

Alcoholism Treatment in the Partial Hospital or Day Program

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Partial hospitalization treatment (PHT)—commonly referred to as daycare treatment—offers substantial benefits in treating alcoholic patients (Longabaugh et al. 1981; McCrady et al. 1981; Hudolin 1964; Vanden Heuvel 1980).

This hybrid treatment setting appears to combine the best of inpatient and outpatient care, while avoiding some of the problems inherent in each of those more traditional settings. Compared with conventional outpatient programs, PHT programs report fewer dropouts (Collins et al. 1980). The program in PHT settings is more intensive, more highly structured, and more varied than is the case in outpatient settings where counseling sessions are the basic modality.

PHT offers some of the benefits of inpatient settings, but does not carry the same negative stigma associated with confinement or institutionalization that often is attached to the inpatient setting (Hudolin 1965). It

also appears that resistance to entering treatment in an inpatient setting is exacerbated by the need to make many personal arrangements and to leave home for a period, not the case for the patient entering a PHT program.

Partial hospitalization has been available as a treatment alternative in other human service fields—such as vocational rehabilitation and mental health—since the 1960s. According to McCrady and associates (1981), a number of studies have shown that PHT is a clinically effective alternative to 24-hour hospitalization for a large proportion of patients who present for inpatient treatment. This population includes all patients who are not homicidal, suicidal, or unable to care for themselves.

Outcome measures on which these studies have based their conclusions include readmission rate, total duration of hospitalization, occupational and social role functioning, and patient and family satisfaction with treatment.

On all measures PHT has compared favorably with inpatient care and has also been more cost effective. It would be reasonable to expect similar results in treating alcoholics in the PHT setting. With the rising cost of treatment, particularly inpatient costs, Longabaugh and associates (1981) believe that "a rigorous comparison of behaviorally oriented treatment delivered in partial and inpatient settings is a high priority."

There are four major variables that determine the efficacy of any treatment services: client behavior, staff competencies and training, treatment environment, and therapeutic theory or approach. It is necessary to examine critically all four of these variables, as well as how they interrelate, in order to learn more about alcohol treatment process and outcome. This article reviews one variable—treatment environment.

Elements of PHT Programs

Partial hospitalization treatment (PHT) is the focus of this article. Even though these programs resemble extended and enriched outpatient programs and are often not in hospital settings, they are characteristically distinctive environments. Other terms are sometimes used to describe this modality, including day treatment, or day or night hospital. This review adheres to the definitions of the National Drug and Alcoholism Treatment Utilization Sur-

vey (NDATUS) (NIAAA 1981). Day care or PHT is "treatment provided by a unit in which the client resides outside of the unit. The client participates in an alcohol abuse treatment program, with or without medication, according to a minimum attendance schedule as defined by the funding source (usually 5 or more hours per day, 5 or more days per week). The client has regularly assigned and supervised work functions (salaried or nonsalaried) at the unit." A somewhat

broader formulation is set forth in the current *Classification of Alcoholism Treatment Settings* at present under development by NIAAA (table 1).

The September 1980 NDATUS (NIAAA 1980) report indicates that only 156 PHT programs existed in the United States at that time, compared with 1,794 inpatient programs and 2,765 outpatient programs. In seeking to assess the potential benefits of PHT programs, 14 such programs were studied. All 14 programs reviewed

conformed to the NDATUS definition except that clients did not have any assigned work functions and their daily attendance was generally for 4 hours rather than 5. While the 14 programs are not necessarily representative of the field, they were deliberately selected from a variety of auspices and settings—labor, management, urban

center, small city, suburban, women's center, hospital related, freestanding, and research study.

From reports, correspondence, and personal contact, information about 12 variables was gathered for each of the programs studied. These variables are the year the program was established, average daily census, socioeconomic

profile of clients, admission (assessment) instrument used, length of treatment cycle, fee policy, program content, treatment strategy, cost benefits and efficacy comparison with inpatient service, Alcoholics Anonymous participation, professional identification of staff, and age range served.

Findings

Most of the programs were established after 1978. The oldest had been established in 1969. The average daily census was 15 to 25 clients. Since there were few PHT centers in most communities, the clientele represented a fairly broad segment of the population. The neighborhood location also tended to influence the type of client who would be attracted to the PHT. For instance, a suburban address brought more middle-class professional clients to the South DeKalb Mental Health Center in suburban Atlanta than was the case in other locations. In most programs it was found that alcoholic clients represented a cross section of unemployed, unskilled, blue-collar, and white-collar persons. Programs in small communities tended to attract a wide spectrum of clients.

Eleven of the fourteen programs used the DSM III instrument for admission assessment. This questionnaire was developed under the aegis of the American Psychiatric Association (1981). There was not much standardization in the duration of the treatment cycle. It ranged from 11 days to 18 months. However, the 11-day or 2-week programs included an aftercare outpatient component. Some programs of longer duration claimed to include an aftercare component, but this is an area requiring further clarification.

Programs generally ran from 9 a.m. to 4 p.m. or from 5 p.m. to 8 p.m., 5 days a week; some centers were also open on Saturday mornings. Nine programs had a sliding fee scale based on the ability to pay, eight had

developed a reimbursement policy with a third-party payer, and four provided services without a fee. The four not charging a fee included a Blue Cross demonstration project at the U.S. Department of Health and Human Services, the United Technologies Center program, and programs in Louisville and Detroit that traditionally do not charge.

All 14 PHT centers had structured programs, including alcohol education offered via discussions and films that covered such topics as medical consequences, myths, job issues, and sexual dysfunction. Individual, group, and family counseling was also available. Some centers also included ancillary support activities such as life skills, homemaking skills, new careers, field trips, aerobics, relaxation therapy, physical education, and recreation.

The only substantial research conducted and reported regarding PHT programs emanates from a study at Butler Hospital—Brown University, one of the centers reviewed in this study. The investigators underscore the importance of PHT as a special support system that allows the patient to maintain contact with his or her familiar environment. There are greater opportunities for real life assessment and rehearsal in PHT settings than in comparable inpatient programs, and staff can more easily monitor patient

cues. Behavioral carryover from the familiar environment to the treatment process and vice versa appears more likely. The patient maintains normal contact with his or her own family and with the workplace (Hudolin 1964). The stigma and problems related to leaving the community for inpatient care and reentering it are avoided in PHT. Interpersonal functioning, especially with spouses and family, improved more in PHT than in the inpatient setting (Longabaugh et al. 1981).

Most of the centers studied commented on the lower cost of providing service within PHT, compared with inpatient settings. The only center to conduct a controlled study was the Butler Hospital—Brown University program. They stated that PHT can be delivered at one-third to one-half the cost in inpatient settings, and suggest that "PHT is more cost effective than an extended inpatient setting for behaviorally oriented treatment of alcohol abusers." The investigators found no difference between the PHT and the inpatient clients' probability of readmission during the 6-month follow-up period. Twenty-five percent of the PHT patients and 23 percent of the inpatients were readmitted. They did caution, however, that for patients who require 24-hour hospital care—acutely suicidal or those with acute medical conditions—PHT would not be appropriate.

All PHTs reviewed consistently either required or expected participation in AA through regular attendance at meetings and involvement in other AA activities.

A variety of disciplines were represented in the centers studied. All staff

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employed were in the helping professions: psychiatrists; bachelors degree and graduate social workers; clinical psychologists; medical doctors; certified, credentialed, or trained alcohol

counselors; and registered and licensed practical nurses.

The PHT centers served clients from 18 to 65 years old, with the largest group falling between 22 and 35. Two

PHT centers provided childcare services (Sacred Heart Women's Day Program and the U.S. Department of Health and Human Services) during the time patients were in treatment.

Program Profiles

While an overall picture of the characteristic elements of PHT settings can be developed from the data discussed above, the specifics of how PHT settings function can be understood only by looking at several of the programs studied. The following descriptions of 5 of the 14 programs reviewed offer a more in-depth look at how PHT settings operate.

United Technologies Counseling Center. The United Technologies Counseling Center (U.T.C.) was established in 1980 to provide a treatment alternative in partial hospitalization. This center in the Greater Hartford, Connecticut, area is the first company-owned treatment program for alcoholics in the United States. The U.T.C. clinical therapist comments that "in 1974 United Technologies began a program at its Pratt and Whitney Aircraft Division in Connecticut to identify, counsel, and motivate alcoholic employees. The program was highly successful over the next 5 years—approximately 1,000 alcoholic employees and dependent family members were helped, and the majority of these individuals were referred to private alcoholism treatment centers.

"In monitoring treatment services over this 5-year period, a need for new treatment alternatives became apparent," he said. "The major reasons were that between 1975 and 1979 the treatment duration doubled and cost tripled. Furthermore, client characteristics have changed. Many employees now seeking help are younger and less impaired.

"We make a distinction between alcoholism (physical and/or psychological dependence) and alcohol abuse in recommending a treatment plan, using both the DSM III established by the American Psychiatric Association

in 1981 and the American Psychiatric Association criteria to establish a diagnosis. The day treatment program is designed to treat alcoholism. While the average length of treatment in the program is 2 weeks, it is varied according to each individual's needs. For example, many employees who had previously been in intensive alcoholism treatment are often able to return to work after only a week in our program. Employees are on sick time or disability leave for this period. We vary each day according to patient's needs, within a general schedule. Family members are strongly encouraged to attend sessions at least once weekly.

"The Day Treatment Program emphasizes the necessity of followup treatment including AA, psychotherapy, and at-work aftercare groups. We recommend and use group or individual psychotherapy for those individuals who need help in addition to AA to resolve other problems.

"Results from our first 2 years of day treatment operation indicate that it is a viable alternative to inpatient alcoholism treatment. While some alcoholics still need hospitalization, we are finding that the majority of U.T.C. employees can be successfully treated in a day treatment program. Employees say day treatment is more responsive to their needs than traditional modes of treatment, and this is of primary concern.

"Seventy-five percent return to their jobs with a stable outcome—only 6 percent have been terminated because of poor adjustment. Nineteen percent are at work, with intensive followup in outpatient care provided by the company. Our employees are moderately to highly skilled and well motivated, and their prognosis is good." While these figures are high for treatment out-

come, Baekeland (1977) points out that "the principal indicators of a favorable prognosis following treatment are social stability, higher socioeconomic status (SES), and motivation. These factors were correlated with success in treatment outcome whether the modality was hospitalization or outpatient treatment" (p. 426).

According to the U.T.C. clinical therapist, "An important prevention trend has been noted, as 60 percent of our clients make self-referrals *before* their production drops and absenteeism increases. In 1980, self-referral accounted for 30 percent of clients in treatment. This increase to 60 percent self-referrals is due to the grapevine working, formal channels of communication operating, and program promotion."

Industrial Rehabilitation Center. The director of the Industrial Rehabilitation Center (IRC) of the United Labor Member Assistance Program, Inc., of Kansas City, Missouri, comments that "once the physical and medical needs of patients have been met in a hospital setting—which can typically occur within 2 to 4 days—it is not only cost effective but also programatically sound to provide alcoholism rehabilitation on a day treatment basis. Day treatment provides daily education, individual and group therapy, and structured activities about treatment goals and objectives, allowing patients to return home at night and on weekends."

Director Maurice Cummings established his treatment rationale in the workplace and with the trade union. "In one sense," he states, "treatment begins with intervention. In the context of United Labor's target population, this intervention begins in the workplace as a result of the labor-management system that United Labor has

established for this purpose.

"A labor-management employee assistance program helps eliminate many of the pitfalls characteristic of other types of intervention. Alcoholism is dealt with by labor and management under the same rules followed with any other illness. It says to the employee that we are willing to help you deal with this illness by setting up the machinery to make it easy for you to get competent help and treatment. It confronts the employee with realistic and observable dimensions such as job performance and absenteeism. It does not imply or deal with moral or emotional conflicts. It eliminates cover-up and links one of a person's key worlds within which he or she operates (workworld) with the treatment of his or her illness.

"It is IRC's belief that the bottom line of any treatment of alcoholism is motivation, and that motivation is the dual responsibility of the treatment center and the person being treated. Too often, we contend, the failure of treatment is written off as the lack of motivation on the part of the patient. However, we believe that motivation for recovery must also come from the rehabilitative treatment program and a dedicated and committed staff through the skilled application of education and individual and group therapy."

According to Cummings, "A person in treatment during the day 5 days a week for 2 weeks returns home nights and weekends. This may be therapeutic to have to deal with the realities of home and other areas of life while in treatment rather than to be isolated from these realities for 21 days."

Cummings cites an average daily patient cost of \$58 for PHT. This includes the psychotherapy, education, and counseling necessary for effective treatment of the alcoholic. He compares this figure with a daily hospital-based cost that averaged \$133 in the Kansas City-St. Louis area in 1981. His program serves 312 patients each year. The cost of a standard 10-day treatment program for this number of patients in the PHT setting costs \$180,960; in an inpatient, hospital-based treatment setting this would cost \$414,960. Consequently, the net an-

nual savings as a result of the use of PHT is \$234,000.

Butler Hospital—Brown University. The value of PHT is even more clearly illustrated by the Butler Hospital—Brown University study (Longabaugh et al. 1981), which presents "a social learning model that views drinking as a learned behavior maintained by its consequences and cued by identifiable discriminative stimuli." The objective was to compare the efficacy and treatment costs of a psychiatric partial hospital setting for the treatment of alcoholism relative to extensive inpatient hospital treatment.

The study, carried out at the Providence, Rhode Island, facility, posited that whatever a person's genetic predisposition toward alcohol abuse, alcohol ingestion is learned behavior. As such, given the right learning conditions, the behavior can be replaced by other kinds of behaviors.

There were 155 patients in the sample. Patients were randomly assigned a behavioral treatment program after detoxification as part of an extended inpatient program or to a PHT setting. Monthly assessments, a 6-month followup, and a 2-year follow-up period after treatment were reported. Analyses of outcomes through the first 6 months following treatment indicated that the drinking behavior, psychological well-being, and social role and occupational functioning of patients treated in the PHT were superior to or equal to those treated as part of the extended inpatient setting. The costs of the partial hospital treatment were significantly less (Longabaugh et al. 1981).

The Butler Hospital—Brown University investigators stated that there were several key elements of behavior treatment that made the PHT setting particularly attractive. Clients need to be able to recognize that abstaining from or moderating their use of alcohol is necessary, but this can be a difficult task that requires new skills. Exposure to the familiar environment is necessary to accurately assess drinking patterns. In the PHT setting patients are exposed to drinking cues on a daily basis, which results in a

more accurate assessment by the clinical staff and the patient of environmental cues for drinking as well as of its cognitive and emotional antecedents. Therefore, clients capacity to recognize high risk situations should be enhanced. The PHT setting also provides increased opportunity for rehearsal of new skills in the natural environment. Leaving each day gives the patient opportunities to seek out drinking cues and rehearse responses, as well as to learn to avoid certain settings, people, or interpersonal interactions while receiving the daily support of the clinical staff.

The PHT services, when compared with the inpatient setting, also provides increased opportunities to teach clients how to anticipate real life situations. For example, the investigators note that "the program's goals are implemented primarily through therapy groups. . . . Patients identify and record drinking urges that occur outside treatment hours, and identify behavior changes necessary to avoid drinking. Environmental restructuring is often encouraged, and patients report the accomplishment of specific goals—ranging from job changes, taking an academic course, involvement in a recreational activity, to meeting non-drinking persons through AA. In addition, social skills training teaches drink refusal and assertion skills. Patients role-play these skills in groups, and practice them outside treatment hours." Table 2 provides an overview of the treatment components of the PHT program at Butler Hospital.

U.S. Department of Health and Human Services. The U.S. Department of Health and Human Services (HHS) Employee Counseling Services established a 2-year evening and weekend alcoholism treatment demonstration project in May 1982 with support from the Blue Cross and Blue Shield Federal Employee Program. All HHS employees having high-option coverage under the Federal Employee Program of Blue Cross and Blue Shield, who live in the Washington, D.C., area, and who have a diagnosis of alcoholism are eligible. An ongoing caseload of 65 patients is projected.

The treatment philosophy espouses a total approach to the problem of substance abuse, including problem identification, prevention, education, counseling, rehabilitation, and follow-up support. Treatment focuses on abstinence and the improvement of job performance.

One of the critical components of this project is to evaluate the cost and effectiveness of treatment. Evaluation will focus on the effect of treatment on employee job performance; the actual treatment success, based on an intake and a followup form; and the changes in health insurance claims of the employees using the program, based on data collected by Blue Cross and Blue Shield.

This project is designed to explore a treatment alternative for employees who may not have sick or annual leave available or who may have family responsibilities that preclude participation in a 28-day program. The intensive-26-week treatment program takes place after working hours, at the worksite; child care is provided for all sessions. During the first 4 weeks, the clients meet each evening from 5:30 to 9:30 p.m., each Saturday from 9 a.m. to 1 p.m., and each Sunday from 1

p.m. to 5 p.m.

Donwood Institute. In a 1973-74 study, the Donwood Institute in Toronto, Ontario, estimated that the cost of alcoholism treatment was \$793 per patient for a day clinic program and \$2,137 per patient for an inpatient program. Eighty-eight percent of the day clinic patients and 84 percent of the inpatients were significantly improved a year after discharge. The cost per "successful" patient, therefore, can be computed as \$901 for the day clinic and \$2,544 for the inpatient program. The health insurance program in the Province of Ontario has recognized the potential effectiveness of the day clinic and now provides full coverage for day treatment in addition to its continued insurance for the inpatient program (MacLachlan and Stein 1982).

Other Programs. Information was obtained from 10 other programs. Detailed descriptions will not be provided; however, information from these other programs is reflected in the overall findings. These programs were the Ellis Hospital Alcoholism Day Treatment Program in Schenectady, New York; the Fulton County Alcohol Treatment Center in Atlanta, Georgia; the Geauga Community

Mental Health Center in Chardon, Ohio; the Jefferson Alcohol and Drug Abuse Center in Louisville, Kentucky; the Kolmac Clinic in Silver Spring, Maryland; the Lorain County Council on Alcoholism, The Giving Tree, in Lorain, Ohio; the Psychiatric Institute Alcoholism Rehabilitation Unit in Washington, D.C.; Sacred Heart Women's Day Care Program in Detroit, Michigan; South DeKalb Mental Health Center Alcohol and Drug Program in Decatur, Georgia; and Step One Services in Fairfax, Virginia.

The information gathered in this review confirms the claims in the literature that PHT is cost effective and innovative and has much to offer in the field of alcohol treatment.

There is no question that more research and more information are needed on treatment efficacy in all treatment environments. Controlled systematic studies have to be conducted and disseminated. Even though tremendous strides have been made in recent years in viewing and treating alcoholism as an illness, our knowledge of therapeutic intervention and outcome still needs much development.

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