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Organization of the services for the treatment of alcohol dependence

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Abstract

The problems related to the consumption of alcohol vary along a gravity continuum. Such a characteristic requests the construction of treatment services that assist to the needs in each one of these situations. Besides, the economical and cultural context of a given community covers the patient of particularities that need to be considered by the service of treatment. This way, the organization of services for the treatment of the dependence of the alcohol should begin for the determination of the structure interns of the institution and its place inside of the net of available attention. The whole construction should be based on the needs of the population-objective (obtained by diagnostic evaluations) and implemented with evaluations and constant monitoring of the wanted impact. Presently, manuals and guidelines available online aid and facilitate the execution of these actions.

Keywords*: Alcoholic beverages. Substance-related disorders. Strategic planning.*

Introduction

The treatment of chemical dependence is a relatively new subject. Less than two centuries ago, the excessive drinking in the United Kingdom was punished with public exposure and the publication of names in the main newspapers of the city.[1] Up to the middle of the 20th century, the word dependence emphasized the clinical complications stemming from the consumption rather than the behavior in itself.[2]

Only since the half of the last century the concept of dependence has stopped being considered as a deviating character or a set of physical signs and symptoms, gaining the characteristics of a mental disorder.[3] Besides, with the understanding of alcohol and drug use as a behavioral pattern, whose severity varies along a continuum, influenced by biological, psychological and social factors, it has arisen the need of organizing services which would attend users in their different stages and would also consider their psychosocial rehabilitation and quality of life.[4]

Therefore, attention services have been created or adapted for the treatment of the different stages of chemical dependence: outpatient settings, psychiatric day programs, brief and long hospitalizations, day-hospitals, (supported housing, therapeutical accompanying, and multiplying agents, among others. In order to widen even more the attention network for these users, the need of sensitizing the primary care network has born, aiming at an early diagnosis and the motivation of users for the treatment.[5] Approaches such as the policy of reducing harm appeared aiming to prevent the harmful consequences for the user's health, such as sexually-transmitted diseases and AIDS, without necessarily interfering in the supply or in the demand.[6]

The knowledge of the particularities of the dependent subject and the variety of available approaches and treatments have brought about new paradigms for the organization of attention services. The team's good will, idealism and effort would not suffice: an attention service should know deeply its organizational structure, determine the profile of its current and potential target-population and the socio-cultural context which surrounds it.[7] It is also necessary to plan the future of the service, to monitor and to assess constantly and systematically the results.[8]

This article aims to present the structural components of an attention service and, afterwards, the stages involved in the planning of its actions, as to build solid and long-lasting therapeutical institutions. Online manuals and guidelines related to the issue are listed in the references for those who want to go deeper in the theme.

The therapeutical framework

The treatment's setting, the composition of the professional team and the type of treatment compose the therapeutical framework[7], i.e., the internal organization of the service. This structure (institutional, professional and theoretical-practical) determines the *modus operandi* of the attention program.

1. Treatment settings

There are uncountable types of treatment settings, although some of them are more known and traditional than the others (table 1). Each of them has advantages and disadvantages in helping the chemically-dependent subject. No service is better than the other, but there are patients more indicated for each service.[1] The understanding and the comprehension of the possibilities and limitations of each treatment setting help the process of adapting a service to the needs of the community to which it gives attention.[9]

The moment of the treatment also influences the choice of the service.[5] Alcohol users with acute abstinence symptoms may require a non-intensive or intensive outpatient setting, day–hospital or even a hospitalization for detoxification. Three weeks afterwards, nonetheless, the abstinence symptoms are not more the predominant problem and less intensive and community approaches can be started. Therefore, the most indicated service for that moment should be recognized and combined with other settings in which the treatment will proceed.[7]

In many countries, the diverse attention settings for chemical dependence are divided into modalities, distributed along a continuum of care. Unfortunately, Brazil has not yet a legislation regulating neither the levels of attention, nor the role of each health professional in the treatment of chemical dependences, although the problems about the theme have been already identified by several local studies.[10] This paucity hampers the rational referral of those who seek specialized

help, overloading the sectors which should be responsible for only part of the treatment.
Even though, the determination – even roughly- of the point of insertion in the treatment network available in a certain region is part of the organization of a service (figure 1). Every service should find its place in helping more efficiently the patient who seeks help and should connect itself to the other available services, in order to create mutual help networks. This reinforces and widens the service's treating strategies and allows the referral of those who have already concluded the proposed treatment, but who still need other approaches.

2. Composition of the professional team

There is a great number of professionals directly involved in the treatment of chemical dependence. Each setting (and the complexity of its organization) requires a specific type of team.[9] A day-hospital is precipously a multidisciplinary setting, whereas a therapeutical community may function with only one specialized health professional, integrated to a group of former users. Regardless the complexity of each service, patients should have access to all the required professionals. Again, besides knowing its limits and its position in the attention network, a service should be also integrated into the whole attention network, in order to potentialize or supply points not covered by its treatment.

3. Type of treatment

The Pan-American Health Organization (OPAS) & Inter-American Commission for the Control of Drug Abuse (CICAD) describe four fundamental aspects to characterize each type of treatment: character of the intervention, therapeutical strategy, therapeutical goals and treatment phylosophy[7] (table 2).
The definition of the treatment type of a service has a structural character and may be identified in any service. Its determination allows more objective assessments about the results obtained, confers seriousness to the procedures and demonstrates the maturity of the team.[7]

Components of an attention service

Independently from the therapeutical framework proposed, a service should provide patients who seek for it an infrastructure capable of meeting their needs and removing barriers which hamper their adhesion to the proposed therapeutic. The National Institute on Drug Abuse (NIDA)[11] considers that every service should provide (within the institution or by means of partnerships and referrals) at least thirteen items (table 3).

Target-population of the service

Despite the clear need of individualizing all and every established therapeutical approach, some services choose a 'previous individualization' for the attention of special populations. This should be always considered when planning the organization of a service, regardless the treatment setting chosen. The adaptation of a service to certain specific populations is fully contemplated, accepted and recommen-

Table 1 – Treatment settings

• Primary care network
• Alcohol and drug community units
• Specialized outpatient unit
• Therapeutical communities
• Self-help groups
• General hospitals
• Day hospital
• Supported housing
• Psychiatric hospitals
• Judiciary system
• Community counseling services (schools, firms, shelters, prisons,...)

SOURCE: Edwards G, Marshall EJ, Cook CCH. O tratamento do alcoolismo. Porto Alegre: ARTMED; 1999.

Figure 1 – treatment settings placed according to the attention level to which they are destined

ded by the specialized literature.[12 13]
Besides, the type of drug used and the severity of patients seen may also arise the need of special services. For example, cocaine users seem to benefit more from intensive outpatient approaches.[14] A service for injecting drug users (IDU) should emphasize, more than any other service, the prevention of STD-AIDS, being the reduction of harm the indicated and well-succeeded approach among these users.[15] An outpatient setting or a detoxification ward for the attention of dependent subjects with associated severe psychiatric disorders (depression, schizophrenia, patients with suicide attitudes), requires a more intensive logistic support, both in the number and in the qualification of health professionals, and in terms of safeness.[16]

Planning of actions

Even if the structured service is not *a priori* dedicated to a restricted profile of patients, the population seeking its help surely has its particularities. Besides, the social context, the profile of the population seen and the type of substance change rapidly. Therefore, a service should be aware of these changes and adapt dynamically its structure, whenever necessary.

1. Diagnosis

The organization of a service starts by the clarification of the available structure (therapeutical framework) and the needs of the subjects who will seek it.[7 17] Some questionings related to this phase are the local prevalence of consumption of psychoactive substances, the mode of administration and the related clinical and social complications; the sociodemographic profile of the target population; the model which would better attend such needs; the efficacy of previous treatment attempts; the existence of supporting services in the region and the team's level of training and understanding.[8]
These data may be obtained by means of official epidemiological surveys, development of a service's database, follow-up studies with groups of patients, qualitative studies with key representatives of the local population or with the service's patients, application of scales for patients' satisfaction, among others.[17]

2. Implementation

The following step consists of the planning of actions, considering the potentialities and limitations of the service to meet the idiosyncrasies of this demand. Such actions should aim at specific objectives and goals, hierarchized according to the priority of each of them.[18]
The priority of actions should not be elaborated exclusively according to financial criteria. The social impact, the feasibility and the acceptability of the alterations that they will produce should also be assessed.[17]
The accomplishment of these actions, within the (internal and exter-

Table 2 – Characterization of the type of treatment according to the OPAS – CICAD

Character of the intervention

This category determines which type of intervention is more prevalent in an attention service. The **biophysical intervention** utilizes physical and non-pharmacological procedures. It is the case of approaches such as acupuncture, massages and electroconvulsotherapy (ECT). No biophysical intervention is used as a primordial approach in the treatment of chemical dependence. The **pharmacological intervention** uses psychopharmacs to relieve the craving, as an aversive method and in the treatment of comorbidities related to the unduly use of psychoactive substances. The **psychological intervention** occurs by means of individual/group psychotherapeutical interventions or through therapeutical accompanying. The **social intervention** aims to modify the social context which surrounds the user. Alcohol and drug community units, actions for the reduction of harm and systemic approaches are some examples. Actually, the services offer **combined interventions**, which joinn the previous approaches in different proportions.

Therapeutical strategy

The therapeutical strategies are organized from the simultaneous or consecutive combination of three components: the **specialized professional treatment** (ambulatories, detoxification wards), non-professional supporting structures (workshops, cultural centers) and mutual-help or self-help non-official activities (Twelve Steps).

Therapeutical Goals

The therapeutical goals are related to the main goal of the treatment. Services determined to treat dependence and its comorbidities beginning from total abstinence promote the decrease in the demand, whereas those interested in acting on the factors stimulating or maintaining the consumption promote the decrease in the supply. Lastly, the services interested in modifying the consequences of consumption, without necessarily influencing the demand, reduce the harm. A combination of the three approaches is always possible.

Philosophy of the treatment

The philosophy of the treatment is related to the ideological aspects which structure the treatment's program. Some examples are the spiritually, biologically, psychologically or socioculturally oriented approaches. The combination of the latter three factors (multifactor orientation) is very common among the contemporaneous models of chemical dependence.

SOURCE: OPAS & CICAD. La dependencia de las drogas y su tratamiento – guia y criterios básicos para el deserollo de programas de avaluación de la calidad y normas para la atención de la dependencia de drogas. OPAS/CICAD; 2000.

nal) reality of each service, requires specific strategies, such as the widening or modification of the attention focus; investment in the professional training or in the widening of the support network; improvement of the workplace setting, among others. Besides, the people in charge of the execution and the resources (human, logistic and financial) needed for the successful accomplishment of the venture should be well established.

3. Monitoring and assessment

The assessment is a constituting (and indissociable) part of the organization of a service.[8 18] It is responsible for the dynamism that every treatment proposal should have. Without the assessment, the service will be submitted to the social changes and the persistent errors which exposes it constantly to wear and anachronism. Besides, the alterations resulting from the actions implemented are, per se, a new reality. All the team should understand them, in order that the adaptations could favor everyone.

A good assessment enables the system to measure the quality and the impact of the actions implemented, identifying, for example, most refractory groups and unsuccessful strategies, opening new discussions in the team in order to solve them.[17] Therefore, all this process should be constantly monitored and assessed to implement beforehand the improvements or modifications needed, profiting from the opportunities and preventing threats to the service's feasibility.[8]

The assessment of a service, based on scientific criteria, is a complex procedure, which requires systematized studies with control groups for the performing of comparisons and randomized samples.[19] Thus, they are difficult to be implemented in services without highly trained professionals. However, it is always possible to gauge the effectiveness of a service, considering some indicators, such as compliance, improvement in the consumption patterns, employment level, among others (table 4).[8]

There are some criteria which can be followed to value the analysis of effectiveness, despite being beyond strictly scientific parameters (table 5).[19] On this issue, it may be highlighted the importance of determining the adhesion to treatment and comparing its results between those who dropped out and those who remained on treatment. For example, a service may demonstrate that 90% of the patients who concluded their treatment are abstinent and significantly improved their social performance. However, they represent only 5% of the patients who started the treatment, therefore, the service worked only for 4.5% of dependent subjects who sought it. It will be necessary to compare the data between those who remained and dropped out in order to, for example, identify barriers for adhesion to treatment and search new motivating strategies.

Conclusion

In Brazil, most of the services are organized based only on the effort and experience of their professionals, what originates services with limited attention and not linked to the local needs.[10 18]

The awareness about the structure of the service and the needs of patients (current and/or potential) guides, refines and optimizes the therapeutical proposal in course. The planning process is the dynamic stage of the organization. At that moment, the several components are systematically arranged and integrated, strengthening potentialities, improving flaws and answering better to the external reality that encircles the therapeutical project.

Although complex, the process of organizing services has currently objective and easily accessible (online) manuals and guidelines.[8 17 18 20 21] which allow its implementation, with willing and motivated teams to face up such challenge.

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Table 3 – Characteristics of the treatment type according to WHO – CICAD

Characteristics
• Individualization of the approach
• Availability of access
• Multiprofessional team
• Flexible treatment plan
• Minimum stay time
• Individual and group psychotherapy
• Pharmacotherapy
• Integrated treatment of the comorbidity
• Detoxification only as the first step
• Volunteer and non-volunteer treatment
• Consumption monitoring
• STD – AIDS
• Planning of the treatment period offered

SOURCE: (NIDA). Principios de tratamiento para la drogadicción. Rockville: NIH; 2001.

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Table 4 – Important points to assess the effectiveness of a treatment service

Compliance	Verifying the compliance with treatment, considering those who made an appointment for the first consultation but have not come, who dropped out after thirty, ninety and one hundred and eighty days and those who completed one year of treatment.
Consumption Patterns	Assessing the improvement in the consumption patterns among patients who have participated in the treatment, compared to the data collected on the admission.
Quality of Life	Assessing the improvement of social indicators (employment, social relationships, ...) among patients who have participated in the treatment and the physical and psychiatric comorbidities among those who have participated in the treatment, compared to data collected on the admission.
Patients' Rights	The services comply with the legislation which standardizes their functioning or protects special populations, such as adolescents and physically-challenged people.
Client's Satisfaction	The service achieves the proposed objectives and the patient's expectations. Using instruments which could be privately filled in by the patient (nominally or anonymously).

SOURCE: Organização Pan-Americana de Saúde & Comissão Interamericana para o Controle do Abuso de Drogas. La dependencia de las drogas y su tratamiento – guia y criterios básicos para el deserollo de programas de avaluación de la calidad y normas para la atención de la dependencia de drogas. OPAS/CICAD; 2000.

Table 5 – Precautions needed in the assessment of the effectiveness of the treatment service

• The assessment of effectiveness should not be performed by the same professional who have conducted the intervention.
• The admission is the time of the first assessment, followed by others - 6, 12, 18 or 24 months afterwards.
• All patients under treatment should be assessed.
• At least 70 – 80% of the patients who dropped out should be contacted and interviewed to be compared with those who remained. This not being possible, the sociodemographic data obtained on the admission should be compared.

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