

MODELS OF STANDARD AND INTENSIVE OUTPATIENT CARE IN SUBSTANCE ABUSE AND PSYCHIATRIC TREATMENT

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ABSTRACT: Intensive outpatient mental health programs are proliferating rapidly. However, findings suggest that intensive treatment may be no more effective than standard treatment. This study compared standard to intensive outpatient programs, within both the psychiatric and substance abuse systems of care, on organization, staffing, and treatment orientation; clinical management practices; and services. A total of 723 (95% of those eligible) Department of Veterans Affairs programs were surveyed nationwide. Psychiatric intensive programs have responded appropriately to their more severely ill patients in terms of the amount and orientation of care, and having a rehabilitation focus. However, the relative lack of basic psychiatric services in psychiatric intensive programs, and the overall similarity of substance abuse standard and intensive programs, may explain why intensive programs have not yielded patient outcomes that are superior to those of standard programs. Mental health system planners should consider differentiating intensive programs using broader criteria and methods.

KEY WORDS: intensive treatment; mental health; psychiatric; standard treatment; substance abuse.

In recent years, psychiatric and substance abuse care has experienced dramatic changes (Fonagy, 1999). One of the most striking has been a shift in the locus of treatment from hospital-based inpatient to outpatient care (Goldman, McCulloch, & Sturm, 1998; Humphreys, Huebsch, Moos, & Suchinsky, 1999; Rosenheck & Horvath, 1998). Outpatient programs are

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assuming a larger role in the continuum of care for mental health patients so that even clients with chronic, severe, and complex disorders, such as those with dual diagnoses, are more frequently receiving treatment in ambulatory care clinics rather than in hospitals or residential facilities.

Within the outpatient modality, intensive treatment programs have been proliferating rapidly during the past decade due to recommendations to match the intensity of mental health treatment to the severity of patients' disorders (Institute of Medicine, 1990). Intensive programs are designed to provide care for psychiatric and substance abuse patients who do not meet criteria for inpatient or residential treatment, but who are judged to need more hours per week of care than standard outpatient care provides. Coincident with these changes in the locus of treatment and patient composition, the psychiatric and substance abuse systems have adopted new management practices such as the use of clinical practice guidelines and performance monitoring (American Psychiatric Association, 1995; Kent & Hersen, 2000; Manderscheid, 1998; Rosenheck & Cicchetti, 1998; Walker, Howard, Walker, Lambert, & Suchinsky, 1995).

Research indicates that intensive outpatient treatment is usually no more effective than standard treatment. In the psychiatric domain, a recent review of randomized controlled trials comparing intensive to standard outpatient programs found evidence from only one trial suggesting that intensive was superior to standard treatment in terms of improving psychiatric symptoms, and no evidence that intensive and standard programs differed on any other clinical or social outcome variable (Marshall, Crowther, Almaraz-Serrano, & Tyrer, 2001). Similarly, in the substance abuse domain, randomized trials of standard versus intensive treatment have found comparable improvement in both types of programs on drug outcomes and life functioning indices among patients seeking help for dependence on a variety of drugs (Alterman et al., 1996; Avants et al., 1999; Coviello et al., 2001; Gottheil, Weinstein, Sterling, Lundy, & Serota, 1998; Rychtarik, Connors, Whitney, McGillicuddy, & Fitterling, 2000; Weinstein, Gottheil, & Sterling, 1997; Weisner et al., 2000).

CHARACTERISTICS OF OUTPATIENT CARE

This study was undertaken to develop a clearer understanding of recent trends in outpatient mental health care, and to help understand why standard and intensive programs have not yielded differential patient outcomes. It describes and compares the current characteristics of intensive and standard outpatient treatment programs in Department of Veterans Affairs (VA) mental health programs nationwide. Currently, relatively little is known about standard and intensive outpatient care, especially how the

growing assortment of intensive programs is being implemented. We examined the organization, staffing, and treatment orientation; clinical management practices; and availability and utilization of services. Comparing standard and intensive programs on these domains should contribute to a better understanding of the lack of superior outcomes among patients treated in intensive rather than standard programs, and inform the future planning of both standard and intensive outpatient treatment.

Intensive programs may offer a wider variety of services overall than standard programs.

Intensive and standard programs were surveyed within both the psychiatric and the substance abuse systems. An earlier comparison of psychiatric and substance abuse inpatient and residential (rather than outpatient) programs found that, even though psychiatric programs had sicker (e.g., more dual diagnosis) patients, they had lower staff-patient ratios and provided fewer services (e.g., counseling, vocational training, aftercare) than substance abuse programs did (Timko, Lesar, Calvi, & Moos, 2003). System planners, program managers, and clinicians need to learn more about how psychiatric and substance abuse outpatient programs resemble and differ from each other, particularly in light of increasing numbers of patients with dual diagnoses who may enter treatment in either venue.

Organization and Staffing

In the VA, the average number of mental health outpatient visits per patient increased during the 1990s, but then declined in 2000 (Piette & Fong, 2001; Rosenheck & Horvath, 1998). Also in the VA, in 1991, only 32% of patients in outpatient substance abuse programs were dually diagnosed (i.e., had both substance use and psychiatric disorders), compared with 42% in 1997 (Humphreys, Huebsch, Moos, & Suchinsky, 1999). There has also been a decrease over time in the average number of mental health outpatient visits per patient in the private sector, despite an increase in the proportion of outpatients with dual diagnoses (Leslie & Rosenheck, 1999). Drawing on a database of substance abuse treatment programs, McLellan, Hahn, Meyers, Randall, and Durell (1997) compared patients in 10 standard outpatient programs with those in 6 intensive programs, and found that patients in intensive programs generally had more severe substance use, psychiatric, and other problems at admission. We expected to find that patients in intensive programs had a greater number of outpatient visits than patients in standard programs and that intensive programs had higher proportions of patients with dual diagnoses and other indicators of poorer functioning.

Higher staff-patient ratios have long been consistently associated with more effective treatment. High ratios are effective in part because they serve as a proxy for the greater amount of attention that patients receive from clinical staff (Coleman & Paul, 2001). In line with intensive programs serving patients who are more severely ill, we anticipated that intensive programs would also have higher staff-patient ratios than standard programs in both the psychiatric and the substance abuse domains.

In addition to caseload and staffing, another important aspect of program organization is the underlying theoretical orientation that guides the provision of services. In this regard, cognitive-behavioral treatment, emphasizing relapse prevention and skills training to develop better ways of coping and more self-efficacy in high-risk situations, is one of the most prevalent substance abuse treatment approaches in both public and private health care settings (Moos, Finney, Ouimette, & Suchinsky, 1999). The psychodynamic orientation has experienced significant challenges in managed care settings (Wheelock, 2000), but is still represented in ongoing outpatient treatment (Galloway et al., 2000). However, a cognitive-behavioral treatment orientation is somewhat more effective with psychiatrically impaired patients (Cooney, Kadden, Litt, & Getter, 1991; Woody et al., 1984) and, therefore, should be more common in intensive than in standard programs.

Management Practices and Policies

Management practices and policies in both the psychiatric and the substance abuse 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 (Walker et al., 1995). 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 began to implement mental health performance monitoring procedures (Rosenheck & Cicchetti, 1998). 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 intensive and standard psychiatric and substance abuse outpatient programs.

Services and Activities

Few empirical studies have examined hypothesized differences between intensive and standard outpatient programs regarding services. Miller

(1995) commented that little treatment for addiction was available in the psychiatric system. In contrast, currently, psychiatric services are often available in substance abuse settings. For example, Grella and Hser (1997), reporting on a county survey of mental health services within drug treatment programs, found that individual psychotherapy was offered by 83% of intensive and 73% of standard outpatient programs. Other studies of substance abuse programs also reported that intensive programs offer services that standard programs do not, such as family counseling and daily living skills training (Avants et al., 1999; Rychtarik et al., 2000), suggesting that intensive programs may offer a wider variety of services overall than standard programs do. However, McLellan and colleagues' database study (1997) found that, whereas patients in intensive programs received more alcohol- and drug-focused services, they received fewer family-focused and employment services than standard-program patients did, and both groups received very few psychosocial services. The breadth of the array of services is important when considering that intensive programs are likely to have a more severely ill patient population.

Intensive programs were more likely to have performance monitoring of individual clinicians.

The purpose of this study was to describe the range of psychiatric and substance abuse outpatient programs and compare standard and intensive programs in terms of their organization, staffing, and treatment orientation; health care management practices; and services offered and utilized. This comprehensive data set represents a step toward developing program norms to which mental health service providers can refer when evaluating the implementation of their own programs. In addition, more complete information about the characteristics of standard and intensive outpatient programs is needed, not only to better understand effectiveness studies, but also to better design new studies so that they will compare well-implemented and clearly differentiated programs.

METHOD

Sample of Programs

A survey was conducted of all 176 substance abuse and all 595 psychiatric outpatient programs in the VA nationwide; no inpatient or residential programs were included in this study of outpatient programs. Completed surveys were received from 176 (100%) substance abuse program managers and 547 (92%) psychiatric program managers, for a total of 723 (95%).

Programs were identified as standard or intensive according to guidelines used by the VA, the American Psychiatric Association (1995), and the American Society of Addiction Medicine (1996), which define standard and intensive treatment according to how many days per week, and for how many hours per day, patients receive care. Specifically, intensive programs provided treatment to patients a minimum of 3 days per week for 3 hours per day, whereas standard programs provided treatment 1 to 3 days per week, for a maximum of 1 to 2 hours per day. Of the substance abuse programs, 75 (43%) were standard programs and 101 (57%) were intensive programs. Of the 547 psychiatric programs, 515 provided the information necessary to be classified; of these, 341 (66%) were standard programs and 174 (34%) were intensive.

Procedure

The survey (available from the authors) 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 the VA. The directors who initially did not respond received follow-up phone calls and letters. This report analyzes the following three types of data from the survey.

Organization, Staffing, and Treatment Orientation. Organizational factors included the percentages of program patients who were dually diagnosed, lived in a VA or non-VA residential facility while they were receiving outpatient treatment (e.g., domiciliary, halfway house), and paid at least some treatment fees with private insurance or out-of-pocket payments. Organizational factors also included program size (i.e., number of unique patients treated in the past year) and the average number of visits per patient per year.

Intensive substance abuse programs had fewer staff with advanced professional degrees, and more addiction therapists and other direct care staff.

Program directors reported the number of full-time equivalent employees (FTEE) in the following categories: Advanced Professional Staff (i.e., psychiatrist [M.D.], psychologist [Ph.D. or Psy.D.], or Social Worker [MSW, CSW, or ACSW]); Nursing Staff (i.e., 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 (e.g., recreational or occupational therapist, vocational rehabilitation specialist, technician, or aide). For each staff category, the FTEE-staff-per-100-patients ratio was calculated.

Treatment orientation was assessed with the Drug and Alcohol Program Treatment Inventory (DAPTI; Swindle, Peterson, Paradise, & Moos, 1995). The Cognitive-Behavioral (Cronbach's $\alpha=.89$) and the Psychodynamic ($\alpha=.91$) scales each consist of four goal and four activity items. Respondents rated the importance of each treatment goal on a 4-point scale, ranging from 0 (none or very little) to 3 (primary focus of treatment). The presence of each activity was rated using a 4-point scale ranging from 0 (not at all like our program) to 3 (major feature of our program). Scale scores were the average of responses to the 8 items and could range from 0 to 3.

Management Practices and Policies. Program directors indicated whether their program currently used (i.e., usually based treated decisions on) any clinical practice guidelines or used American Psychiatric Association guidelines specifically. Directors also indicated whether their program regularly engaged in 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 non-emergency supplemental services; a single case manager who coordinates all of a patient's care from the beginning of treatment through discharge; weekly staff meetings and case review; continuing medical education required for staff; client outcome follow-up; patient satisfaction surveys; requirement that patients who drop out of treatment have to wait a designated period of time to begin treatment again; and testing patients for alcohol or drug use.

Services Offered and Utilized. Directors of both psychiatric and substance abuse programs indicated whether eight different treatment services were provided by the program (e.g., assessment and diagnosis of psychiatric disorder, individual or group counseling or psychotherapy for psychiatric problems). Directors of psychiatric programs only were asked whether five additional treatment services were provided (i.e., occupational or recreational therapy; discharge planning; training in social skills, daily living skills, and stress management). For each service listed on the psychiatric and substance abuse program surveys, the director also reported the percentage of patients using that service.

RESULTS

We compared intensive programs with standard programs within the psychiatric and substance abuse systems of care separately. Standard and intensive programs were compared by means of *t* tests (continuous variables) or chi-square tests (categorical variables).

Organization, Staffing, and Treatment Orientation

Psychiatric Programs. Table 1 compares standard and intensive outpatient programs on organizational factors, staffing, and treatment orientation. Reflecting the poorer functioning of patients receiving intensive treatment, intensive programs had higher proportions of patients with both psychiatric and substance use disorders and living in residential facilities (while they received outpatient treatment), and a smaller proportion paying program fees using private sources. In the psychiatric system, intensive programs served fewer patients than did standard programs. As expected, intensive-program patients had a greater number of visits, on average.

Regarding staffing, psychiatric intensive programs had higher staff-patient ratios in the "other" direct care category than standard programs did. "Other" direct care staff referred to, for example, recreational or occupational therapists, vocational rehabilitation specialists, and technicians or aides. Compared with standard programs, intensive programs were more likely to adhere to a cognitive-behavioral treatment orientation, and were less likely to use a psychodynamic approach.

Substance Abuse Programs. Standard and intensive programs had equivalent proportions of patients with dual diagnoses, and of patients paying their fees with private sources. Comparable to psychiatric programs, intensive programs had a higher proportion of patients living in residential facilities while they obtained outpatient services. Standard and intensive substance abuse programs did not differ on numbers of patients served or visits per patient in the past year. Whereas intensive programs had a smaller ratio of professional staff to patients, they had more addiction therapists and "other" direct care staff. Standard programs and intensive programs were equally likely to have a cognitive-behavioral or psychodynamic treatment orientation.

Management Practices

Psychiatric Programs. In the psychiatric system, standard and intensive programs showed some similarity on health care management practices (Table 2). However, intensive programs were more likely to have performance monitoring of individual clinicians, a single case manager to coordinate patient care throughout treatment, weekly staff meetings and case review, client outcome follow-up, patient satisfaction surveys, the requirement that patients who drop out of treatment must wait a designated period of time to reenter the program, and testing patients for substance use.

Substance Abuse Programs. Substance abuse standard and intensive programs did not differ on health care management practices.

TABLE I
Organizational Characteristics and Staffing of Standard and Intensive Outpatient Programs

	Psychiatric		Substance Abuse	
	Standard Mean	Intensive Mean	Standard Mean	Intensive Mean
<i>Patient Factors</i>				
Percentage of patients who have both psychiatric and substance use diagnoses (i.e., dual diagnosis)	31.37	49.86	43.47	41.67
Percentage of patients who live in a VA or non-VA residential facility	19.80	42.85	25.22	47.34
Percentage of patients who pay at least some program fees with private insurance or own funds	8.57	5.47	6.61	8.32
<i>Organizational Factors</i>				
Number of patients (past year)	1,156.12	482.90	667.56	646.03
Number of visits per patient	15.14	63.87	29.98	21.76
<i>Staff:Patient Ratio (per 100 patients)</i>				
Advanced professional staff	1.57	1.27	.63	.44
Nursing staff	.41	.74	.37	.44
Addiction therapist	.20	.20	1.46	2.13
Other direct care staff	.26	1.23	.14	.29
<i>Overall Treatment Orientation</i>				
Cognitive behavioral	1.89	2.07	2.22	2.20
Insight/psychodynamic	1.50	1.25	1.21	1.17

* $p < .05$. ** $p < .01$. *** $p < .001$.

TABLE 2
Health Care Management Practices of Standard and Intensive Outpatient Programs

	Psychiatric		Substance Abuse		χ^2
	Standard (%)	Intensive (%)	Standard (%)	Intensive (%)	
<i>Management Practice</i>					
Use clinical practice guidelines	53.1	51.7	42.6	57.4	.41
Use American Psychiatric Association Guidelines	40.1	34.0	44.9	47.1	.06
<i>Regularly Used Practice</i>					
Separate quality review committee	37.6	39.9	57.3	53.5	.26
Performance monitoring and feedback for each clinician	55.6	65.3	66.7	78.2	2.91
Written approval by utilization review required for patients' non-emergency supplemental services	5.3	7.0	4.1	7.9	1.13
Single case manager coordinates patients' care throughout treatment	57.5	70.5	78.7	73.3	.68
Weekly staff meetings and case review	79.7	91.9	92.0	98.0	3.62
Client outcome follow-up	52.8	65.3	56.0	64.4	1.25
Patient satisfaction surveys	72.6	82.1	78.7	82.2	.33
Patients who drop out must wait a designated period of time to begin treatment again	3.7	21.6	22.7	34.7	3.00
Testing patients for alcohol or drug use	48.5	64.5	94.7	96.0	.19

* $p < .05$. ** $p < .01$. *** $p < .001$.

Services Offered

Psychiatric Programs. In the psychiatric domain, services targeted to patients' psychiatric problems specifically, including assessment and diagnosis, and counseling, were offered more frequently in standard than in intensive programs (Table 3). Couples or family counseling was also offered more frequently in standard than in intensive programs. On the other hand, work therapy or training, vocational or educational counseling, occupational or recreational therapy, discharge planning, social skills training, and daily living skills training were more frequently available in intensive programs.

Substance Abuse Programs. Substance abuse standard and intensive outpatient programs did not differ on the likelihood of offering specific treatment services.

Patients' Utilization of Services

Psychiatric Programs. Table 4 presents the percentage of patients using services in programs that offered them. In these programs, intensive program patients were more likely than standard program patients to receive individual or group counseling for their psychiatric problems, and to attend 12-step self-help groups for substance use problems. Patients in intensive programs were also more likely to utilize work therapy, vocational or educational counseling, HIV counseling, occupational or recreational therapy, discharge planning, social skills training, daily living skills training, and stress management training, when they were offered.

Substance Abuse Programs. When the services were offered, patients in substance abuse intensive outpatient programs were also more likely to receive couples or family counseling, work therapy, vocational counseling, and HIV counseling than were patients in standard programs. They also were more likely to attend 12-step self-help groups than patients in standard programs.

DISCUSSION

Sizeable proportions of patients in psychiatric and substance abuse outpatient specialty care, particularly in psychiatric intensive programs, had dual diagnoses. Compared with patients in psychiatric standard programs, those in psychiatric intensive programs received a greater amount of care that was focused on rehabilitation rather than counseling services. Substance abuse standard and intensive programs were similar on organization, management practices, and services offered.

TABLE 3
Services Offered in Standard and Intensive Outpatient Programs

Services Offered	Psychiatric		Substance Abuse		χ^2
	Standard (%)	Intensive (%)	Standard (%)	Intensive (%)	
Assessment and diagnosis for psychiatric disorder	91.8	72.8	93.3	93.1	.01
Individual or group counseling or psychotherapy					
Psychiatric	95.3	86.1	84.0	80.0	.46
Alcohol and drugs	56.2	60.2	98.7	95.0	1.91
Couples or family counseling	72.6	62.2	43.2	56.8	.20
12-step groups (e.g., Alcoholics Anonymous)	17.6	21.4	45.3	55.4	1.76
Work therapy or training	23.6	59.5	33.3	35.6	.10
Vocational/educational counseling	65.3	84.5	46.7	56.0	1.50
HIV screening and counseling	68.9	70.1	80.0	87.0	1.55
Occupational or recreational therapy	27.3	61.3	—	—	—
Discharge planning	55.6	83.8	—	—	—
Training					
Social skills	59.7	82.1	—	—	—
Daily living skills	46.2	72.8	—	—	—
Stress management	60.8	62.8	—	—	—
					.20

* $p < .05$. ** $p < .01$. *** $p < .001$.

TABLE 4
Utilization of Services Offered in Standard and Intensive Outpatient Programs

	Psychiatric			Substance Abuse		
	Standard Mean	Intensive Mean	t	Standard Mean	Intensive Mean	t
<i>Percentage of Patients Using Service</i>						
Assessment and diagnosis for psychiatric disorder	88.90	87.29	-.61	77.48	76.91	-.10
Individual or group counseling or psychotherapy						
Psychiatric	51.34	68.64	5.64***	39.99	39.48	-.09
Alcohol and drugs	37.42	44.86	1.41	89.93	91.50	.42
Couples or family counseling	13.11	15.36	.96	12.60	19.33	2.05*
12-step groups (e.g., Alcoholics Anonymous)	33.05	54.74	2.60**	23.56	43.73	3.27***
Work therapy or training	25.86	55.45	5.64***	7.47	15.85	2.28*
Vocational/educational counseling	24.23	51.27	6.83***	16.11	33.66	3.48***
HIV screening and counseling	16.85	32.15	3.57***	54.47	79.03	3.82***
Occupational or recreational therapy	30.93	72.01	7.80***	—	—	—
Discharge planning	64.62	74.94	2.11*	—	—	—
<i>Training</i>						
Social skills	41.42	75.59	8.11***	—	—	—
Daily living skills	41.52	67.99	5.47***	—	—	—
Stress management	36.11	64.99	5.97***	—	—	—

* $p < .05$. ** $p < .01$. *** $p < .001$.

Organization, Staffing, and Treatment Orientation

Consistent with McLellan and colleagues' study (1997) of substance abuse programs, in both the psychiatric and substance abuse systems, patients in intensive programs were functioning somewhat more poorly than those in standard programs, in that they were more likely to reside in a residential facility while receiving outpatient care. They were less likely to pay program fees with private insurance or personal funds. In psychiatric intensive programs, 50% of patients were diagnosed with both psychiatric and substance use disorders, compared with 31% in standard programs. In contrast, substance abuse standard and intensive programs had quite similar proportions of dual diagnosis patients (42–43%).

Findings showing that dually diagnosed patients treated in psychiatric programs have more severe psychiatric diagnoses than those treated in alcohol and drug addiction programs (Primm et al., 2000) suggest that psychiatric intensive outpatient programs may be treating a particularly ill patient population. Overall, these percentages of dual diagnosis patients in ambulatory care are comparable to those in hospital and residential psychiatric and substance abuse facilities (Timko et al., 2003), indicating that, currently, outpatient programs are as likely to be treating dually diagnosed patients as are inpatient programs. This is the case even though outpatient programs are less heavily staffed than inpatient units (Timko et al., in press).

In substance abuse programs, the presence of professional staff may create a sense of distance between staff and patients.

In the psychiatric system, intensive programs treated a smaller number of patients annually than did standard programs, and patients in intensive programs had about four times as many visits on average than patients in standard programs. Apparently, psychiatric intensive programs were appropriately giving more treatment to their more severely ill patients. In keeping with the similar percentages of dually diagnosed patients in both standard and intensive programs in the substance abuse system, the two program types were comparable on organizational characteristics.

The effort of psychiatric intensive programs to meet the needs of a severely ill patient group was further evidenced by higher staff-patient ratios in the category of Other Direct Care, which included recreational or occupational therapists, vocational rehabilitation specialists, and technicians. In the substance abuse domain, intensive programs had fewer staff with advanced professional degrees, and more addiction therapists and "other" direct care staff. The Timko and Moos study (1998) of mental health pro-

grams suggested that a staff with a less professional focus may provide a good match to poorly functioning substance abuse patients. They indicated that the presence of professional staff may create a sense of distance between staff and patients, and found that programs with more alcohol and drug counselors had more patient support, autonomy, and personal expression, and provided more practical guidance on how to go about building a life after treatment. Addiction therapists tend to be recovering individuals who draw on their personal experiences to pursue a wide range of treatment goals using varied treatment techniques (Kemker, Kibel, & Mahler, 1993; Mulligan, McCarty, Potter, & Krakow, 1989; Stoffelmayr, Mavis, & Kasin, 1998). Having more staff using this approach may help to create a beneficial treatment milieu for patients with housing, financial, and relationship problems.

Regarding treatment orientation, psychiatric intensive programs put more emphasis on a cognitive-behavioral orientation, and less on a psychodynamic approach than did standard programs. Again, this result is in keeping with the higher percentage of patients with dual disorders in intensive programs, in that cognitive-behavioral treatment was found to be more effective than other therapies among patients whose clinical status was more complex (Cooney et al., 1991; Woody et al., 1984). Substance abuse standard and intensive programs did not show a difference in orientation, which is consistent with the similarity of their patient groups, and with findings that staff of specialized addiction services tend to be eclectic in their approach to treatment (Ogborne, Wild, Bruan, & Newton-Taylor, 1998).

Management Practices

In light of current efforts to adopt evidence-based practices (American Psychiatric Association, 1995; Kent & Hersen, 2000; Manderscheid, 1998; Rosenheck & Cicchetti, 1998; Walker et al., 1995), it was somewhat surprising that only about half of the programs used clinical practice guidelines of some kind. Recently, researchers have begun to identify barriers to such use by mental health staff, including staff members' lack of necessary knowledge and skills to assimilate practice guidelines, and organizational dynamics that undermine the ability of staffs to implement and maintain new techniques, such as having multiple and competing goals, fluid involvement of key managers and colleagues, and other bureaucratic constraints (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Rosenheck, 2001). These researchers have also identified strategies to overcome these barriers and foster more use of practice guidelines, such as packaging practices to make them more user-friendly, and directly addressing organizational dynamics within the treatment staff team to form coalitions.

A number of management practices were used regularly by the majority

of psychiatric and substance abuse standard and intensive programs, including performance monitoring of each clinician, coordination by a case manager of each patient's care throughout treatment, weekly staff meetings and case review, client outcome follow-up, and patient satisfaction surveys. The high percentages of programs conducting patient satisfaction surveys implies that patients' views are considered in planning care. Psychiatric standard programs tended to be less likely to use management practices regularly, possibly because they are more difficult to implement in larger programs (Sosin, 2001). The high rates of testing patients for alcohol and drug use in psychiatric treatment may represent a new trend, as the percentage of patients with concomitant substance use disorders has risen. The greater proportions of psychiatric intensive programs than standard programs that test for substance use is again consistent with the higher proportions of dual diagnosis patients in those programs.

Services

Regarding services offered and utilized, intensive programs differed more from standard programs in the psychiatric than in the substance abuse domain. In particular, psychiatric intensive programs were more likely to offer rehabilitation services (e.g., work training, vocational counseling, occupational therapy, discharge planning, skills training) than were psychiatric standard programs. When these services were available, they were also more likely to be used by patients in psychiatric intensive programs.

In addition, when they were offered, the services of work therapy and vocational counseling were more likely to be used by substance abuse patients in intensive programs than those in standard programs. Moreover, patients in intensive programs, whether psychiatric or substance abuse, were more likely to use HIV counseling services. The Broome, Joe, and Simpson (1999) study of outpatient drug abuse programs found a reduction in HIV-related risk behaviors during treatment, suggesting that HIV counseling services are important to HIV and AIDS prevention policies. More generally, the greater availability and use of rehabilitation-focused services, found particularly in psychiatric intensive programs, are consistent with the intent of intensive programs to provide more comprehensive care.

The similarity of substance abuse standard and intensive programs was seen in the finding that close to 100% of substance abuse programs offered counseling targeted at substance use disorders. Again, the high percentage of psychiatric programs offering substance abuse counseling may reflect a recent trend in response to rising numbers of dual diagnosis patients. Relatively fewer standard and intensive programs offered 12-step groups for alcohol and drug problems, and substance abuse programs were more likely to offer this service than were psychiatric programs. Pa-

tients in intensive psychiatric and substance abuse programs were more likely to attend 12-step group meetings when they were offered than were patients in standard programs.

Only about half the programs used clinical practice guidelines of some kind.

Substance abuse standard and intensive programs were also similar in that the majority offered individual or group counseling for patients' psychiatric disorders. Psychiatric standard programs were more likely to offer this service than were psychiatric intensive programs, but when the service was available, psychiatric patients in intensive programs were more likely to use it. Although couples or family counseling was offered somewhat frequently by programs, especially psychiatric standard programs, it was used by small proportions of patients, perhaps because individuals with mental health problems tend to be unmarried or estranged from family members (Barry, Fleming, Greenley, Kropp, & Widlak, 1996; Mowbray, Ribisl, Solomon, Luke, & Kewson, 1997).

Limitations and Conclusions

The findings must be considered in light of the fact that standard and intensive outpatient programs were compared within the psychiatric and substance abuse services of the VA. Publicly funded by the federal government, the VA operates the largest psychiatric and substance abuse treatment systems in the United States. Studies comparing mental health care within and outside the VA suggest that VA-based findings may generalize somewhat better to non-profit than to for-profit settings, although all three systems share similarities. For example, Calsyn, Saxon, Blaes, and Lee-Meyer (1990) found that physician and nurse staffing of methadone maintenance programs was similar in VA and non-profit settings, which had lower staffing levels than for-profit programs. The VA had the most psychologists, however, reflecting its multidisciplinary approach to providing mental health treatment services (Calsyn et al., 1990). Rodgers and Barnett (2000) found that federal substance abuse programs were less likely than for-profit or non-profit settings to provide family therapy, but were equally likely to offer individual therapy or group therapy. Rosenheck, Desai, Steinwachs, and Lehman (2000) compared VA and non-VA services for schizophrenic patients in two states, and they found that, although VA services were less focused on rehabilitation and community-based service delivery, they were of similar quality and effectiveness. For example, VA and non-VA outpatients were equally likely to have seen a psychiatrist, and to have been offered individual or group therapy and family therapy.

Within the VA's outpatient psychiatric treatment services, intensive programs appeared to be responding appropriately to a more severely ill patient population by providing more visits, a cognitive-behavioral treatment orientation, and more staff and services focused on rehabilitation. However, patients and their families in intensive programs were less likely to be offered basic counseling services. Substance abuse standard and intensive outpatient programs showed fewer differences on patient characteristics, treatment orientation, and available services, although intensive programs hired fewer professional staff and hired more addiction and rehabilitation therapists. Possibly, because substance abuse intensive programs have a shorter history than psychiatric intensive care does, they are less well developed than, and distinguishable from, standard programs.

These findings, that show the relative lack of basic counseling services in psychiatric intensive programs, and the overall similarity of substance abuse standard and intensive care, may explain why intensive programs have not yielded patient outcomes that are superior to those of standard programs. Mental health system planners should consider differentiating intensive programs using broader criteria than those in current guidelines (Sosin, 2001), such as those based on organizational (e.g., program size, caseload, staffing), management, and service-related factors. A more useful approach than a simple standard-versus-intensive dichotomy may be to develop a typology of psychiatric and substance abuse programs to characterize the main models of care currently being practiced (Timko & Moos, 1991).

Whether programs are described according to a dichotomy or more complex typologies, new effectiveness studies should characterize programs comprehensively, so that researchers and practitioners can examine why patient outcomes differ or do not differ in selected treatment settings. As the effectiveness studies of different models of care accumulate, the comprehensive descriptions of these models will also allow comparisons of programs across studies. New evaluations should continue to examine (a) associations between different types of programs, whether they are designated as standard, intensive, or otherwise, and (b) outcome indices assessing symptoms and functioning, among substance abuse, psychiatric, and dual diagnosis patients.

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