer quality support and guidance free of charge. Thus, they constitute a resource that can be used throughout the recovery process and an efficient complement to outpatient treatment[15].

Temporary House: opened in 2015, it offers 20 sites for social reception for a maximum period of 30 days, being a rear service of *Programa Recomeço* for those who decided to seek help spontaneously, but whose desire is threatened by the lack of housing structure, or for those users who need to wait one to two days to be referred to the accredited TCs[16].

Family New Start in Citizenship Integration Centers (CICs): in order to motivate the user of psychoactive substances to seek help through the involvement of the

family, a partnership between the Citizenship Integration Centers (CICs) was signed with the Secretariat of Justice and Defense of Citizenship (SJDC) which resulted in the expansion of the action of *Programa Recomeço* instituting *Recomeço Família* (Family New Start) in the CICs. The activities are carried out by a multidisciplinary team and aim to guide and treat the relatives of the addicts, assisting them in the regularization of personal documents, legal guidance, and in the mediation of family conflicts, in order to reorganize the users' lives.

Monitored Housing of Programa Recomeço: a service that is part of the URH and offers 36 housing and treatment sites for crack addicts in high social vulnerability who are linked to outpatient treatment in the CAPS AD III CRATOD and are in a final phase of the recovery process. It is a drug-free space, with a focus on maintaining abstinence and social reintegration[17].

Results

The Medical and Statistical Archive Service (*Serviço de Arquivo Médico e Estatístico*, SAME) accounted for 83,741 screenings during these six years: 41,049 in the first three-year period and 42,692 in the second, with a growth variation of 4% in the last three years.

The hospital sector responsible for observation comprises the CAPS AD III CRATOD observation and rest beds and detox hospitalizations in beds. This sector showed differences in the analysis of comparative data from the first three-year period to the second, 6,824 voluntary hospitalizations were performed in the first three years *versus* 5,933 in the second, showing a decrease of 13%. In the first three-year period, 1,738 patients were admitted involuntarily *versus* 3,255 in the second, resulting in an increase of 87.3%. In the compulsory hospitalizations, there was a comparative decrease of 45.5% (22 *versus* 12 hospitalizations respectively).

As for the results of the application of the rapid tests, these are available since 2016 with 12,318 tests performed, including HIV, Syphilis, and Hepatitis B and C.

Regarding the individual services provided in the CAPS AD III CRATOD in the Intensive modality, 2,506 were recorded in the 1st triennium and 8,512 in the 2nd, with an increase of 240%; the Semi-intensive service performed 4,789 and 10,596 calls, respectively, representing an increase of 121%. The Therapeutic Groups grew by 137% when compared to the two trienniums (3,233 *versus* 7,655), and the number of participants grew by 244% in the same period (27,102 *versus* 93,180).

The *Recomeço Família* program instituted in the CICs served 5,960 people from 2014 to 2015 and, in the following three years, 18,164, representing a mean increase of 205%. 720 groups were held in the first triennium and 1,535 in the second, with a mean increase of 113%.

Reception in the Therapeutic Communities grew by a mean of 17% (3,048 *versus* 3,567 shelters) in the last three years of *Programa Recomeço*.

Regarding the Temporary House, there were 662 shelters since 2017 when it was implemented. Monitored Housing assisted 69 residents in its first eleven months of operation, of which 51% remained in the Housing, the rest were socially reinserted (Table 2).

Table 2 - Data from the Alcohol and Other Drugs Reference Center, from 2013 to 2018

Unit (No.)		2013	2014	2015	1st Triennium	2016	2017	2018	2nd Triennium	Total
Individual care services	Screening	11,638	14,114	15,297	41,049	12,165	13,507	17,020	42,692	83,741
	New Patients	6,302	5,045	4,683	16,030	4,737	5,657	5,383	15,777	31,807
Hospitalizations	Voluntary	1,857	2,765	2,202	6,824	2,080	2,066	1,787	5,933	12,757
	Involuntary	435	711	592	1,738	842	1,316	1,097	3,255	4,993
	Compulsory	3	14	5	22	2	2	8	12	34
CAPS*	Intensive	-	1,620	886	2,506	1,809	2,598	4,105	8,512	11,018
	Semi-intensive	-	2,850	1,939	4,789	2,253	3,810	4,533	10,596	15,385
Therapeutic Groups	Groups	-	1,497	1,736	3,233	2,066	2,846	2,743	7,655	10,888
	Patients	-	13,454	13,648	27,102	25,562	33,850	33,771	93,180	120,282
Therapeutic Community	Voluntary	141	1,363	1,544	3,048	1,255	1,213	1,099	3,567	6,615
Temporary House	Voluntary	-	-	-		-	340	322	662	662

*CAPS = Psychosocial Care Center

Discussion

The treatment concepts and strategies for addiction have changed dramatically in recent years[18]. In Brazil, especially in large cities, poverty, lack of access, and the scarcity of qualified health services are the biggest challenges for the treatment of this disease[12]. Our results show how these conceptual and political changes, when well-coordinated, can result in treatment scope and effectiveness.

It took years of experimentation and adjustments to achieve the current CRATOD model. Currently, it stands as the first and most complex specialized chemical addiction service in the countries called Low Middle Income Countries (LMIC) capable of offering a continuous treatment approach, covering from low demand actions to highly complex and sophisticated actions to reduce demand, designed to meet the many needs of the users[19].

The current model of care and treatment of the service has been adapted over the past 6 years, with the first 3 years being years of structuring and implementing new programs, protocols, and agreements signed. In the following years, the consolidation of the CRATOD as a service of excellence was being established in conjunction with a new contribution to the Brazilian public policies[20], resulting in a service that combines the offer of social protection with various treatment approaches[21].

Initially, structuring the service flow between the services - URH and CRATOD - was a fundamental strategy for integrating actions, which were initially understood as antagonistic[21], but that throughout this partnership, proved to be complementary, and consequently, effective. This partnership added to the 24-hour service offer culminated in the reception of a highly diversified patient demand and an increase of almost 400% in the assistance records computed by the CRATOD Information and Statistics Center (SAME) between 2016 and 2018 compared to previous years. Thus, the main and most common difficulties in accessing specialized treatment have been gradually overcome in the country.

However, other issues that hinder the search for treatment still remain present in a portion of society and in part of the health care environments[22]. Thus, the stimulus to be treated is fundamental to overcome possible resistance[9]; for this, the training of specialized professionals is an essential element for a reception that encourages and motivates the individual to be able to take the first steps towards abstinence[23-24]. In this sense, *Programa Recomeço* and the CRATOD have been concerned with the annual qualification of their employees and with each phase from pre-treatment to formal treatment, offering the individual support and care initially, and subsequently, a range of possibilities for treatments depending on the severity of each case[25]. This meticulous work focuses on stimulating the patient to seek treatment voluntarily.

In addition, over these six years, the CAPS AD III CRATOD had an important growth in its assistance based on the formulation of the Singular Therapeutic Project (PTS) and on the definition of the treatment phases, from adherence to the phase of abstinence maintenance, passing through the moments of lapses and regressions[26]. In this perspective, our results show an increase in demand and adherence to treatment, increasing the assistance in the intensive modality of the CAPS AD III CRATOD by 240%, this modality being directed to more serious cases due to the lack of help and social support that requires a daily organization of the user's routine and motivation.

Due to this expressive increase in demand for the service and with the inauguration of the URH, in mid-2016, the CRATOD observation and rest unit started to have male and female detox beds and, in 2013, it became the articulation service of *Programa Recomeço*, and together with the Secretariats of Social Development and Justice and Defense of Citizenship added to the treatment offered in the CAPS AD III CRATOD the possibility of hospitalization for detoxification regulated by the CROSS and voluntary social reception in Therapeutic Communities (TCs)[27].

The 13% reduction in voluntary hospitalizations from the first triennium to the second can be explained by the improvement in the experience and training of the clinical staff and by the improvement of the medical diagnostic criteria, thus reducing voluntary hospitalizations due to exclusively social demand. A second reason can be the fact that the CRATOD starts to assist the most serious cases in the health network, such as users with severe psychiatric and clinical comorbidities, which require more acute interventions like brief hospitalizations[28]. In the same sense, the 17% decrease in hospitalizations in TCs was due to the construction of new protocols for hospitalization in this type of treatment environment linked to the decentralization of vacancies to the Regional Health Departments (*Departamentos Regionais de Saúde*, RHD) of the state of São Paulo.

Thus, a careful assessment of the patient's clinical diagnosis as well as the factors related to the quality of the health service provision is of utmost importance for reaching the goals of treatment adherence and success in this population. In this perspective, the constant updating regarding the valorization of the treatment practices, both in the field of Psychiatry and Pharmacology, as well as in the management of emergency and urgent situations, including hospitalization and its modalities, in addition to the psychological and psychotherapy assessment techniques, with a focus on constant training of the professionals within the multidisciplinarity proposal in

force in the CRATOD, are factors frequently analyzed to improve care, and consequently, to bring innovations.

Recent research studies have demonstrated the link between high prevalence rates of Sexually Transmitted Infections (STIs) and the use of crack, especially in low- and middle-income countries[29]. In view of this scenario, the CRATOD, in line with the World Health Organization (WHO) recommendations, instituted in 2016 screening through rapid testing of high sensitivity and treatment of the most prevalent diseases in this population[30-32], offering medications for the treatment of syphilis, Hepatitis (B and C), and HIV, with more than 12,000 tests performed in 2018[33-34].

These interventions are in line with a new world view of the treatment of drug addiction, which considers as part of the process of social reintegration recovering the health and citizenship of drug users[4]. Actions in this regard were also the scope of the *Recomeço Família* Program, which reduced the social and judicial harms resulting from substance use by serving more than 18,000 people, an increase of 240% in the first triennium compared to the second.

Social exclusion resulting from the degradation of bonds in years of drug use is common in this population, especially among crack users[35]. The desire to want to be treated or even in situations when abstinence has already been achieved are not actions that can be more than enough for many users to restore their family relationships[36]. Thus, the Temporary House and Monitored Housing seek to remedy this problem, making it possible to offer accommodation and housing at different times of treatment[17,37]. This assistance and care network, which pragmatically prioritizes the well-being and the search for recovery of these individuals, is capable of increasing motivation and consequently adhering to the service, thus enabling social reintegration[17]. Our results show that the effectiveness rate was 51% in patients who completed the monitoring process in the first 11 months of operation of the Assisted Housing - an unprecedented model hitherto in Brazil[17], indicated for patients who, according to the needs of their PTS, attained abstinence but who do not have an immediate vacancy available in the equipment of the protective social network.

Within this logic, the CRATOD became the institution that most performs low-demand actions, in the logic of harm reduction in the country, being the only one that develops reception and housing models compatible with the various phases for the long recovery process of psychoactive substance users.

Conclusions

This article brings up data from the CRATOD experiences that ratify the robustness of these transformations over the past few years, demonstrating that the consolidation of the service was structured through a service flow aimed at the constant motivation of the user in the various stages and committed to a service preferably based on the community, in a multidisciplinary manner and concerned with the global care for the drug addict.

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