

Trends in Acute Mental Health Care: Comparing Psychiatric and Substance Abuse Treatment Programs

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Abstract

This study compared psychiatric and substance abuse acute care programs, within both inpatient and residential modalities of care, on organization and staffing, clinical management practices and policies, and services and activities. A total of 412 (95% of those eligible) Department of Veterans Affairs' programs were surveyed nationwide. Some 40% to 50% of patients in psychiatric and substance abuse programs, in both inpatient and residential venues of care, had dual diagnoses. Even though psychiatric programs had a sicker patient population, they provided fewer services, including basic components of integrated programs, than substance abuse programs did. Findings also showed that there is a strong emphasis on the use of clinical practice guidelines, performance monitoring, and obtaining client satisfaction and outcome data in mental health programs. The author's suggest how psychiatric programs might better meet the needs of acutely ill and dually diagnosed patients (eg, by incorporating former patients as role models and mutual help groups, as substance abuse programs do; and by having policies that balance patient choice with program demand).

Introduction

Historically, the psychiatric and substance abuse systems of acute care have been quite distinct.^{1,2} Substance abuse and psychiatric programs are licensed and monitored under separate authorities, and

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Journal of Behavioral Health Services & Research, 2003, 30(2), 145–160. © 2003 National Council for Community Behavioral Healthcare.

substance abuse and psychiatric services have been provided by different agencies. The 2 systems have had separate financing mechanisms and have often competed for public health funds. Staff education, training, and credentialing procedures differ between the substance abuse and psychiatric treatment systems; patients' eligibility criteria for receipt of services also differ. Traditionally, interventions for substance use and for psychiatric disorders have relied on separate and sometimes conflicting philosophies and procedures.

Recent trends in psychiatric and substance abuse acute care

In recent years, both the psychiatric and substance abuse systems of care have experienced dramatic changes.³ One of the most striking has been a shift in the locus of treatment from hospital-based inpatient to community residential care.⁴⁻⁶ Community residential facilities are assuming a larger role in the continuum of care for mental health patients so that clients with chronic, severe, and complex disorders are being placed in such facilities rather than in hospitals.⁷⁻⁹ Another notable change involves new management practices, such as the use of clinical practice guidelines and performance monitoring, in both the psychiatric¹⁰⁻¹² and substance abuse¹³⁻¹⁶ systems.

Coincident with these structural and policy changes, both the psychiatric and substance abuse systems have had an increasing prevalence of dual diagnosis patients, especially within publicly funded organizations.^{1,17,18} The apparent increase, perhaps due in part to improved techniques for identifying multiple disorders,¹⁹ has heightened recognition of the need for integrated treatment programs. In an integrated program, psychiatric and substance abuse approaches are brought together by the clinical team. This ensures that patients receive consistent explanations of their disorders and coherent prescriptions for treatment rather than contradictory messages from psychiatric staff on one hand and substance abuse staff on the other.¹⁷ Although there is agreement that all patients with co-occurring psychiatric and substance abuse problems need treatment for both, studies showing the benefits of integrated treatment have focused mainly on chronic and severely mentally ill patients.²⁰

Despite the historical differences, conceptually, treatments for patients with substance use disorders and those for patients with psychiatric disorders share common ground. Both hold the doctrine that treatment may require a long-term approach in which stabilization, education, and self-management are central.^{20,21} We focus here on whether the shared pressures of the shift from inpatient to community residential care and new management practices, along with a larger dually diagnosed patient population, have created commonalities in approach and increased the similarities between substance abuse and psychiatric programs. We also consider how well psychiatric and substance abuse programs' policies and services match their patient populations.

Current characteristics of care

To develop a clearer understanding of the practical outcome of recent trends in acute mental health care, the authors describe and compare the current characteristics of psychiatric and substance abuse treatment. Specifically, we examine the organization and staffing, clinical management practices and policies, and services and activities in Department of Veterans Affairs' (VA) psychiatric and substance abuse programs nationwide. Publicly funded by the federal government, the VA operates the largest psychiatric and substance abuse treatment systems in the United States. We surveyed VA psychiatric and substance abuse programs within both the inpatient and residential modalities of care.

Organization and staffing

In VA inpatient substance abuse programs, only 21% of patients were dually diagnosed with both substance use and psychiatric disorders in 1988, compared to 35% in 1995.²² A comparable increase of dually diagnosed patients occurred in VA inpatient psychiatric programs, such that close to 40% of discharged patients in 1995 had comorbid disorders.^{23,24} During the same period, the proportion of dually diagnosed patients in community residential facilities providing services to veteran

and nonveteran substance abuse patients increased from 17% to 37%.²⁵ The authors focus here on whether these percentages have risen further in the past 5 years.

During the 1990s, as documented in private agencies, the length of stay decreased for inpatient mental health (ie, psychiatric and substance abuse combined) care.²⁶ Regarding length of stay for substance abuse care specifically, in the 1980s, the typical treatment consisted of a 28-day inpatient hospitalization, whereas presently, most substance abuse programs provide inpatient treatment for 14 days or less. Following an inpatient stay, many substance abuse patients are referred to community (nonhospital) residential treatment.⁴ A nationwide study of psychiatric inpatient care from 1988 to 1994 reported a decrease in patients' average length of stay and noted that inpatient episodes were typically focused on managing crises and stabilizing symptoms.⁶ However, the functional deficits of psychiatric patients are likely to be more entrenched and chronic than those of substance abuse patients, requiring longer episodes of acute care as well as long-term support.

Ries² reported some key staffing differences between the psychiatric and substance abuse treatment systems. The psychiatric treatment system has traditionally had more medical doctors and professionally trained staff²⁷ and higher staff to patient ratios because psychiatric units have needed more personnel to deal with psychotic, bizarre, suicidal, or potentially violent behaviors. From 1970 to 1992, the number of professional direct care staff in state mental hospitals increased by 48%, while the number of nonprofessional staff decreased by 55%.²⁸ As substance abuse treatment settings have admitted more dually diagnosed patients, they have also hired more professional staff, including psychiatrists and psychologists.²⁹ Substance abuse programs may now more closely resemble psychiatric programs on staff composition as staffing differences between the 2 systems have lessened.

Management practices and policies

Management practices and policies in both the substance abuse and psychiatric systems have moved toward standardization and accountability in service delivery, to increase the cost-effectiveness of care. The American Psychiatric Association took the lead on psychiatric and substance abuse guideline development efforts, commencing in the early 1990s. To determine whether the implementation of practice guidelines improves patients' outcomes, client follow-ups are recommended.¹³ Performance indicators for evaluating psychiatric and substance abuse care did not appear in the literature until the mid-1990s, at which time health care systems such as the VA began to implement mental health performance monitoring procedures.¹² Although the use of practice guidelines, patient follow-ups, and performance monitoring, as well as other procedures such as case management and utilization review, have proliferated in recent years, there is a scarcity of data on the prevalence of these practices in psychiatric and substance abuse programs.

As clinical management practices have become more structured, so too have substance abuse programs' policies for patients. The study of community residential facilities treating substance abuse patients by Timko et al.²⁹ found that, in 1998, facilities were more likely than they were in 1995 to have policies that restricted patients' choice of individual daily living patterns.²⁹ Earlier, Timko found that, compared to psychiatric programs, substance abuse programs had higher requirements for patients' functioning (in terms of physical and mental health and daily living skills) and less acceptance of patients' problem behavior.³⁰ Substance abuse programs were more restrictive in that they limited patients' options for individual patterns of daily living. Similarly, compared with residential facilities that treated both substance use and psychiatric disorders, specialized substance abuse programs had higher expectations for functioning and less acceptance of problem behavior, and placed more restrictions on patients' choices of day-to-day routines.^{18,31}

Services and activities

There have been few empirical studies to examine hypothesized differences between the psychiatric and substance abuse treatment systems on services and activities. Psychiatric programs have

traditionally put more emphasis on differential diagnosis and use of medications to treat patients' disorders,^{2,21,27,30} whereas substance abuse programs emphasize the availability of self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. Discussions with peers, providing both support and confrontation, have also been more available on substance abuse than on psychiatric units.^{30,32,33}

Miller³³ commented that little treatment for addiction was available in the psychiatric system. This was based in part on Ries and Samson's survey³⁴ of directors of inpatient psychiatry units associated with university-based psychiatric residencies. Only 10% of the directors reported any kind of specialized treatment for alcohol or drug abuse on their psychiatric units.

In contrast, limited evidence suggests that currently, psychiatric services may be somewhat more readily available in substance abuse acute care settings. Grella and Hser,³⁵ reporting on a county survey of drug treatment programs, found that the majority of inpatient and residential programs offered general psychiatric or psychological services either on-site or by contract with another provider. More specifically, in both modalities, programs were likely to provide individual psychotherapy and psychotropic medication. In keeping with these results, both inpatient and residential alcohol and drug treatment facilities currently tend to provide individual counseling, as well as group and family counseling, self-help groups, and psychosocial and vocational rehabilitation.^{4,14} Timko et al.²⁹ found that substance abuse facilities were increasingly likely to have specialized counseling and psychoeducational, rehabilitation, and medical services, and social and recreational activities, suggesting the possibility that substance abuse programs may offer a wider variety of services overall than psychiatric programs do.

Here, we compare psychiatric and substance abuse acute care programs, and focus on whether their similarities and differences are consistent from inpatient to residential care. More specifically, we identify the prevalence of dually diagnosed patients in both systems and venues of care, and consider whether residential facilities provide appropriate staffing and services for their relatively disturbed patients.

Method

Sample of programs

A survey was conducted of all 114 substance abuse and all 318 psychiatric inpatient and residential programs in the VA nationwide. Completed surveys were received from 114 (100%) substance abuse and 298 (94%) psychiatric program managers, for a total of 412 (95%). Of the 114 substance abuse programs, 57 (50%) were inpatient programs and 57 (50%) were residential programs. Of the 298 psychiatric programs, 230 (72%) were inpatient programs and 68 (28%) were residential.

Procedure

The survey was mailed to all VA program directors, along with a letter explaining its purpose. The letter explained that the survey was being conducted with the approval of the offices that oversee mental health care and health services research in VA. The program directors who initially did not respond received follow-up phone calls, letters, and additional copies of the survey. This report analyzes the following 3 types of data from the survey.

Organization and staffing

Organizational factors included program size (ie, number of operational beds); the average percentage of patients admitted to the program per month with psychiatric diagnoses only, substance abuse diagnoses only, or both psychiatric and substance abuse diagnoses; and patients' average length of stay (in weeks). Program directors reported the number of full-time equivalent employees (FTEE) in the following categories: Advanced Professional Staff (ie, psychiatrist, MD; psychologist, PhD

or PsyD; or social worker, MSW, CSW, or ACSW); Nursing Staff (ie, registered nurse, RN; clinical nurse specialist, MSN; nurse practitioner, vocational or practical nurse, LVN or LPN; or nursing assistant); Addiction Therapist; or Other Direct Care Staff (ie, nonpsychiatrist, MD; pharmacist; physician assistant; recreational or occupational therapist; vocational rehabilitation specialist; technician or aide; and other direct care staff positions). For each staff category, the FTEE staff per patient ratio was calculated. The FTEE direct care staff to patient ratio was also computed.

Management practices and policies

Program directors were asked to indicate whether their program currently used any clinical practice guidelines or used American Psychiatric Association guidelines specifically. The authors also asked directors to indicate whether their program regularly used any of the following management procedures: separate quality review committee; performance monitoring and feedback for individual clinicians; requirement of written approval by a utilization review staff person or committee before a patient can receive nonemergency supplemental services; a single case manager who coordinates all of a patients' care from the beginning of treatment through discharge; use of seclusion or restraints; client outcome follow-up; and patient satisfaction surveys.

Program policies were assessed with items from the Policy Choice scale of the Policy and Service Characteristics Inventory (PASCI).³⁰ These items reflect the extent to which the program provides options from which patients can select individual patterns of daily living. Specifically, directors indicated whether the program prescribes set times for patients to wake up, go to bed, bathe, or be in the program at night; and whether the program allows or encourages (rather than discourages or deems intolerable) 11 different behaviors on the part of patients (eg, decorating their room, skipping breakfast to sleep late, and preparing their own meals in the kitchen).

Services and activities

Program services and activities were also assessed on the PASCI.³⁰ Directors indicated whether 20 different treatment services were provided by the program (eg, assessment and diagnosis, detoxification, individual or group counseling or psychotherapy targeted at patients' psychiatric disorders, and medications for psychiatric and/or substance use disorders). They also noted how often each of 10 program-organized activities (such as exercise periods or movies) were offered; responses were coded as "often" (ie, at least once per week) or "rarely" (ie, at most, twice per month).

Results

The authors separately compared the inpatient and the residential psychiatric programs with the inpatient and the residential substance abuse programs on their program characteristics by means of *t* tests (continuous variables) or chi-square tests (categorical variables).

Organization and staffing

Inpatient programs

Table 1 compares the psychiatric and substance abuse inpatient programs on organizational factors and staffing. Confirming the programs' classification, psychiatric programs admitted a larger percentage of psychiatric patients and substance abuse programs admitted a larger percentage of substance abuse patients. In both psychiatric and substance abuse programs, however, about 40% of patients admitted each month were dually diagnosed. Psychiatric programs were larger than substance abuse programs (ie, had more operational beds) and had a longer average length of stay. Regarding staffing, substance abuse programs had more addiction therapists; otherwise, psychiatric and substance abuse programs were comparable on staff to patient ratios.

Table 1

Organizational characteristics and staffing of inpatient and residential psychiatric and substance abuse programs

	Inpatient*		<i>t</i>	Residential†		<i>t</i>
	Psychiatric (mean)	Substance abuse (mean)		Psychiatric (mean)	Substance abuse (mean)	
<i>Organizational factors</i>						
Size	33.78	19.71	5.79	42.93	32.48	1.25
Percentage of patients admitted per month with						
Psychiatric diagnosis only	49.59	2.06	17.58	19.85	1.54	4.48
Substance abuse diagnosis only	11.02	51.11	-8.01	27.35	60.41	-5.59
Both psychiatric and substance abuse diagnoses	38.65	46.82	-1.66	52.53	39.52	2.11 [‡]
Average weeks of stay (median)	13.20 (2.14)	3.05 (2.11)	2.43 [‡]	14.39 (13.14)	9.22 (4.28)	3.18 [§]
<i>Staff-patient ratio</i>						
Professional staff	0.16	0.27	-1.40	0.08	0.08	0.11
Nursing staff	0.88	0.99	-0.39	0.12	0.11	0.40
Addiction therapists	0.02	0.20	-5.15	0.03	0.12	-4.04
Other direct care staff	0.16	0.41	-1.61	0.15	0.15	0.00
All direct care staff	1.04	0.88	1.34	0.24	0.33	-2.25 [‡]

*Inpatient: psychiatric ($N = 230$); substance abuse ($N = 57$).†Residential: psychiatric ($N = 68$); substance abuse ($N = 57$).[‡] $P < .05$.[§] $P < .01$.^{||} $P < .001$.

Residential programs

Table 1 also compares the psychiatric and substance abuse residential programs on organizational factors and staffing. Again, confirming the programs' classification, psychiatric programs admitted a larger proportion of psychiatric patients and substance abuse programs admitted a larger proportion of substance abuse patients. However, both types of programs admitted a high percentage of dual diagnosis patients: on average, over one-half of patients admitted to psychiatric residential facilities each month had dual diagnoses, and this was true of almost 40% of patients admitted to substance abuse residential facilities. Psychiatric and substance abuse residential programs were equivalent in size, but psychiatric programs had a longer average length of stay.

Also within the residential modality of care, substance abuse programs had more addiction therapists per patient. In addition, overall, substance abuse residential facilities had more direct care staff per patient than did psychiatric residential facilities.

Management practices and policies

Inpatient programs

As seen in Table 2, psychiatric and substance abuse inpatient programs had similar management practices, except that, as expected, psychiatric units were more likely to use seclusion or restraints. In

Table 2

Health care management practices of inpatient and residential psychiatric and substance abuse programs

Management practice	Inpatient			Residential		
	Psychiatric (%)	Substance abuse (%)	χ^2	Psychiatric (%)	Substance abuse (%)	χ^2
Use any clinical practice guidelines	63.3	70.2	0.96	47.1	56.1	1.03
Use American Psychiatric Association clinical practice guidelines	39.9	42.9	0.12	39.5	24.2	1.90
Regularly used practice						
Separate quality review committee	59.0	57.9	0.02	57.4	64.9	0.76
Performance monitoring and feedback for each clinician	66.4	73.7	1.15	75.0	82.5	1.03
Written approval by utilization review required for patients' nonemergency supplemental services	5.3	7.0	0.32	20.6	1.8	13.58*
Single case manager coordinates patient's care throughout treatment	50.2	75.4	12.32*	72.1	83.9	2.53
Seclusion or restraints	75.2	14.3	56.94*	1.8	3.9	0.47
Client outcome follow-up	61.1	71.9	2.36	85.3	78.9	0.86
Patient satisfaction surveys	85.2	82.5	0.25	83.8	87.7	0.39

* $P < .001$.

addition, substance abuse programs were more likely to have a patient's care from intake to discharge coordinated by a single case manager. The policies of the psychiatric and substance abuse programs are shown in Table 3. Inpatient psychiatric programs were more likely than substance abuse programs to have a set time at which patients bathed or showered. Psychiatric programs gave patients more choice to smoke, have their own furniture, and go out in the evenings than did substance abuse programs.

Residential programs

Psychiatric and substance abuse residential programs also had similar management practices (Table 2). Psychiatric programs were more likely to require written approval by a utilization review committee or responsible staff member for a patient to receive nonemergency, supplemental services (eg, chest x-ray and dental exam). Residential psychiatric and substance abuse programs did not differ on policies regarding having a set time for waking up, going to bed, bathing, or being back in the program in the evening (Table 3). Psychiatric programs gave residents more choice to have a TV, radio, or stereo in their bedrooms, to go out in the evenings, and to spend the weekend away from the facility than did substance abuse programs.

Table 3
Policies of inpatient and residential psychiatric and substance abuse programs

Policies	Inpatient			Residential		
	Psychiatric (%)	Substance abuse (%)	χ^2	Psychiatric (%)	Substance abuse (%)	χ^2
Program regulates						
Wake up time	97.6	95.2	0.64	78.9	72.5	0.60
Bed time	90.0	95.2	1.32	78.9	84.3	0.52
Bath time	66.4	45.2	6.48 [†]	31.6	37.3	0.39
Curfew	92.4	95.2	0.46	98.2	92.2	2.38
	Psychiatric (mean)	Substance abuse (mean)	<i>t</i>	Psychiatric (mean)	Substance abuse (mean)	<i>t</i>
Program allows or encourages						
Smoking in program	28.0	11.9	5.44*	19.3	17.6	0.05
Have own furniture in room	6.2	0.0	4.86*	26.3	17.6	1.18
Moving furniture around in room	30.3	33.3	0.15	54.4	45.1	0.93
Skip breakfast to sleep late	9.5	4.8	1.14	19.3	15.7	0.24
Have TV in room	10.4	7.1	0.46	45.6	20.0	8.05 [†]
Have radio/stereo in room	56.4	42.9	2.58	93.0	76.0	6.21 [†]
Hang pictures in, decorate room	56.9	52.4	0.29	78.9	82.4	0.20
Prepare own meal in kitchen	10.9	21.4	3.11	50.9	37.3	2.03
Go out in evenings	50.2	19.0	14.85 [‡]	89.5	56.9	15.52 [‡]
Spend weekend away from program	50.0	42.9	0.72	91.2	60.8	14.68 [‡]

**P* < .05.

[†]*P* < .01.

[‡]*P* < .001.

Services and activities offered

Inpatient programs

Substance abuse programs were more likely than psychiatric programs to offer a number of services (Table 4), including crisis intervention, individual or group counseling specifically for an alcohol or drug use disorder, couples or family counseling, and peer counseling. Likewise, substance abuse programs were more likely to provide both 12-step and non-12-step self-help groups and psychoeducation for both patients and family members, as well as social skills and stress management training and vocational counseling and rehabilitation services. Furthermore, substance abuse programs were more likely than were psychiatric programs to offer HIV screening and counseling, and aftercare services.

As shown in Table 5 there were some differences between inpatient psychiatric and substance abuse programs on social-recreational activities offered. Substance abuse programs were more likely to offer organized recreation (eg, softball or basketball teams) and classes or lectures, and less likely to offer arts and crafts or a social group.

Table 4

Services offered in inpatient and residential psychiatric and substance abuse programs

Services offered	Inpatient		χ^2	Residential		χ^2
	Psychiatric (%)	Substance abuse (%)		Psychiatric (%)	Substance abuse (%)	
Assessment and diagnosis	96.5	100.0	2.76	72.1	98.0	17.36 [‡]
Crisis intervention	84.5	97.6	7.18 [†]	77.9	92.2	4.71 [*]
Detoxification	55.1	64.3	1.24	5.9	37.3	19.07 [‡]
Individual or group counseling, psychotherapy						
For psychiatric disorder	94.7	87.7	3.09	80.6	80.7	0.00
For alcohol and/or drug use disorder	72.7	96.5	19.55 [‡]	82.1	98.2	10.17 [‡]
Couples, family counseling	74.4	95.2	11.45 [‡]	47.8	90.2	25.66 [‡]
Religious, spiritual counseling	95.6	97.6	0.42	83.8	98.0	7.77 [†]
Peer counseling	29.2	61.9	15.94 [‡]	35.8	64.7	9.08 [†]
12-step groups (AA, NA)	39.4	100.0	68.36 [‡]	48.5	96.1	36.44 [†]
Non-12-step self-help groups	20.4	52.4	17.08 [‡]	26.5	54.9	9.98 [‡]
Psychoeducation						
For patients	88.5	100.0	9.34 [†]	74.6	98.0	15.05 [‡]
For family members	69.2	83.3	3.81 [*]	35.8	84.3	29.68 [‡]
Social skills training	76.5	90.5	4.77 [*]	79.1	88.2	1.77
Stress management training	68.1	95.2	16.90 [‡]	57.4	88.2	14.44 [‡]
Vocational/educational counseling	70.5	88.1	6.42 [†]	88.2	92.2	0.51
Vocational rehabilitation, work training or therapy	36.3	57.1	6.30 [†]	70.6	78.4	0.94
Medications	95.2	97.6	0.59	51.5	90.2	22.15 [‡]
HIV screening and counseling	90.8	100.0	7.42 [†]	80.9	100.0	15.74 [‡]
Nutrition counseling	96.9	100.0	2.40	85.3	100.0	11.86 [‡]
Aftercare services	64.8	97.6	24.86 [‡]	57.9	84.3	9.36 [†]

* $P < .05$.† $P < .01$.‡ $P < .001$.**Residential programs**

Again, substance abuse programs offered more services than did psychiatric programs (Table 4), including assessment and diagnostic services, crisis intervention, and detoxification. Substance abuse programs also offered more counseling targeted at patients' alcohol and drug use problems. Further, substance abuse programs were more likely to offer couples/family, religious/spiritual, and peer counseling, as well as 12-step and non-12-step self-help groups, psychoeducation for patients and

Table 5

Social-recreational activities offered in inpatient and residential psychiatric and substance abuse programs

Social-recreational activities offered	Inpatient			Residential		
	Psychiatric (%)	Substance abuse (%)	χ^2	Psychiatric (%)	Substance abuse (%)	χ^2
Exercise, physical fitness	83.0	81.0	0.10	71.9	76.5	0.29
Organized recreation	41.5	59.5	4.58*	50.9	62.7	1.55
Films, movies	71.7	78.6	0.87	61.4	70.6	1.01
Classes, lectures	40.1	69.0	11.96 [†]	36.8	39.2	0.06
Cards, other games	80.7	69.0	2.63	56.1	60.8	0.24
Religious services	86.8	85.7	0.04	71.9	70.6	0.02
Social, coffee hours	60.4	54.8	0.46	38.6	46.0	0.60
Arts and crafts	90.1	64.3	15.61 [†]	64.9	68.6	0.17
Club, social group	31.6	16.7	4.14*	21.1	29.4	1.00
Discussion groups	42.0	50.0	0.91	42.1	49.0	0.52

* $P < .05$.[†] $P < .001$.

their family members, and stress management training. Moreover, substance abuse programs were more likely to offer patients medications specific to psychiatric and/or substance abuse problems, HIV screening and counseling, nutrition counseling, and aftercare services. As shown in Table 5, psychiatric and substance abuse residential programs did not differ on what social-recreational activities they offered.

Discussion

Strikingly, some 40% to 50% of patients in psychiatric and substance abuse programs, in both inpatient and residential venues of care, had dual diagnoses. Even though psychiatric programs had a sicker patient population, in that a higher proportion of patients had psychiatric disorders, surprisingly, these programs provided fewer services than did substance abuse programs. The findings also show a strong emphasis on the use of clinical practice guidelines, performance monitoring, and obtaining client satisfaction and outcome data.

Organization and staffing

Psychiatric programs had more severely ill patients overall, inasmuch as psychiatric disorder-only patients, who constituted a higher proportion of the clientele in psychiatric programs, are likely to have poorer psychosocial and cognitive functioning than substance use disorder-only patients.³⁶⁻³⁸ In addition, over one-half of patients in residential psychiatric programs were dually diagnosed, which was higher than the proportion of such patients in residential substance abuse programs. Primm et al³⁹ found that among dually diagnosed patients, those treated in psychiatric programs had more severe psychiatric diagnoses than those treated in alcohol and drug addiction programs.

Consistent with the overall finding that psychiatric programs are treating a more severe and chronic population, patients had longer lengths of stay in psychiatric than in substance abuse programs. In a study of a combined sample of inpatient and residential facilities, Timko³⁰ also found longer lengths of stay in psychiatric than in substance abuse treatment. In this study, the average length of stay in inpatient psychiatric programs was quite long (13 weeks), probably because the sample included

psychiatric extended care units. The median length of stay for inpatient psychiatric programs was 15 days, which is similar to the average length of psychiatric hospitalizations in other surveys.^{6,40}

Another possible reason that lengths of stay were longer in the psychiatric programs is that they were less likely to have aftercare services. One strategy for maximizing the efficient utilization of mental health beds is to rapidly mobilize aftercare resources.⁴¹ Acute psychiatric inpatients may have inappropriate long-term stays because community services that can provide an alternative to hospitalization are not available.^{42,43} Long-term patients also frequently have complex behavioral and physical problems that make placement outside of the hospital difficult.⁴³

Although larger treatment programs generally provide a wider array of services,⁴⁴ the psychiatric programs, which were larger than the substance abuse programs, provided fewer services. Timko's study³⁰ found that higher staffing levels were associated with more services being offered in mental health programs. Consistently, substance abuse programs offered more services and had more addiction therapists per patient than did psychiatric programs. There were also more direct care staff members per patient in residential substance abuse programs than in residential psychiatric programs.

Management practices and policies

Psychiatric and substance abuse programs differed little on their management practices, reflecting the recent changes that both systems of acute care have undergone. The majority of inpatient psychiatric and substance abuse programs used clinical practice guidelines, and roughly half of residential programs did so. The majority of both inpatient and residential programs also had quality review committees, monitored the performance of individual clinicians, followed up on clients' outcomes, and conducted surveys of patients' satisfaction. These findings support recent observations that the mental health system has been increasingly impacted by an emphasis on the cost-effectiveness of care.³ In addition, they suggest that residential programs are altering their management practices to meet standards set in inpatient settings.

One-half of inpatient psychiatric programs had a single case manager coordinating patients' care throughout treatment; this practice was more frequent among substance abuse programs. Drake et al⁴⁵ noted that case management is often not provided in psychiatric care settings, despite research showing that it is effective for improving patients' symptoms and functioning and reducing their inpatient utilization.⁴⁶⁻⁴⁸ Also, psychiatric inpatients often refuse case management when it is offered because it is seen as intrusive and demanding.^{49,50} In addition to supportive functions such as service linkage and client advocacy, case management for psychiatric patients, more than that for substance abuse patients, may emphasize monitoring the client's mental state and social functioning. Assertive and persistent monitoring may result in less client satisfaction because clients perceive case managers to be controlling or even harassing.^{51,52} Reconciling the monitoring and support functions of case management remains an important issue within psychiatric programs.

The authors found that substance abuse programs in both the inpatient and residential modalities of care had somewhat more restrictive policies than did psychiatric programs, which is consistent with findings by Kasproff et al,³¹ Sacks et al,¹⁸ and Timko.³⁰ In addition, a prior evaluation of VA substance abuse inpatient programs reported that patients had little freedom of choice and that staff were not accepting of patients' problem behavior. Programs that excluded patients with psychiatric diagnoses were more restrictive than those that accepted such patients.^{53,54}

Services and activities

Within both the inpatient and residential modalities of care, substance abuse programs were more likely than psychiatric programs to offer a variety of formal services, including crisis intervention; individual or group addiction-oriented counseling; couples or family counseling; psychoeducation for patients and family members; stress management training; and, as mentioned, aftercare services. Moreover, in contrast to substance abuse programs, less than half of psychiatric inpatient and

residential programs offered peer counseling, 12-step groups, or non-12-step mutual support groups, and less than half of residential psychiatric programs offered family counseling or psychoeducation for family members. With respect to crisis intervention, in a substance abuse program, a relapse to alcohol/drug use is seen as a crisis, which is handled by the majority of substance abuse programs. In contrast, in psychiatric programs, a crisis typically is an acute exacerbation of psychiatric symptoms, which may be handled in a general emergency room or by a separate psychiatric emergency service.⁵⁵ Together, results concerning alcohol and drug counseling, family-oriented services, and mutual help groups indicate that addiction services in psychiatric programs continue to be insufficient,^{33,34} especially when the higher prevalence of dual diagnosis patients is considered.

Patients with psychiatric disorders often are deemed inappropriate for help involving active interactions with peers or family members because they are seen as less able than substance use disorder-only patients to handle relationship-oriented interventions.^{56,57} In fact, however, dual diagnosis and substance use disorder-only patients are equally likely to attend, be accepted by, feel comfortable in, and benefit from mutual support groups, whether the groups are targeted primarily to alcohol and drug problems or to both psychiatric and substance abuse problems.⁵⁸⁻⁶² The fellowship offered in self-help group meetings may also be provided by programs' social-recreational activities that are group-focused, such as organized team sports.⁶³ Organized recreation, as well as program-coordinated classes, was again more frequent in inpatient substance abuse than in inpatient psychiatric programs.

Regarding services, the authors also found that inpatient psychiatric programs were the least likely to offer vocational services, and that residential psychiatric programs were less likely to provide medications to patients for their psychiatric and/or substance abuse problems than were residential substance abuse programs. Vocational and medication services, as well as case management, formal and informal help for substance abuse problems, and family psychoeducational services, are basic components of integrated programs,^{17,27} but were more frequently offered by substance abuse programs than by psychiatric programs. To respond appropriately to a patient population that increasingly has comorbid psychiatric and substance use disorders, planners within the psychiatric acute care system will need to provide more of these key services.

Implications for Behavioral Health Services

The findings must be considered in light of the fact that psychiatric and substance abuse programs were compared within one integrated public-sector health care system. That is, in VA facilities, substance abuse and psychiatric services, as well as primary medical care, are either accessible at a single site (ie, the co-location model of integrated care), or the treatment sites are linked by procedures to refer patients between sites (ie, the distributive model).⁶⁴ Our findings may not generalize to private and nonprofit health care systems that maintain separate agencies for psychiatric and substance abuse care, or that serve patients with more economic and social resources and less severe and chronic disorders. However, the basic findings of the rise in dually diagnosed patients and the relative lack of integrated care seem to characterize the current conditions of mental health care. In fact, psychiatric and substance abuse programs may be even more distinct when they operate within nonintegrated systems.

Psychiatric and substance abuse care should be provided within an integrated system, because such systems tend to provide more accessible and coordinated care, as well as better quality and less costly care overall.⁶⁴⁻⁶⁶ Organizing psychiatric and substance abuse programs under one system would better meet the needs of the large and increasing number of dual diagnosis patients by enhancing the consistency and continuity of services. Furthermore, integration of the mental health system with medical services may achieve the greatest continuity of care and client satisfaction, when preventive, primary, acute, and chronic care management are provided to patients. Different models of integration need to be considered and evaluated to answer the question of which model demonstrates superior performance over time.

Overall, substance abuse programs appear to be more adequately prepared for meeting the needs of the growing numbers of acutely ill and dually diagnosed patients than are psychiatric programs. In addition to offering more addiction services, psychiatric program planners may consider emulating substance abuse programs by having former patients who are role models (ie, are stabilized and well-functioning) attend program events such as graduations, or serve as treatment counselors. Volunteer or paid staff in residential mental health programs who are themselves in recovery draw on their personal experiences when working with patients.^{67,68} This approach helps to create a treatment milieu in which patients feel supported, autonomous, and free to discuss personal issues, and in which practical guidance is provided on how to go about building a life after treatment.⁶⁹

Psychiatric programs should also follow substance abuse programs by emphasizing involvement in mutual support groups. That is, mutual help groups may be beneficial not only for managing substance abuse problems but also for overcoming daily living and social skills deficits that are common among psychiatric and dual diagnosis patients.^{70,71} They can provide long-term continuity of care for psychosocial and cognitive difficulties as well as an addiction.

The policies of psychiatric programs gave patients somewhat more freedom of choice over aspects of daily living (eg, to have a TV in their room, to go out in the evenings, and to spend the weekend away from the program). On one hand, this freedom helps to prepare patients for life in the community,⁷² but on the other, it reduces the demand to fully participate in structured program services and activities.⁷³ Because psychiatric patients often need a less demanding environment than substance abuse patients do,⁷⁴ psychiatric programs may have more difficulty striking the optimal balance between patient choice and program demand in their policies.

One way to provide this balance is to give patients as much choice as possible, while encouraging them to take part in collective activities. Compared with a control group, patients given both choice and group activities improved more.⁷⁵ Engaging in activities with others (eg, serving on a council or committee) may help to underscore to patients that they can structure their day-to-day routines while simultaneously participating fully in treatment and cooperating with their peers. The tension between patient choice and program demand may also be reduced by program policies that are clearly communicated via orientation sessions and handbooks for new patients, and periodic newsletters, for example.⁷⁶

The program's demand for full participation in treatment activities may also involve providing more comprehensive case management services. A study of dual diagnosis patients found that when a unified approach to treatment was initiated by the case manager and adopted by all service providers, patients were able to master the full range of skills and self-responsibility required to live in the community.⁵⁰ In this approach, the case manager accompanied the patient to meetings with the probation officer to resolve legal difficulties, with program staff to work on abstinence and learn how to clean, shop, use medications, and manage money, and with other patients to learn how to socialize. Patients progressed from viewing these meetings as serving a monitoring function and thus experiencing them as intrusive, to feeling supported and becoming active participants in their management plan.

Finally, there is a need for evaluations of the increased use of clinical practice guidelines and performance monitoring,¹³ especially regarding their effects on staff morale and effectiveness and patient outcomes. Proponents of guidelines argue that they assist patients in making informed health care decisions, and help practitioners to use appropriate health care interventions and reduce inappropriate care. Detractors contend that guidelines lead to "cookbook medicine" by stifling innovative clinical practice and the application of new treatment procedures. In addition, even when clinical managers endorse the use of clinical guidelines in their program, it is unclear whether or how this endorsement is reflected in treatment providers' practice. At present, given the scarcity of relevant empirical findings, conclusions about the positive or negative consequences of mental health treatment guidelines are largely speculative. It is important that future studies assess the impact of practice guidelines, performance monitoring, and other management practices on treatment staff's

perceptions and behaviors, and on the outcomes and cost-effectiveness of substance abuse and psychiatric care.

Acknowledgment

This research was supported by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development Service (IIR 95-011).

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