Maintaining the Continuum of Care: Arguing for Community-Based Residential Addiction Treatment Programs

Rick Csiernik

Many controversies exist within the addiction field. Among the most prominent is which is "better": residential inpatient care or outpatient counselling (Annis, 1984; Borkman, et al, 1998; Kaskutas et al., 1998; Sherk, 1997; Twelve Step Working Group, 2000)? Alcoholism and other psychoactive drug abuse treatment in Canada is currently delivered by a diverse network of programs with administrative and fiscal linkages to government ministries, public institutions, private organizations, and lay groups. Alcoholism counselling in North America was initially organized, promoted, and governed by lay groups of recovering alcoholics responding to neglect by social workers and other helping professionals. The initial addiction counselling programs to emerge in North America—after Alcoholics Anonymous (AA) created an environment to allow for the provision of assistance to alcoholics—were inpatient residential treatment facilities (Chappel and Dupont, 1999; Csiernik, 1997).

In the 1950s, a highly structured program at Wilmer State Hospital in Minnesota was created and became known as the Minnesota Model. It includes seven core components:

1. Integration of professional staff with trained recovering alcoholics as social workers and other counsellors who knew little of alcoholism;
2. Focus on the disease concept of alcoholism with a linkage to 12-step-related (AA) fellowships;
3. Family involvement;

4. Abstinence from all psychoactive substances;
5. Emphasis on patient and family education;
6. Individualized treatment plans; and
7. Sustained 12-step based aftercare (Chappel and Dupont, 1999).

Originally this treatment regimen lasted from 28 to 42 days, though average program length in Canada has now generally been reduced to 21 to 28 days as a result of decreased government funding. These sanatoriums or rehabilitation farms were used to sequester alcoholics from their environments and from the general public. Residential programs developed in two directions: hospital-based and community-based or social model programs. While both typically used the principles of AA as their foundation, hospital-based programs employed medical personnel, while social model programs initially used recovering alcoholics as counsellors. Social model programs also differed from purely medical model programs in terms of physical environment, staff role, basis of authority, view of recovery, governance, and community orientation. Generally, social workers were not actively involved in the early development of either of these two treatment options (Chappel and Dupont, 1999; Galanter, 1987).

Beginning in the late 1960s, research began to demonstrate that not only was residential programming more costly than outpatient counselling, it was also not necessarily the most efficient method of assisting substance abusers. The first studies to explore this issue were conducted at the Maudsley Hospital in London, England (Edwards and Guthrie, 1966, 1967; Edwards, et al., 1977). A one-year follow-up study of male alcoholics reported that there was no significant difference in outcome between those who had received outpatient counselling and those who had received several months of inpatient treatment. Helen Annis (1984) of the Ontario Addiction Research Foundation (now the Centre for Mental Health and Addiction) conducted an extensive international literature review and examination of the inpatient versus outpatient question. She concluded that outcomes studies indicated that in-hospital alcoholism programs with a duration of a few weeks to a few months showed no higher success rates than did periods of brief hospitalization of a few days. She also reported that partial hospitalization, or day treatment programs, produced outcomes equal, or superior, to those produced though inpatient hospitalization at one-half to one-third the cost. Through the 1980s and 1990s, a greater emphasis was placed by government funders upon outpatient resources with residential programming playing a lesser role in the continuum of care. This has led to a concern among those working in this branch of addiction treatment (Twelve-Step Working Group, 2000) particularly as substance abusers are a heterogeneous group, necessitating different types of counselling methods and options.

ALSO OF INTEREST WAS THAT FEMALE SUBJECTS WERE MORE LIKELY TO BE ABSTINENT ONE AND TWO YEARS POST-COMPLETION THAN WERE MALE SUBJECTS.

Research Findings

Despite the perceived limitations of residential programming in the addiction field, studies examining social model programs are relatively limited in the literature. Alford, Koehler, and Leonard evaluated a residential program using a 12-step treatment philosophy in 1991. Their study consisted of 98 male clients and 59 female adolescents and young adult clients aged 13 to 29, who were chemically dependent. The researchers discovered that those who completed the program had higher rates of abstinence six months post-completion than those who had dropped out. Also of interest was that female subjects were more likely to be abstinent one and two years post-completion than were male subjects.

Stanley (1999) reviewed the outcomes of a residential program that served over three thousand patients over the course of two years. It combined a primary care health unit with a residential addiction treatment program, including AA involvement, for patients with a drug addiction and either a chronic medical or psychiatric diagnosis. This residential service served clients who fell outside traditional treatment programs. Stanley found that positive changes occurred across all client groups, including those categorized as hard to serve.

The largest single addiction study ever conducted in North America, Project MATCH (1997), spent $47 million examining alcoholism treatment in the United States. Among the conclusions made by the researchers was that short-term inpatient treatment was an important means through which clients become aware of, and orientated to, 12-step groups, their primary source of aftercare and relapse prevention.

These studies support earlier research findings from Australia. Smith (1985; 1986), using a quasi-experimental design, studied both men and women with a dependence on alcohol. He compared those in a residential program featuring AA involvement and staff with a recovery history to those in a hospital-based detoxification centre. After 14 to 19 months, 79% of the treated women and 62% of the treated men remained abstinent while only 3% of the women and 5% of the men who only used the detoxification services were still abstinent.

Shepard, et al., (1999) stated that for clients with low or moderate severity of substance abuse, short-term residential counselling was no more effective than outpatient models and in fact, as expected, was costlier. However, when it came to those clients who scored in the high range of substance abuse severity, regular and intensive outpatient treatment programs were considerably less successful in creating abstinence. It was the short-term residential

programs that produced a success rate over one third higher, with success being defined as ongoing abstinence. Short-term residential counselling produced the best outcomes of any of the program options for severely dependent clients. In their analysis, which used abstinence rate divided by cost of program, short-term residential counselling was not only the most cost-effective programming option for high-severity substance abusers, it also had the third best cost-effectiveness ratio of the 15 treatment options presented in the analysis. Short-term residential programming consistently ranked ahead of intensive outpatient options, as well as long-term residential rehabilitation programs. Thus, while in simple cost-outcome studies outpatient care is less costly, when factoring in problem severity, short-term residential counselling not only produces positive results, but also emerges significantly ahead of other options, financially, within the continuum of care.

SHORT-TERM RESIDENTIAL COUNSELLING PRODUCED THE BEST OUTCOMES OF ANY OF THE PROGRAM OPTIONS FOR SEVERELY DEPENDENT CLIENTS.

Likewise, French (1995) argued that in general, in techniques for identifying and measuring treatment, outcomes vary depending upon program objectives and the terms used to define a successful outcome. Many programs that may appear cost-effective in fact have hidden costs associated with re-admission and relapse especially when there is inappropriate or inadequate follow-up and community support. As previously noted, Annis (1984) in her ground breaking work demonstrated that lengthy hospital stays were no more effective than shorter hospital stays in producing abstinence. However, this has been misinterpreted by some to indicate that all forms of residential programming in the addiction field are financially inappropriate. In fact, non-medical residential facilities following the social model program approach, have made the claim that they are the most cost-effective residential alternative for appropriately assessed and matched clients (Borkman, et al., 1998). French (1995) states that the value of non-hospital-based services have been poorly analyzed and should not be included when critiquing hospital-based residential programs. Even Barnett and Swindle's (1997) work that supports reducing inpatient residential programming to 21 days only examined hospital-based programs, which are inherently more expensive. In fact, 21 day hospital programs can be considerably more expensive than 28-day social model programs. Thus, all residential programs should not and cannot be lumped together for cost-effectiveness purposes. Borkman, et al., (1998); Shepard, et al., (1999); and the Twelve Step Working Group (2000) have all stated that community-based residential addiction treatment programs remain the best match for substance abusers with substantial functional impairment and physical dependency.

Conclusion

It is unlikely that any social worker providing casework services will not have a portion of his or her clients whose presenting, contributing, or underlying problems relate to a drug dependency or addiction in some way. For many clients, addiction-specific counselling will be an important component of their treatment plan, but what type of counselling is best? It was once tempting to assume that more treatment was better treatment, and that longer or more "intensive" interventions would yield superior outcomes. It subsequently became both tempting and fashionable to claim that time-limited outpatient treatment is better because it could be shown to be the most fiscally prudent. However, neither absolute is totally accurate. It is essential that time is taken in the assessment process to match the client to the most appropriate resource, as both outpatient and residential programs have strengths and limitations.

However, the acknowledgement that there should be a continuum of care (Ontario Substance Abuse Bureau, 2000) necessitates supporting and properly funding the entire continuum of care from withdrawal management to relapse prevention programming. Until clients with substance dependency problems become a homogeneous population we, as social workers, need to advocate for the presence and maintenance of the entire continuum of care to allow for the widest possible range of services for those with whom we work. It serves no purpose to fight among ourselves for the artificially limited treatment dollars available when the loss of any component diminishes the entire continuum. No one technique stands out as the panacea for substance dependency treatment and thus, we remain best served by providing an integrated continuum of care for the continuum of Canadians in need. The research discussed illustrates that while apparently more costly, community-based residential addiction treatment programs not only serve a specific population extremely well, they actually serve that population in a more cost-effective manner than other more inappropriately matched resources.

While not for everyone, community-based residential addiction treatment programs are beneficial for many and need to remain an integral aspect of the comprehensive integrated treatment continuum. A balance should be maintained between community and institutional treatment, outpatient and inpatient counselling so that our clients' needs remain first on the agenda.

References

Alford, G.; R. Koehler and J. Leonard. (1991). Alcoholics Anonymous/Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study. *Journal of Studies on Alcohol*, 52(2), 118-126.

Annis, H. (1984). Is inpatient rehabilitation of the alcoholic cost effective? Con position. *Advances in Alcohol and Substance Abuse*, 5(1-2), 175-190.

Barnett, P. and R. Swindle. (1997). Cost-effectiveness of inpatient substance abuse treatment. *Health Services Research*, 32(5), 615-629.

Borkman, T., et al. (1998). An historical developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, 15(1), 7-17.

Chappel, J. and R. DuPont. (1999). Twelve-Step and mutual-help programs for addictive disorders. *The Psychiatric Clinics of North America*, 22(2), 425-446.

Csiernik, R. (1997). *Introduction to Substance Use and Abuse*. Hamilton: McMaster University.

Edwards, G. and S. Guthrie. (1966). A comparison of inpatient and outpatient treatment of alcohol dependence. *Lancet*, February 26, 467-468.

Edwards, G. and S. Guthrie. (1967). A controlled trial of inpatient and outpatient treatment of alcohol dependency. *Lancet*, March 11, 555-559.

Edwards, G., et al. (1977). Alcoholism: A controlled trial of "treatment" and "advice." *Journal of Studies on Alcohol*, 38(5), 1004-1031.

French, M. (1995). Economic evaluation of drug abuse treatment programs: Methodology and findings. *American Journal of Alcohol Abuse*, 21(1), 111-135.

Galanter, M. (1987). Peer-directed self-help treatment for alcoholism. *Alcoholism: Clinical and Experimental Research*, 11(5), 413-415.

Kaskutas, L.; D. Marsh and A. Kohn. (1998). Didactic and experiential education in substance abuse programs. *Journal of Substance Abuse Treatment*, 15(1), 43-53.

Ontario Substance Abuse Bureau. (2000). *Response to the Integrated Plan for Thames Valley*. Toronto.

Project MATCH. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29.

Shepard, D., M. Larsen and N. Hoffman. (1999). Cost-effectiveness of substance abuse services. *The Psychiatric Clinics of North America*, 22(2), 385-404.

Sherk, C. (1997). *Addiction Treatment Services Restructuring: A Draft Plan*. Toronto: Ontario Ministry of Health.

Smith, D. (1985). Evaluation of a residential AA program for women. *Alcohol and Alcoholism*, 20, 315-327.

Smith, D. (1986). Evaluation of a residential AA program. *International Journal of the Addictions*, 21, 33-49.

Stanley, A. (1999). Primary care and addiction treatment: Lessons learned from building bridges across traditions. *Journal of Addictive Diseases*, 18(2), 65-82.

Twelve Step Working Group. (2000). *Twelve-Step Orientated Residential Treatment Programs in Ontario*. Cambridge.

Rick Csiernik, MSW, PhD, RSW, is an Associate Professor at the School of Social Work, King's College, University of Western Ontario.