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The History and Future of “Aftercare”

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At its best, modern state-of-the-art addiction treatment involves a sequenced process of screening, assessment, therapeutic intervention (often involving multiple levels of “stepped down” care), and relatively brief “aftercare” services that often include referral to mutual support groups. This model of care is successful for many clients, but a substantial percentage of clients, following only one or two levels of care, experience relapse and repeated admissions to acute treatment. This acute model of intervention and brief aftercare is being challenged by findings from the literature on chronic disease management as well as by a group of addiction treatment researchers who are advocating new models of sustained recovery management. In this article, we will review the history of aftercare, highlight lessons from recent continuing care research, and offer our vision of the future of continuing care as a concept and a clinical activity.

Aftercare: A Brief History¹

America’s first addiction treatment programs—the nineteenth century inebriate homes, inebriate asylums and the for-profit cure institutes—were spawned by, or themselves spawned, recovery mutual aid societies, e.g., Washingtonian Temperance Society, Ollapod Club, Godwin Association, Ribbon Reform Clubs, and the Keeley Leagues. As inebriety specialists came to recognize the high rate of post-institutional relapse, they intensified linkages to these societies and began to organize their own systems of patient follow-up. Many medical superintendents maintained a prolific correspondence with former patients that evolved into the first institutional alumni newsletters.

Efforts to provide extended professional support following treatment remained weak until the Massachusetts Hospital for Dipsomaniacs and Inebriates established 29 outpatient clinics in 1906. These clinics marked the beginning use of outpatient treatment as a transition between institutional sequestration and re-entry into community life. The outpatient clinic model was further developed

¹ This historical synopsis is abstracted from White (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery*.

when the Emmanuel Clinic (Boston) started a social fellowship (the Jacoby Club) to support alcoholics during and after their treatment. Following its founding in 1935, Alcoholics Anonymous increasingly served as an after-treatment support structure for the early hospitals with which it collaborated. Recovering entrepreneurs began to organize AA Farms and AA Retreats that evolved into private treatment centers and halfway houses.

Mid-twentieth century follow-up studies of narcotic addicts treated at the two federal narcotics hospitals revealed post-treatment relapse rates of more than 90 percent. This led to a call first for aftercare clinics that would follow-up such patients, and then to a call for the development of local, community-based treatment programs. Civil commitment programs in California, New York and Illinois also suffered from high post-treatment relapse rates during their heyday in the 1960s. Again, the absence of effective post-treatment aftercare services was cited as a primary causes of their failure.

The need for post-treatment support services was also recognized within the residential model of alcoholism treatment that emerged in Minnesota in the late 1940s and 1950s. It became clear that there were many clients treated at Pioneer House, Hazelden and Willmar State Hospital who needed much more support than A.A. alone could provide. This triggered the growth of halfway houses linked to these treatment facilities and new systems of post-institutional follow-up such as the first full-time traveling aftercare workers.

All of these events created a clearer vision of the need for post-treatment support services and assured that aftercare would be a point of discussion in the design of local programs of the 1960s and 1970s. Two additional influences on this continuing history were the subsequent development of a “step down” approach to treatment reflected in the placement criteria of the American Society of Addiction Medicine, and the first rigorous research on the effects of post-treatment support services (reviewed by Donovan, 1998). The former shifted the addiction field’s thinking from “aftercare” to “levels of care” and “continuing care,” and the latter underscored the importance, timing and ideal nature of post-treatment support services.

Seven Lessons from Continuing Care Research

Several conclusions can be drawn from recent research studies on continuing care services.

1. Addiction treatment is marked by a high post-discharge relapse and readmission

rates.

Of people admitted to public treatment in the U.S., 60% have been in treatment before (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). The future window of opportunity lies in monitoring client progress and intervening in the time between these treatment admissions.

2. Most people completing addiction treatment are precariously balanced between continued recovery and re-activation of addiction. Short-term abstinence is not predictive of long-term abstinence; recovery from addiction is not stabilized (point at which risk of relapse dramatically declines) until four to five years of symptom remission (Jin, et al., 1998). This suggests the need for monitoring and sustained recovery support services during the early years of recovery.
3. Post-treatment utilization of continuing care services is low, with studies showing that as few as 20% of clients attend two or more continuing care groups in the month following their discharge (Donovan, 1998).
4. The window of greatest vulnerability for relapse for most clients is the first 30 days following discharge from primary treatment. In Project MATCH, 50% of the clients in the outpatient study arm had their first relapse within 30 days after discharge from treatment (Babor, et al., in press). In a randomized study of adolescent continuing care services, 52% of the “usual continuing care” group relapsed compared to only 31% in the “assertive continuing care” group in the 30 day window following discharge from residential treatment (Godley, et al., 2002). Taken together with Donovan’s findings that relatively few clients have a significant aftercare experience, these studies suggest the need for more effective linkages to continuing care services immediately following discharge from primary treatment.
5. Continuing care services vary widely across treatment programs. Among the most typical of such services are step-down to lower levels of care, continuing care-orientation groups, brief or extended professionally-directed continuing care groups, passive or active referral to mutual aid groups, peer-based recovery support services (e.g., alumni activities), and linkage to recovery homes (or other transitional living environments) (Donovan, 1998).
6. Active participation in mutual aid groups such as Alcoholics Anonymous are associated with decreased substance use and increased emotional health (Montgomery, et al., 1997), but these potential benefits are limited by low rates of post-treatment mutual aid affiliation and high rates of attrition following initial mutual aid exposure.
7. While controlled studies have produced mixed findings on the efficacy of

continuing care services (McKay, 2001), more intensive approaches can increase post-treatment continuing care participation and improve clinical outcomes (Godley, et al., 2002). Such assertive approaches shift the responsibility for continued contact from the client to the counselor and involve extended telephone follow-up and home visits for monitoring, support, and early re-intervention (Stout, et al., 1999; Godley, et al., 2002; Dennis, Scott, & Funk, in press). Continuing care interventions using behavioral (contingency) contracting, family involvement, case management, couples relapse prevention groups, and the community reinforcement approach also show promise (Donovan, 1998; Godley, et al., 2002).

The Future of Continuing Care

Addiction has been treated in America for more than 200 years with the expectation that a brief intervention combined with brief “follow-up” or “aftercare” could generate sustained recovery. There is growing recognition that this model is insufficient for many clients, particularly those who present with high problem severity and chronicity, high rates of co-occurring problems, and low family and social supports (McLellan, et al., 2000). What is being advocated for such clients is an alternative model of sustained recovery management (White, Boyle, & Loveland, in press; Stout, et al., 1999) that wraps acute interventions within a larger and more sustained continuum of pre-treatment, in-treatment and post-treatment recovery support services. The recovery management model provides acute detoxification and stabilization but places its greatest emphasis on sustained and assertive monitoring and feedback; peer-delivered recovery education and coaching (support and problem-solving), ongoing linkage to indigenous systems of support, enrichment of the post-treatment recovery environment (family, social network, school/workplace, and community), and, when necessary, early re-intervention to minimize the harm from relapse and to re-initiate the recovery process (See www.bhrm.org for details).

This emerging model of recovery support services will need to be rigorously evaluated to determine what unique combinations and sequences of services generate the best long-term recovery outcomes. Recovery management calls not for larger doses of traditional services but earlier intervention and more sustained intervention using assertive outreach methods to keep clients engaged. In particular, the model extends the duration of post-treatment support services, intensifies those services during windows of initial and subsequent vulnerability, and moves the locus of recovery support from the treatment environment to the

natural environment of the client. The management of all chronic disorders is expensive, but advocates of recovery management suggest that sustained support may provide a less expensive and a more clinically effective alternative to recycling people through multiple episodes of acute treatment. Future research will determine if this new vision of continuing care and these new experiments in recovery management are capable of producing improved clinical outcomes and a better stewardship of community resources.

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