1.6 US study establishes optimal durations for drug detoxification and rehabilitation

Findings A new computerised information network provided the opportunity to track clients across practically the entire publicly funded alcohol and drug treatment system in Boston (USA). This system deals predominantly with poor clients lacking private health insurance.

The data was used to establish whether cut-off points could be identified beyond which longer treatments were not associated with higher rates of treatment completion as judged by the therapeutic staff. Over 5000 discharges from each of four treatment types were studied. Cut-off points were: residential detoxification, six days; short-term residential treatment, 26 days; long-term residential, 120 days; long-term outpatient (excluding methadone maintenance), 140 days.

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It was reasoned that if treatment completion leads to better outcomes, this should be reflected in the readmission patterns of clients retained for at least these durations. Subsequent detoxes were considered an indication that the previous treatment had failed. Similarly, any readmission following long-stay programmes indicated unsuccessful rehabilitation. In contrast, admissions to longer term therapy after detox or short programmes indicated successful preparation for rehabilitation. Readmissions consistently matched these expectations. For example, after under 120 days in rehabilitation 48% of clients had to be detoxed over the next two years compared to 29% after longer stays.

In context The study attempted to reconcile treatment retention as an indicator of success with the pressure from US medical insurance companies to cut costs by curbing lengths of stay. In the UK similar pressures (especially on residential rehabilitation) arise from community care funding and health authority stringencies. The findings suggest that a treatment duration can be established below which cutting scheduled programmes imperils outcomes, while on average longer lengths do not confer greater benefits. However, optimal lengths differ for different programmes. Other US research indicates that the benefits of residential treatment can survive even radical cuts in length, perhaps because regimes are restructured such that treatment progress and completion are achieved in a shorter time.

Practice implications Limiting programme lengths without restructuring regimes to maintain completion rates (or cutting lengths beyond the point where completion rates *can* be maintained) could be counter-productive, even in the narrow sense of later costs due to readmissions. However, beyond a certain level, simply staying longer in a programme does not buy additional benefits. Drug misuse databases in the UK could be adapted to empirically establish such cut-off points rather than imposing purely cost-driven limits. The proportion of clients achieving these optimal lengths of stay would be a more meaningful proxy for treatment success than treatment duration *per se*.

Main sources Shwartz M., Mulvey K.P., Woods D., *et al*. "Length of stay as an outcome in an era of managed care. An empirical study." *Journal of Substance Abuse Treatment*: 1997, 14(1), p. 11–18. Copies: apply Alcohol Concern or ISDD.

Contact Professor Michael Shwartz, School of Management, Boston University, 595 Commonwealth Avenue, Boston, MA 02215, USA. E-mail mshwartz@bu.edu.