Castle Craig Clinic Extended Care Unit Follow-Up Study 2000 from 1/9/97 to 31/8/99, Published June 2000

Report Contents

The Purpose

This study examines the outcome of clients referred to the Extended Care Unit at Castle Craig. All clients completed a period of primary treatment and the vast majority were referred from the primary care unit at Castle Craig for further rehabilitation. There were no exclusion criteria, with all clients who were admitted to the extended care unit during the study period being included. A study of the effectiveness of extended treatment was the primary goal.

An Outline of the Treatment

The Extended Care Unit treatment approach is usually referred to as 12 Step treatment or Minnesota Model. This 12-step, abstinence based approach is based on the disease concept of addiction and integrates the 12 Step programme principles of Alcoholics Anonymous and Narcotics Anonymous. However the Extended Care Unit offers additional necessary treatment including group therapy, various forms of cognitive behavioural counselling including Rational Emotive Behaviour Therapy and Reality Therapy, family therapy and aftercare planning along with "Life Skills" work. All clients also participate in "rolling programmes" of Lectures, Assertiveness Training and formal instruction on Relapse Prevention and Health Promotion. Additional use of lectures and specialised groups are used for the recurrent problems of Anger and Stress Management. Individual therapy adopts an eclectic and individualised approach, with all clients working to personalised treatment plans.

A high percentage of clients arrive with outstanding court appearances, debts and other financial problems. Many are homeless and socially deprived and these issues are addressed through liaison with Lawyers, Probation Officers, Housing Officers and Social Services.

To provide a continuum of support Castle Craig offers aftercare group therapy held at four locations across Scotland. All clients are encouraged to attend one or more of these weekly aftercare group sessions on an ongoing basis for a period of up to two years after completing their residential treatment.

The Follow-Up Study

This study information was gathered through direct contact, postal questionnaires, telephone contact with clients or the clients authorised contact person. In many instances information was obtained from the client's Social Worker.

Written authorisation to follow-up was given by all the study clients prior to completion of their treatment. Additional information regarding those with uncontrolled intake was accepted from close and reliable friends when this could be verified by at least one other person. A sustained attempt was made to contact all clients within the study group.

The study group either completed treatment, discharged themselves or were discharged by the treatment team at Castle Craig between the dates 1.9.97 and 31.8.99 (a two year period). The study group comprises of 128 males and 78 females, making a total of 206 passing through treatment over the 2 year period. 123 were diagnosed as alcohol dependent and 83 were diagnosed as drug addicted using DSM-IV diagnostic criteria. Two patients were re-admitted to ECU during this period and both outcomes were recorded. The mean lapse in time passing between the patients leaving treatment and the start of the study was 429 days, with all having left treatment for a minimum of 6 months. The average length of stay in ECU was 85 days with a minimum stay of 1 day and a maximum stay of 289 days. The average length of stay for those who completed treatment was 118 days.

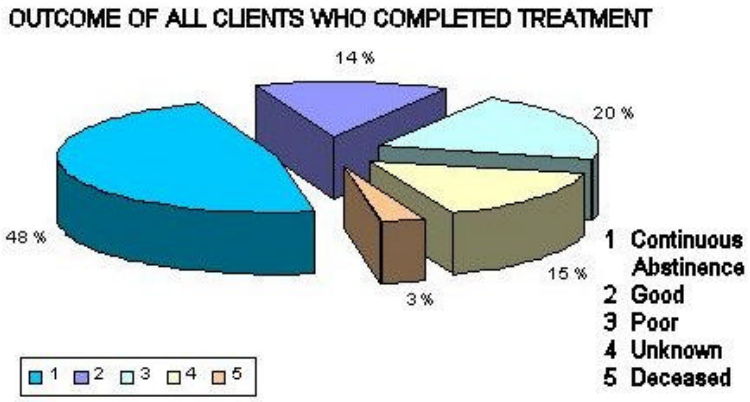
The profile of clients referred to the Extended Care Unit is of a severely dependent group who have undergone previous in-patient and out-patient treatments. 87% of the study group were classified severely dependent, 85% having undergone previous in-patient and out-patient treatments and 75% of the clients had had repeated hospitalisations for alcohol or drug related problems.

The outcome categories were defined as follows

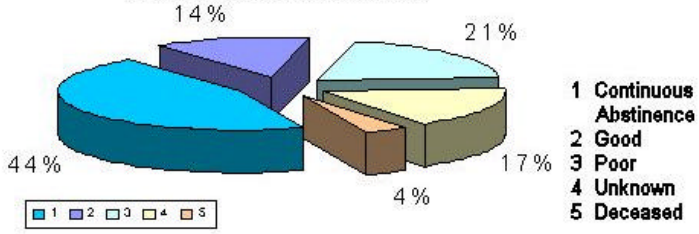
Continuous Abstinence:	Having consumed no alcohol, no drugs (including cannabis) since completing treatment.
Good:	No more than 3 relapses and continuously abstinent for at least 3 months before point of follow-up.
Poor:	Those drinking and/or taking drugs including those claiming an improvement in control of intake.
Unknown:	Despite several attempts to contact.

The following bar charts examine the responses to the follow up questionnaire completed for all traceable clients. This questionnaire asked the client or the clients contact person to answer a series of questions in order to grade the clients present physical health, mental health and general quality of life. The client or contact person made one choice between - much worse, worse, same, improved or much improved for each of the three areas.

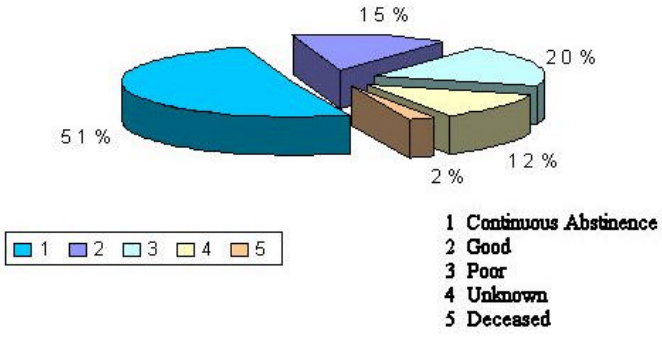
Alcoholics Anonymous and Narcotics Anonymous meetings attendance was also recorded in a similar fashion.



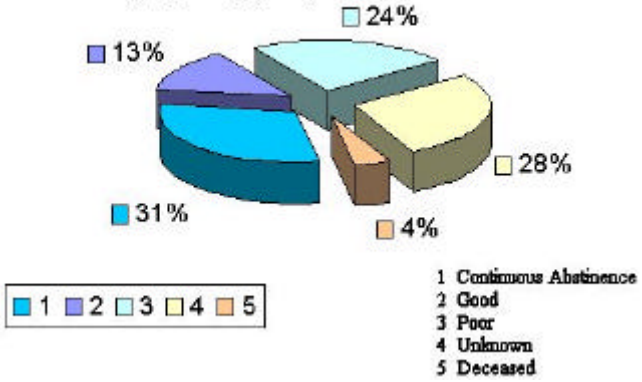
OUTCOME OF ALCOHOL DEPENDENT CLIENTS
WHO COMPLETED TREATMENT



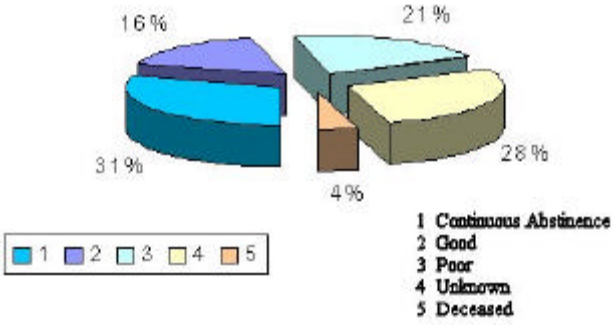
OUTCOME OF DRUG DEPENDENT CLIENTS
WHO COMPLETED TREATMENT



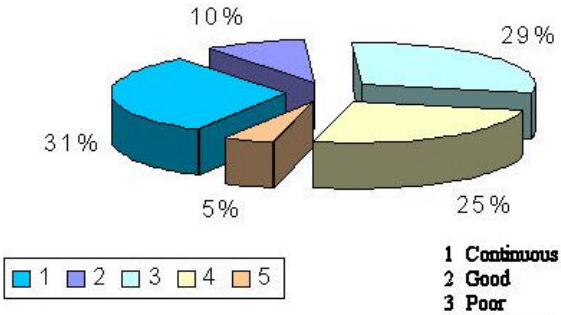
OUTCOME OF TOTAL SURVEY
Alcohol and Drug Dependency (N=206)



OUTCOME - ALCOHOL DEPENDENT (N=123)

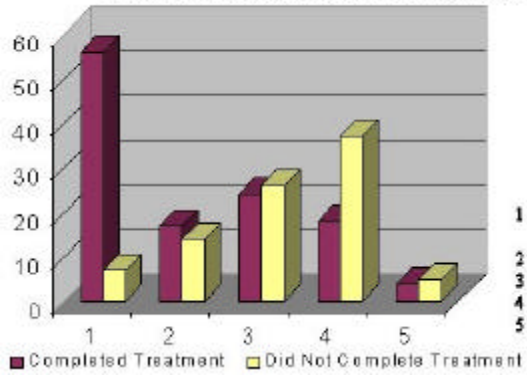


OUTCOME - DRUG DEPENDENT (N=83)



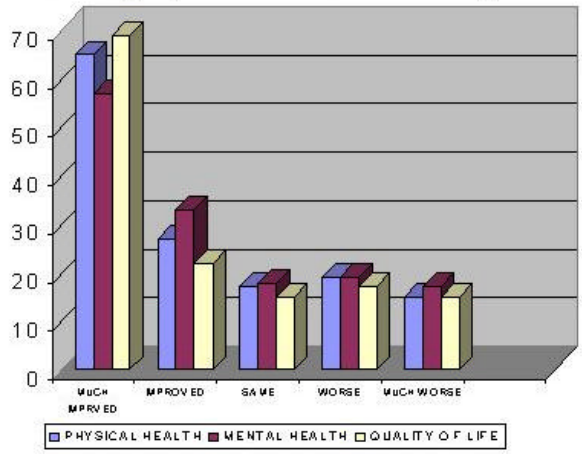
1 Continuous Abstinence
2 Good
3 Poor
4 Unknown
5 Deceased

CONTRAST BETWEEN THOSE COMPLETING TREATMENT AND THOSE NOT COMPLETING TREATMENT

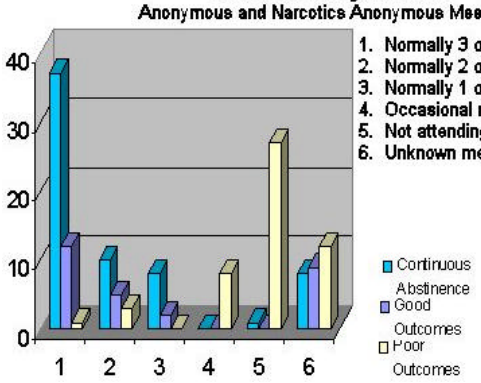


1 Continuous Abstinence
2 Good
3 Poor
4 Unknown
5 Deceased

COMBINED ALCOHOL AND DRUG DEPENDENCY
All Client responses
Measuring Physical and Mental Health and Quality of Life



Numbers Attending Alcoholics Anonymous and Narcotics Anonymous Meetings



1. Normally 3 or more meetings pw
2. Normally 2 or more meetings pw
3. Normally 1 or more meetings pw
4. Occasional meetings attendance
5. Not attending meetings
6. Unknown meetings attendance

RESULTS

This follow-up study focused on treatment outcomes for clients at the Castle Craig Extended Care Unit (ECU). The study focused on the outcome of 206 patients, who had been consecutively admitted to the ECU at Castle Craig, and all clients were included in the study, no one was excluded. The results of the study are shown in the included Pie Charts and Bar Charts. The mean time between patients leaving treatment and their entry into the study was 429 days.

The Results for Clients who Completed Treatment

The total number of patients who completed the recommended duration of treatment was 119. 48% of this group of treatment completers maintained unbroken continuous abstinence (from all drugs including alcohol and cannabis) and a further 14% were in a good outcome category abstinent at the time of follow-up. The abstinent and improved outcome figure for this group of treatment completers was 62%. The results, therefore, for this group of clients who completed an average of 17 weeks in extended care are very good indeed.

Overall 58% of alcoholics were classified abstinent/good outcome and 66% of addicts were classified abstinent/good outcome.

The Results of the Total Group

31% of the total group had achieved continuous unbroken abstinence, and an additional 13% of the total group were classified as in a good outcome category, i.e. no more than 3 brief relapses and with a minimum period of 3 months continuous abstinence prior to assessment. Many of these would have been abstinent for several months, a year or longer. The overall figure was 44% of abstinent/good outcome. Marked improvement in physical and mental health and quality of life was characteristic of those in this group.
47% of the total group of alcohol dependent clients were in an abstinent/improved category and 41% of the drug dependent clients were in an abstinent improved category.

DISCUSSION

Addiction is a treatable condition. The 12-Step treatment approach which is utilised at ECU is often referred to as Minnesota Model and has been extensively reviewed by Cook (Cook C. 1988). Twelve Step facilitation has been scientifically validated by Project MATCH a seminal research study, where patients were randomly assigned to three types of therapy.

A major task force report (the Polkinghorne Report) by the Department of Health (1996) emphasised the need for patients to have access to the type of treatment and level of care most likely to benefit them; there should be access to residential care and Minnesota model treatment was mentioned as one of the three main types of rehabilitation. This report was endorsed by the Scottish Office "Planning and Provision of Drug Misuse Services" (1997).

The results of this study have to be considered in the context that the vast majority of clients referred to extended care suffer from an additional significant co-morbid condition. Depressive illness, anxiety states, brain damage, post traumatic stress disorder and pathological gambling are often present. It is, in fact, as a result of the significant psychopathology, poor psychological and social functioning of these clients that referral to extended care was made in the first place.

The following table demonstrates demographic data from 100 consecutive admissions to primary treatment at Castle Craig Clinic during 1998.

DEMOGRAPHIC CHARACTERISTICS OF 100 PATIENTS ADMITTED TO CASTLE CRAIG PRIMARY TREATMENT

	%
Male	67
Female	33
Currently in a supportive relationship	22
Homeless/hostel/temporary accommodated	42
Unemployed	82
Psychiatric hospitalisation	55
Suicide attempt	67
General (medical) hospitalisation	76
Counselling, out patient treatment	80
Current family problems	61
Offending behaviour	65

Patients admitted to primary treatment in the main clinic are therefore at the severe end of the spectrum of chemical dependence. It is from this group that the most severely compromised are selected for referral to extended care.

This study firstly demonstrates the effectiveness of treatment. Secondly it shows that the longer our clients spent in treatment, completing the recommended course the better the outcome. 24% of non-completers compared to 62% of those who completed treatment were abstinent at the time of follow-up. Research in fact has shown that therapeutic communities and other types of residential programmes are effective in reducing drug use, unemployment and antisocial behaviour and length of time spent in treatment is an important predictor of client outcomes from these programmes (Bale et al 1980; DeLeon 1984; Hubbard et al 1989; Simpson 1979). An analysis of data collected from the Treatment Outcome Prospective Study (TOPS) confirmed again a strong relationship between time spent in treatment and clinical outcomes. The longer clients spent in treatment the less likely they were to use heroin, cocaine, marijuana and the more likely to be employed and to have committed no crimes during the previous year. (Condelli et al 1994) Simpson (1979) reported that clients needed to spend at least 90 days in residential treatment before they began to show reductions in opioid and non opioid use, arrests and unemployment. NTORS (NTORS Bulletin 4) identified that a critical period of 90 days in treatment was required to optimise outcome for drug misuers in long stay residential establishments.

More intensive treatment for alcohol dependent patients has also been found to be associated with better outcome by a number of researchers with higher abstinence rates and higher levels of non-problem drinking. (Feuerlein & Kufner 1989 Monahan & Finney 1996)

The results for drug misusers i.e. 41% abstinent in the Castle Craig study compare favourably with the 2-year outcome figures from NTORS (Bulletin 4) the largest ever UK study of treatment outcomes for drug misusers. This study reported that 37% of clients who had received residential treatment were abstinent from all illicit target drugs (these excluded cannabis and alcohol) at 2-year follow-up.
The NTORS report further concluded "that clients in residential programmes presented with some of the most severe problems and complex needs and these clients made some of the greatest treatment gains".

The study nevertheless draws attention to a weakness that requires our ongoing attention i.e. that a proportion of clients in extended care do not complete the recommended period of treatment. In accordance with our ISO 9002 Quality Assurance commitment audit of premature discharges and changes in treatment practice have led to improvements in client retention in ECU and in 1998 there was a 7% increase in completion of treatment by clients compared with the previous year. During the

following 6 months there was a further 9% increase in client retention compared with the previous year and a 16% increase in retention compared with the first year of the study. NTORS researchers conclude that prolonged treatment of several months may be needed to consolidate the therapeutic gains and rather than reducing the treatment duration attempts should be made to maximise cost effectiveness of services by increasing rates of client retention. (Gossop M. et al 1999)

CONCLUSION

Alcohol and drug addiction are major public health problems. Evidence of increasing alcohol related health damage is shown by the steep rise in admissions to general hospitals in Scotland for patients with alcohol related diagnoses during the period 1983-1995. During this period there was a 5-fold increase in admissions for alcohol abuse and a 3-fold increase for alcohol dependence with a doubling of death rates for men and women for alcoholic cirrhosis, (Chick J. (1997). There has been a 6-fold increase in the number of new addicts in Scotland since 1989 the epidemic bringing with it the additional health problems of hepatitis C and HIV.

Purchasers are often sceptical about the benefits of treatment and society's expectations of treatment effectiveness are often too high. Effective treatment does not always mean cure, especially in the case of a relapsing illness such as addiction but there is evidence that treatment does make a difference in lowering crime rates and containing health care costs.
The costs of alcohol misuse in the UK are in the region of 2 billion pounds per annum. Treatment is costly and there are many studies which point to the financial benefits of treatment.

Studies in the US have shown a saving of $6 and more for every $ spent on treatment (Gerstein et al 1994; Finigan 1996; Ohio Dept of Alcohol and Drug Addiction Services 1996). NTORS showed that for every extra £1 spent on drug misuse treatment there is a return of more than £3 in terms of cost savings associated with lower levels of crime.

It has become increasingly difficult in the present climate to justify inpatient treatment and there is pressure from funding authorities to reduce the length of treatment. Determining suitability for inpatient and residential treatment and the duration of stay should, however, be related to the severity of the condition and outcome results.

The results of this study show that abstinence and "success" for a group of severely dependent patients are clearly facilitated by completion of the period of treatment that is considered clinically appropriate, with a significant enhancement of outcomes for both addicts and alcoholics.

Very short periods of stay in a primary or secondary care unit are only cost effective when the decrease in stay is clinically appropriate. When patients are discharged too soon the reduced stay is not clinically advantageous, as the study shows, and could, in fact, be a waste of financial resources.

In summary: 44% of a total group of severely alcohol and drug dependent clients, classified as severely dependent, with significant health and social problems, and 62% of treatment completers were in an abstinent/good outcome category at follow-up. Clients in these groups also reported marked improvements in physical and mental quality of life. These results are encouraging and suggest that Castle Craig offers cost effective treatment for clients with severe dependence and social deprivation.

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