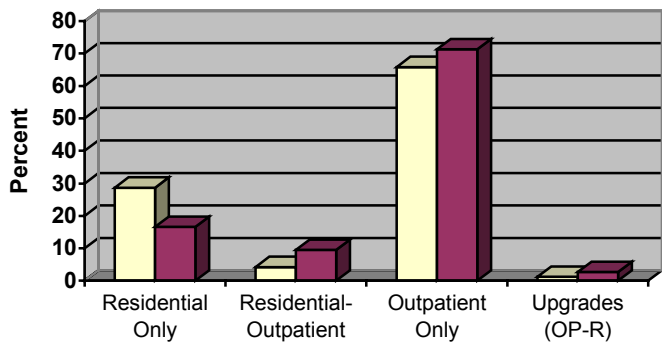


Effect of Managing Treatment on Continuity of Care

In late 1997, DADS initiated changes in the adult system of care. By striving to treat clients in programs that were most suited to their needs, it was the expectation that client outcomes would be enhanced at the same time that costs were contained. Traditionally, clients were admitted to residential programs alone and stayed until rehabilitation was complete, or they were admitted to outpatient programs alone. With the new system and its centralized intake, only clients with the highest needs would receive residential placement, and residential services would be provided for a shorter period, only as long as needed to stabilize the client. Following residential care, the client would be transferred to outpatient care to complete rehabilitation. Transitional housing was made available to those who were homeless or living in unsafe living environments, but whose level of treatment need was for outpatient services.

Figure One.
Adult Clients by Treatment Pattern



Research shows that remaining in treatment for 90 days or more is a strong predictor of positive treatment outcomes. Figure Two shows that continuity of care is associated with longer treatment stays. Clients who begin in residential treatment have been assessed to be in the most need for treatment, hence their lengths of stay extend well beyond 90 days when they go from residential to outpatient level of care. However with residential care alone they are well under the recommended standard. Clients originating in outpatient services stay somewhat fewer days on average, in keeping with their lower assessed need. In contrast, the small number of Upgrades appear to be most complex and have the longest average treatment stay. With the increase in numbers receiving continuity of care, it is clear that overall our clients now have a higher probability of success following treatment.

Outpatient treatment is the starting point for most of our clients, accounting for 67% of all clients in the first year of managed care, 1997, and 74% in 2001. However, what happened to those clients who started treatment at a more restrictive level of care, such that continuity of care from residential to outpatient programs was expected? Figure One shows that among those clients whose care originated with residential services, continuity of care from residential to outpatient services occurred for 13% of the clients in 1997 and 36% in 2001. Continuity in terms of upgrades from outpatient to residential care increased but remain a small number. Continuity of care has increased, although much work remains to be done.

Figure Two.
Average Length of Stay By Treatment Pattern

