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Referral source and its relationship with the completion of a 12-week intensive outpatient program and continuing care program

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REFERRAL SOURCE AND ITS RELATIONSHIP WITH THE COMPLETION OF A 12-WEEK INTENSIVE OUTPATIENT PROGRAM AND CONTINUING CARE PROGRAM

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Abstract

Research suggests that employer referrals to addiction treatment facilities play a significant role in the completion of the treatment programs. Individuals who are coerced into treatment with the threat of the loss of their jobs are more likely to continue treatment. Since program completion is important for the long term process, length of time in treatment increases the likelihood the individual will remain abstinent (Miller, 1994). This particular study consists of an examination of a 12-Week Intensive Outpatient Program, followed by an optional, but highly recommend, Continuing Care Program. A statistically significant difference was determined to exist between the completion rates of the subjects who were referred into the 12-Week Intensive Outpatient Program by their employers, as compared to other sources of referrals. Also, employer referred subjects were more likely to complete the optional Continuing Care Program.

Referral Source and its Relationship with the Completion of a 12-Week Intensive Outpatient Program and Continuing Care Program

Over the past 25 years, as the United States has waged a "war" against substance abuse, there has been an increasing uneasiness among substance abuse treatment providers with the unstable, and sometimes poor, outcomes that result from mainstream treatments (Rotgers, 1996). Recent publicity about the cost and failure of addiction rehabilitation efforts; dangerous drug and alcohol use among pilots, air traffic controllers, star athletes, and Hollywood celebrities; and drug related accidents, suicides, and violent crime have focused the public's attention on the need to wage an all out war on drug abuse before it undermines society itself (Gwynne, 1988).

Chemical addictions – whether to alcohol, cocaine, heroin or other substances – exact an enormous toll on addicted individuals, their families, and society as a whole. Alcoholism costs the United States an estimated $86 billion a year in health care costs and reduced productivity costs, while the federal drug control programs cost approximately $15 billion annually (Bender, 1997). Bender also notes that these figures do not include the amount that local and state agencies spend on drug programs, the amount our government agencies spend fighting alcoholism, and the cost of crime and lost productivity caused by drug abuse (1997). Additionally, these monetary figures do not measure the emotional and social price paid by addicts and their families, as a whole.

Despite the high cost of addiction, helping addicts overcome their addiction is often difficult. In fact, an overwhelming number of addicts never overcome their addictions, and many require three or more courses of treatment to successfully combat their addiction (Bender, 1997). Experts in the field believe that for an addict to succeed

with treatment, they must want to overcome their addictions; in other words, no treatment will be truly effective if the addict is not motivated from within to change. The first step an addict needs to take to recover is to admit that they are an addict. The second step is to choose a treatment program best suited to their needs.

The approach to the addiction patient requires skill and knowledge in the nature and prognosis of addictive illnesses. Addiction is frequently regarded as an independent illness. The causes of this illness are not known, however, the best available evidence reveals a biological basis for addictive use of alcohol and drugs. Alcoholics and drug addicts are more likely to accept recommendations and suggestions if they are advised they have an illness rather than a moral problem (Miller, 1994).

The cardinal manifestations of alcohol and drug addiction are defense mechanisms – denial, minimization, rationalization, and projection (Miller, 1994). Addicts, partly unconsciously, deny drug use despite direct evidence, or an assured source that confirms substance use. Addicts frequently project responsibility for their issues onto someone or something else, which in turn causes their immediate problems to be less complicated with which to deal.

Many recent studies show that substance abuse treatment is effective, not just by reducing the use of alcohol or drugs, but also in relieving many of the medical, social, psychological, and family problems so often associated with addictive disorders (McLellan, 1997). Most treatment programs are effective with at least some of the patients they treat; however, some programs are particularly effective with specific types of patients. In fact, the idea of "matching" the right type of patient to the right kind of program has become attractive to clinicians and administrators (McLellan, 1997). Studies

show that "matched" patients receive more effective services, stay in treatment longer, are more likely to complete treatment, and have a better 6-month outcome than did the standard care patients in the same types of programs (McLellan, 1997). Studies also indicate that successful treatment outcome is strongly correlated with the length of time in continuing care (Miller, 1994). The longer the addict participates in a treatment program, the greater the likelihood of maintaining abstinence.

Treatment outcome studies find significantly reduced medical utilization, enhanced employment performance, and fewer legal issues post discharge from a treatment program (Miller, 1994). When high-risk situations are encountered without adequate coping resources and there is low self-efficacy, there are positive expectancies for a risk of relapse (Miller, 1996). However, by participation in a treatment program that increases knowledge, coping skills, and support resources, the less likely the individual is to relapse.

Patient retention is one of the most important goals for addiction treatment programs (Magura, 1998). Studies reveal that in-treatment variables are better predictors of retention in the program, rather than pretreatment variables. Patients with individual and environmental strengths for treatment were more likely to be retained than those with fewer strengths (Joe & Simpson, 1991). One may assume that patients with strengths are more likely to comply with treatment regimens, thus avoiding problems, and preventing premature termination.

There are numerous and sometimes divergent schools of thought regarding the best types of treatment for addicts. However, all of the models can be reduced to two basic types. These are the "pure" inpatient treatment unit and the outpatient rehabilitation

model (Giannini, 1999). In both models, each patient is treated with a team approach. The components of each team may very among institutions; however, a team almost always includes; a psychiatrist, who performs the actual evaluations and detoxification; an internist, who deals with severe medical complications; and registered licensed practical nurses, who perform nursing and counseling duties. Normally there are certified chemical dependency counselors, in most cases recovering addicts themselves, who work directly with patients during treatment. According to Giannini, these key members of the team provide support and a practical counseling approach (1999). The ultimate goal of the treatment program is to move the patient from a dependent status to an autonomous status. This usually involves the intermediate step of interdependence. The interdependence is reinforced between the patient, other patients, and the treatment team. After the initial treatment, this interdependence is fostered by members of various "anonymous" groups, such as; Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous. Contrary to many professionals' impressions, AA has a clear commitment to working with the professional community. In the 1970's a committee called Cooperation with the Professional Community (CPC) was developed to increase the communication between the professionals in the field and AA, to assist professionals working with alcoholics by being an available community resource (Riordan, 1994).

Outpatient programs, such as the one involved in this study, are generally organized around a 12-step model and involve the development of group identity to facilitate the interdependent process. Family and group therapy are commonly organized around the treatment process. The outpatient type treatment programs were initially

developed in reaction against the inpatient rehabilitation models (Giannini, 1999). The founders of the outpatient type of treatment program felt that a real recovery could not take place in the isolation of an inpatient program. Their point of view was that "any one could stay drug-free on an island" (Giannini, 1999). However, true rehabilitation only could take place if the patient interacted during their recovery process with those elements in their personal environment that initially provoked and maintained their drug seeking behaviors. In the outpatient treatment models, addicts are encouraged to interact with the elements of their individual environment that can not be changed. As a result, they are able to bring their emotional reactions to this environment and the resultant problems to the staff and patient group for immediate consultation, intervention and resolution (Giannini, 1999).

Once an individual has completed the intensive outpatient treatment, they are provided with the option to enter into a continuing care program. This is a structured outpatient treatment involving urine testing to ensure that alcohol and/or drug use does not continue. This type of treatment is a continuation of the professional care that is found in formal addiction treatment and a bridge to lifelong 12-step fellowship attendance (DuPont, 1997).

Individuals with addiction problems may be referred to treatment by many different sources. These sources can include self, employer, physician, family member, court ordered, etc. Patients referred into treatment by their employers are an important group in themselves. These individuals differ from others, for they are confronted with an immense amount of pressure to enter into treatment programs. Employer referred individuals are usually coerced into substance abuse treatment under the threat of the loss

of their jobs (Lawental, 1996). Research reveals that coerced participants are significantly more likely to remain in treatment, than self referred participants. Successful treatment outcome is strongly correlated with the length of time an individual spends in continuing care. The longer an individual participates in a treatment program; the likelihood they will maintain abstinence is greater. Additionally, post treatment follow-up of patients coerced in to treatment indicate marked improvements in substance abuse, employment, medical, family and psychiatric problems (Lawental, 1996). Lawental states that workplace urine surveillance is successful in detecting employees with significant substance abuse problems, and that referral to standard treatment is associated with substantial improvements in the resolution of these problems (1996). Employers have paired the use of urine testing procedures with the threat of job loss to coerce the detected employees into obligatory substance abuse treatment programs. For coerced participants, failure to abide by the terms of the mandatory evaluation and referral procedure is considered grounds for dismissal. The coerced patients are generally open about not wanting to participate in treatment; however, they are more likely to complete treatment than those who were self-referred (Lawental, 1996).

The purpose of this study is to determine if the type of referral source has an influence upon the successful completion of the 12-Week Intensive Outpatient Program and/or Continuing Care Program. The resulting two hypotheses are:

Ho1: No statistical difference exists between the source of referral and the successful completion of the 12-Week Intensive Outpatient Program.

Ha1: A statistical difference exists between the source of referral and the successful completion of the 12-Week Intensive Outpatient Program.

Ho2: No statistical difference exists between the source of referral and the successful completion of the Continuing Care Program.

Ha2: A statistical difference exists between the source of referral and the successful completion of the Continuing Care Program.

Method

Subjects

From 06-30-98 to 07-01-99 a total of eighty-six subjects participated in the Intensive Outpatient Program (IOP) and the optional Continuing Care Program at a local treatment center in southern West Virginia. However, data could not be located for 2 of the 86 subjects. Of the 84 remaining subjects, 22 were female and 62 were male. There were 30 individuals referred to the program by their employer, 11 by self, 7 by a family member, 19 by a physician, 6 were court ordered, and Beacon Hospital referred 11. The ages of the subjects ranged from 17 to 62 years, with a mean age of 39.92. The social/economic status of the subjects varied, and occupations ranged from an array of positions, including dentists, manual laborers, students, etc.

To analyze the successful completion of the 12-Week Outpatient Program and the successful completion of the Continuing Care Program, the 84 subjects for which data were available, were categorized according to referral source. Of the 84 subjects with the opportunity to participate in the 12-Week Outpatient Program and Continuing Care Program, 30 were referred by their employer, and 54 were referred by other sources.

Procedure

Subjects were obtained from a local treatment center in southern West Virginia, which provides a 12-Week Intensive Outpatient Program, followed by a Continuing Care

Program to individuals with addiction problems. Subjects who entered the program between 06/30/98 – 07/01/99, were utilized from admission data of the 12-Week Intensive Outpatient Program. Staff provided information verifying the subjects' completion of the initial program, entrance into the Continuing Care Program, as well as completion of the Continuing Care Program.

The 12-Week Intensive Outpatient Program took place on Mondays and Thursdays, from 5:30pm – 6:30pm, followed by group therapy from 6:30pm – 7:30pm. The initial program was a series informative educational lectures, led by qualified counselors. The lectures consisted of topics such as; recovery stages, relationships, relapse warning triggers, denial, spirituality, stress management, shame, addiction, attitudes, behaviors, as well as the disease concept, and medical aspects of addiction. After each educational lecture, a Group Therapy Session took place. This time was allotted for discussion with peers and counselors concerning the recent educational lecture, as well as any other issues or concerns the individuals may have been experiencing. Along with the Monday and Thursday night sessions, the 12-Week Intensive Outpatient Program had a special series of lectures that was geared toward the family of the substance abusers. Family members and significant others were expected to attend these sessions, to increase their knowledge of substance abuse and to aid with the support the patients need during recovery. Please see Appendix B for an outline of the phases and objectives of the Outpatient Program.

The Continuing Care Program was an optional after care program, offered to the individuals who completed the 12-Week Intensive Outpatient Program. Although not required, but certainly encouraged, the Continuing Care Program offers an additional

twenty-six sessions that consisted of further group discussion on relevant addiction issues. These sessions took place on Wednesdays from 4:30pm – 5:30pm, and were led by a licensed counselor.

Results

A Wilcoxon-Mann-Whitney test was utilized to determine if a statistical difference existed between the completion rates of subjects in the 12-Week Intensive Outpatient Program, who were employer referred and those referred by other sources. The Wilcoxon-Mann-Whitney test resulted in a significant difference (z=-1.984,p>.05). This information provided support for rejecting the null hypothesis.

A Wilcoxon-Mann-Whitney test was also utilized to determine if a statistical difference existed between the completion rates of subjects in the Continuing Care Program, who were employer referred and those referred by other sources. The Wilcoxon-Mann-Whitney test resulted in a significant difference (z=-2.312,p>.05). Again, this provided support for rejecting the null hypothesis.

Discussion

The data revealed that 93% of the individuals referred by their employers to the treatment program completed the 12-Week Intensive Outpatient Program, compared to the 76% completion rate of the other referral sources. Comparison of the Continuing Care Program indicated that 53% of the employer-referred individuals completed the program, compared to only 28% of the other sources of referrals. The statistical analysis revealed that a statistical difference exists between employer referrals, as opposed to other sources of referrals, and the successful completion of the 12-Week Intensive Outpatient Program and the Continuing Care Program.

This study, as well as comparable studies, suggests that individuals who are referred into addiction treatment programs by their employers, as opposed to other referral sources, are more likely to complete treatment. These individuals are also more likely to enter into and complete a Continuing Care Program.

Considering the fact that the Continuing Care Program is an optional after care program, it was interesting to see that employer referred individuals continued to be more likely to complete treatment, even considering the fact that they were not outwardly forced to enter into this program. I feel this is a significant finding in its self. These results may be attributed to the fact that the employer referred individuals are more likely to remain in the initial treatment program, and gain knowledge about their addiction and the effects it has on their lives. Additionally, they gain the support and resources needed to remain abstinent. It is my opinion that this new found outlook on life and the encouragement that treatment can make a difference, causes these individuals to continue treatment to maintain the positive changes that have occurred their lives.

I would suggest a follow up study that researches the employment classifications of the individuals referred in to treatment by their employers, in order to determine if the types of occupations were evenly distributed. This information would be useful in determining if the type of occupational classification had an effect on the completion rates.

This study has limitations, specifically the number of subjects used in the study. The study could be improved by included participants in the 12-Week Intensive Outpatient Program and Continuing Care over a two, or possibly, three-year span. By increasing the data set size, the statistical power would be maximized to detect

differences between the individual sources of referrals and successful completion of the program. Due to confidentiality issues, the subjects in the study were not to be contacted directly. If permission were obtained to contact the subjects, then inquires could be made to determine if relapse occurred since completing the program. By having this additional piece of information, factors contributing to the success of the program could be evaluated. If the staff of the treatment program were aware of the type of individuals who successfully completed their program, without relapse, then they could specifically gear their program toward those types of individuals, or could make changes to the existing program, to increase its effectiveness for those who relapsed after the completion of the program.

It should be noted that any interpretation that a low retention rate, by itself, is a mark of a poor program, and a higher retention rate is an invariable mark of a good programs should be rejected (Magura, 1998). However, differences in retention rates do raise question that need to be addressed by more in-depth clinical and programmatic research.

APPENDIX A: OUTLINE OF PHASES AND OBJECTIVES

Phase I: Introduction

Objectives:

- Define alcoholism and other chemical dependencies as a disease
- Gain understanding of the biochemical process of alcoholism
- Identify attitudes and expectations about the disease, self, and each other
- Begin the process of positive communication

Phase II: Disease Concept

Objectives:

- Identify characteristics and symptoms of the disease of chemical dependency
- Examine and identify symptomatology of the alcoholic/addict
- Explore the parallelism of the symptoms of the chemically dependent person and the family member/significant other

Phase III: Family Roles

Objectives:

- Be aware of the survival roles of each family member in a chemically dependent family, their feelings and behavior
- Recognize and identify personal survival role behavior
- Define how survival role/behaviors repeat from childhood to adulthood and negatively impact family interactions

Phase IV: Progression of Family Illness

Objectives:

- Identify the symptoms of the family disease and its progression
- Begin to identify and share feelings of the here and now
- Define the purpose of ALANON, and increase the knowledge of self-help,12-step programs

Phase V: Issues in Recovery as they relate to the Family

Objectives:

- Identify positive communication techniques
- Continue to discuss attitudes about the disease and recovery process

Phase VI: AA/NA, ALANON Orientation

Objectives:

- Identify irrational beliefs and strategies to change attitudes
- Define relapse process/event and counter behaviors to triggers
- Discuss AA, NA, and ALANON

APPENDIX C: STATISTICAL DATA

Wilcoxon-Mann-Whitney Test

Ranks

	Referral Source	N	Mean Rank	Sum of Ranks
12 week IOP	employer referred	30	37.80	1134.00
	not employer referred	54	45.11	2436.00
	Total	84		
Continuing care	employer referred	30	35.60	1068.00
	not employer referred	54	46.33	2502.00
	Total	84		

Test Statistics[a]

	12 week IOP	Continuing care
Mann-Whitney U	669.000	603.000
Wilcoxon W	1134.000	1068.000
Z	-1.984	-2.312
Asymp. Sig. (2-tailed)	.047	.021

a. Grouping Variable: Referral Source

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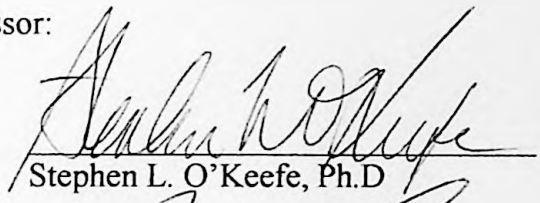

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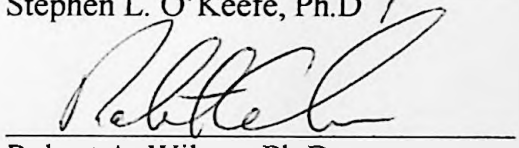

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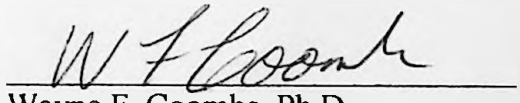

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