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SPECIAL ARTICLE

Introducing care management to Brazil's alcohol and substance use disorder population

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Brazil has a sizable alcohol and substance use disorder (ASUD) population, yet there are considerable gaps in treatment access and retention. ASUD, a chronic medical condition, is highly comorbid with medical and behavioral health disorders. This indicates a need for more targeted interventions in order to achieve health care integration (a major goal of Brazil's health care system). Care management – that is, the organization of patient care by an institution – is a viable strategy to engage individuals with ASUD who might benefit from treatment but are not aware of or do not use the available resources, as well as to help maintain patients in treatment. Care management is considered an essential supplement to the treatment of chronic disease. The objective of this article is to discuss the applicability of care management for the treatment of ASUD within the public health care system in Brazil. We describe models of care management that have been adopted internationally and identify the feasibility and advantages for its adoption in Brazil.

Keywords: care management; substance use; Brazil; treatment integration

Introduction

Alcohol and substance use disorders (ASUDs) are chronic disorders that are highly comorbid with hypertension, sexually transmitted diseases, and behavioral health conditions.[1,2] Additionally, tobacco use and risky alcohol consumption provide a major contribution to the burden of noncommunicable diseases in Brazil.[3] Therefore, ASUDs have become an important public health issue[1,4,5] and strongly affect several areas of an individual's life, such as housing, employment, and family relationships.[5]

Despite their prevalence,[1,2] ASUDs are still a challenge in terms of treatment engagement. People in need of ASUD services are not stable in treatment. A national household survey has shown that less than 10% of individuals with alcohol use disorders who are willing to stop drinking have been treated for their alcohol problem.[3]

A high proportion of ASUD patients not engaged in treatment are either incarcerated or homeless.[6,7] This is visible in the several ''cracklands'' (areas where people openly use drugs, particularly crack) in São Paulo, Rio de Janeiro, and other smaller cities. Despite the introduction of specialized treatment and harm reduction strategies in these areas, treatment engagement and retention are still a serious challenge.[8]

There are several possible reasons for this lack of treatment engagement: psychosocial aspects such as stigma and obliviousness to treatment need; absence of wrap-around and evidence-based services; lack of public awareness of treatment options; service staff training, qualifications, and satisfaction.[9,10] Due to their chronic nature and associated comorbidities, ASUDs frequently require several treatment strategies within a continuum of care, including harm reduction, detoxification, and outpatient, day clinic, and inpatient treatment. However, the linkages between levels of treatment are not well organized, resulting in low treatment adherence as patients move along the continuum.

The low rates of ASUD treatment utilization and adherence are especially disturbing because evidence-based treatment can improve outcomes for the ASUD population, even among patients with severe dependence and co-occurring disorders.[11-13]

Treatment of substance abuse in Brazil

Brazil's public healthcare system – the Unified Health System (Sistema Único de Saúde – SUS) – is intended to offer universal access to healthcare, including care for mental health and ASUDs.[14] The three main levels of health care strategies for mental health and ASUDs in Brazil are primary care (Family Health Strategy [Estratégia Saúde da Família – ESF]), specialized outpatient clinics (Center of Psychosocial Care [Centro de Atenção Psicossocial – CAPS]), and the inpatient system (general hospitals and therapeutic communities).

In 2013, ESF covered 56.2% of the Brazilian population. The distinctive feature of ESF is that it employs community health workers (CHWs) to conduct outreach and home visits.[15] CHWs are community members with basic training in health promotion and disease prevention. While ESF offers services to address a wide range of health issues, including dengue, HIV, family planning, and

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access to social programs, prevention and education services related to mental health and ASUDs are rarely provided due to, among other reasons, lack of training. To address this need, since 2013-2014, more than 290,000 workers (CHWs and nursing assistants) have been trained in Pathways of Care (Caminhos do Cuidado), a strategy implemented by the federal government to build capacity in ASUDs.[16]

The second level of care is CAPS (and more specifically, "CAPS-ad" for alcohol and drugs), which consists of outpatient clinics staffed with nurses, social workers, psychologists, and psychiatrists who specialize in mental health and ASUDs.[14] CAPS provides services to patients already diagnosed with ASUDs.

Finally, patients with ASUDs may receive inpatient treatment in specialized wards of the public hospital system, psychiatric clinics, or therapeutic communities. The therapeutic communities, which are typically based on farms, promote recovery through employment and rely on a treatment model more related to religion than to medical strategies.

Unfortunately, this system is still highly fragmented and there is no organized structure to reach and retain patients with ASUDs, despite the fact that the Psychosocial Care Network (Rede de Atenção Psicossocial – RAPS) was created in 2011 with the aim of increasing the access and integration of mental health and ASUD services. There are several challenges to the system, including lack of broad and ongoing evidence-based treatment training, a nonexistent national electronic mental health record that is accessible to providers, and low availability of services in parts of the country.[17,18] Navigating the system is a challenge for patients, their families, and even for providers.

Adopting a model of care management could help mitigate current challenges with treatment engagement and retention for patients with ASUDs in Brazil. Aimed at facilitating care coordination and service integration, care management is considered an important supplement to the treatment of chronic diseases in several countries.[19-21] It has helped to increase access and adherence to ASUD treatment, and to enhance linkages with other services (e.g., HIV treatment).[21,22]

The objective of this paper is to present care management as a possible strategy that could benefit the treatment of ASUDs in the Brazilian public healthcare system. We describe models of care management within the framework of the chronic care model (CCM) and identify some advantages to justify its adoption in Brazil.

Integration: the chronic care model (CCM)

Most health care systems – including Brazil's – are focused on treating acute conditions. This kind of care deals with the immediate problem and is characterized by rapid diagnosis and treatment where the patient is a passive recipient of care. This model is ineffective for treating patients with chronic health conditions such as ASUDs. As a result of the increasing rates of chronic health conditions, CCM was developed in the mid-1990s.[23] CCM promotes high-quality chronic disease management by placing a strong emphasis on the integration and coordination of care in order to help patients develop effective chronic disease self-management skills.

Integration produces beneficial results for ASUD treatment. Multiple studies have shown that evidence-based ASUD services must be integrated with mental and primary health care and, more broadly, with social services (including the legal system), in order to decrease drug use, improve health, prevent crime, and reduce recidivism.[24,25] Care management can help achieve such integration.

Care management

Care management is a social service intervention with a long history of assisting individuals with multiple complex needs.[19-21] It is a comprehensive, client-centered approach meant to help individuals access needed services and resources in order to live and function within the community.[19-22] Care management interventions have been implemented internationally across various settings and populations,[22,26] including individuals suffering from ASUDs.[19,21,27-31]

Care management for ASUD populations began in the 1980s [20] and has been used to either link patients receiving treatment to additional services or to link individuals not receiving treatment to care.[32] Care management interventions have been adopted for various subsets of the ASUD population, including dually diagnosed individuals,[29] homeless populations,[21] substance-dependent women,[30] and parolees.[31] It is important to note that care management is not simply a tool for connecting individuals to treatment but a strategy meant to address the associated social (e.g., homelessness, joblessness, etc.) and health (e.g., diabetes, mental health issues, heart disease, etc.) challenges preventing successful functioning within the community.[19]

Although this approach has been used extensively, there is no universal agreement on how to conduct a care management intervention.[27] Most models of care management employ care managers – dedicated staff members who link clients to existing services or provide services themselves,[12] – but there is a wide range of service models that vary in intensity and scope.[19-22,27] Models that are effective for people with ASUDs include the brokerage model, the generalist model, assertive community treatment (ACT), and critical time intervention (CTI).[19-22,33,34]

The brokerage model is the least intensive model of care management.[19] Care managers help clients identify their needs and passively refer them to ancillary or supportive services.[19,21] There is very little interaction between the care manager and the client, and all tasks are typically completed within one or two meetings.[19,21] This model is recommended for less severe, more high-functioning individuals who have enough social capital to be able to manage their treatment with minimal assistance from a care manager.

The generalist model (or standard model) involves the more commonly accepted functions of care management – assessment, planning, linking, monitoring, and advocacy – and tends to be characterized by closer involvement

between the care manager and the client.[19,21] The frequency of contacts and the duration of services may vary,[19] and the approach is geared towards providing ongoing supportive care.

ACT is a full service model that entails a comprehensive role for a team of care managers.[19,21,29] It is characterized by smaller and shared caseloads; use of most services within the community rather than in a clinic; 24-hour responsibility for clients; and direct provision of most services rather than brokering.[29] ACT is frequently provided to individuals suffering from co-occurring mental health and substance use disorders who do not typically use outpatient/community services, are prone to frequent relapses/re-hospitalizations, and have severe psychosocial impairment.[19,29]

Lastly, CTI applies many of the same strategies of the ACT model; however, it is significantly less intensive and has a more finite set of goals.[34] This time-limited model, provided after discharge from an institution, primarily aims to reduce the risk of homelessness and other adverse outcomes by providing direct emotional and practical assistance to the client in order to strengthen long-term ties to community supports.[33,34] Ideally, the care manager, or the CTI worker, establishes a working relationship with the client prior to discharge,[33] and the model is delivered in three phases over a nine-month period.[34] Phase one focuses on providing intensive support and assessing available in-community resources.[33] Phase two, the ''tryout phase,'' is dedicated to testing and adjusting the system of support developed in phase one.[33] While the care manager continues to directly assist the client, the client and support networks are encouraged to resolve issues on their own.[34] Finally, phase three focuses on completing the transfer of responsibility to both the client and the formal/informal community supports that will provide ongoing/long-term care to the client.[33,34] This transfer of care is not abrupt; rather, it represents the culmination point of a work that lasted nine months.[33]

Patient-centered care is essential to all of these models. The care manager must be responsive and respectful of the values, preferences, and needs of the patient and must ensure that those principles guide the care and services provided to the client. Since the ultimate goal of care management is self-management, the care manager is a temporary aid meant to bolster the client while the client builds the necessary mechanisms to self-manage the condition(s) and maneuver through a complex health system with the available resources.

Adopting care management in Brazil

The time is ripe for adopting care management in Brazil's public healthcare system due to the aforementioned challenges related to ASUD treatment engagement and retention. Further, recent research on noncommunicable diseases in Brazil suggests the need for better care coordination and integration.[3] Care management could help address these issues.

There are a number of ways through which care management could be included in the Brazilian treatment continuum, from primary care to ASUD specialty treatment. While existing professionals, including nurses and social workers, could be educated to work as care managers, other professionals who are less expensive could also be trained to make the strategy sustainable. For example, an adaptation of the CTI model at CAPS in Rio de Janeiro used professionals with high school degrees to act as care managers for people with schizophrenia.[35]

In Brazil's primary care model (ESF), CHWs already serve as unofficial care managers and could receive appropriate training and supervision in mental health and ASUDs to link patients to treatment by performing early screening of ASUDs. Evidence-based strategies such as screening, brief intervention and referral to treatment (SBIRT) and motivational interviewing (MI) should be part of the training for CHWs. The ''Caminhos do Cuidado''[16] was a training program that provided basic skills in mental health, with an emphasis on ASUDs, to CHWs. While this was an important start, the project was finished without a plan to maintain training and supervision.

CAPS (including CAPS-ad) generally receives patients with more severe ASUDs than primary care. Care management at CAPS would include tasks such as organizing smooth transitions for patients coming from both primary care and inpatient units (warm handoffs), fostering enduring relationships with the other levels of care for constant assistance and monitoring (given the chronic and relapsing nature of addiction), and referring to wraparound services (such as legal and educational assistance, social services). Such strategies can improve treatment adherence.

Similar care management activities could be implemented in inpatient units. However, because the main objective of ASUD treatment is to provide readaptation to life in society, care management work should focus on well-coordinated discharge plans to help increase engagement and adherence to less intensive levels of care, as well as to reduce avoidable readmissions to inpatient, emergency, and prison units.

Care management could be applied to several other subsets of Brazil's ASUD population. For example, in São Paulo's ''crackland,'' existing outreach workers, who link severely addicted (and oftentimes, homeless) patients to treatment, could team up with psychologists or social workers in their local treatment centers to improve transition planning and close the gaps with professionals working in the other levels of care and with the justice system. Particularly, given the large number of patients in this population with HIV/AIDS and syphilis, strong linkages with specific medical services are essential.[8]

Although we suggest that care management may improve the treatment of ASUDs in Brazil, we do not assert that it is the definitive solution to all challenges facing the system. A common misconception about this intervention is that by incorporating it into the continuum of care it will automatically improve an individual's health needs. Care management is not treatment for ASUDs; rather, it is a method by which individuals can be connected to the care and services needed. In addition to this misconception, other factors (e.g., variation in the terminology/definition used to describe care management,[19-21,36] the expectation that care management will improve numerous and

varied outcomes,[19] and the lack of a universal method/tool to measure effectiveness[26,37]) have led to mixed results on the efficacy of this intervention. Nevertheless, even the least intensive model of care management has been shown to positively influence service utilization and to reduce substance use related problems.[22,27]

Conclusion

The gaps in access to ASUD treatment, as well as the fragmentation within the existing public healthcare system in Brazil, indicate a need for more targeted interventions in order to achieve health care integration. Care management offers a viable solution for connecting individuals who need treatment but may not be aware of available resources and provides support to retain patients in treatment as they move along the continuum of care. Not only does this approach offer wraparound, patient-centered services but also the flexibility to adapt to the needs of any population. Existing interventions in Brazil could serve as a model for adopting care management and making this a feasible option for improving and increasing access to treatment services for the country's ASUD population.

Disclosure

The authors report no conflicts of interest.

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