Godley, M. & White, W. (2011) Telephone recovery checkups: An assertive approach to post-treatment continuing care. *Counselor*, 12(4), 28-31.

Telephone Recovery Checkups: An Assertive Approach to Post-Treatment Continuing Care

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Follow-up studies of addiction treatment confirm the generally positive effects of acute treatment episodes, but these same studies also document wide variability in post-treatment adjustment and the erosion of treatment effects over time. Studies of the potentially prolonged course of severe alcohol and other drug (AOD) problems (sometimes referred to as "addiction careers") combined with studies confirming the high rates (more than 50%) of resumed AOD use following treatment and high rates of multiple treatment admissions (64% of all patients entering treatment) have produced two significant shifts in the field. The first is a more clinically sophisticated conceptualization of addiction as a potentially chronic disorder (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000; White & McLellan, 2008); the second is a call to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (White, 2008).

Recovery management calls not for larger doses of traditional services, but earlier and sustained intervention using assertive outreach methods to keep patients engaged. In particular, the model extends the duration of post-treatment recovery 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 patient (White & Godley, 2003). A distinguishing feature of recovery management is its emphasis on post-treatment monitoring, support, and early re-intervention as continuing care/recovery management strategies (Kelly & White, 2010).

This article will 1) review the state of continuing care following addiction treatment in the U.S., 2) summarize the findings of a randomized controlled trial of telephone-based continuing care, and 3) discuss emerging and future innovations in continuing care.

The State of Continuing Care

A review of research studies (White, 2008) related to the need for and effects of continuing care following addiction treatment leads to five primary conclusions.

1. People discharged from addiction treatment are precariously balanced between continued recovery and resumption of AOD use.
2. The risk of resumed AOD use is highest in the first 90 days following completion of treatment, but the risk of future lifetime relapse does not subside below 15% until one reaches 4-5 years of sustained recovery (Jin, Rourke, Patterson, Taylor, & Grant, 1998).
3. Continuing care in the form of post-treatment monitoring and support can enhance long-term recovery outcomes in both adults (Scott, Dennis, & Foss, 2005; McKay et al., 2010) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007; Kaminer, Burleson, & Burke, 2008).
4. Practices related to post-treatment continuing care vary widely across treatment programs, but national data reveal that only a small percentage of patients admitted to treatment receive structured, intensive, and sustained post-treatment support.
5. Many addiction treatment programs rely almost exclusively on participation in recovery mutual aid groups to support their patients in the transition from recovery initiation to recovery maintenance, but this strategy is undermined by low rates of linkage/affiliation and high rates of attrition over time.

The lack of sustained monitoring and recovery support services in contemporary addiction treatment programs and the resulting consequences in terms of compromised recovery outcomes have led to calls for assertive approaches to continuing care. These approaches:

- encompass all admitted patients/families, not just those who "successfully graduate";
- place ultimate responsibility for post-treatment contact with the treatment institution, not the patient;
- provide continued support in a mix of professional and peer-based formats;
- involve both scheduled and unscheduled contact;
- capitalize on temporal windows of vulnerability (e.g., the first 90 days following treatment) and increase monitoring and support

- individualize and vary the duration and intensity of checkups and support based on each patient's changing problem severity and recovery capital (personal and environmental resources to prevent relapse and build a rewarding life free of alcohol and other drug use);
- utilize assertive linkage rather than passive referral to communities of recovery;
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support, and a growing array of internet-based resources;
- emphasize support contacts with patients in their natural environments;
- may be delivered either by counselors, recovery coaches, or trained volunteer recovery support specialists; and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time.

Studying assertive approaches that rely on lower-cost telephone- and internet-based interventions is critical since sustaining the above-described approaches can be costly, particularly if done on a face-to-face basis over an extended period of time.

Testing the Effectiveness of Telephone-Based Continuing Care

Several researchers have suggested the untapped potential of telephone-based continuing care following addiction treatment (See McKay, 2009 for an excellent review). In addition to being less costly to deliver, telephone-based approaches offer several potential advantages to patients, including

- convenience (less disruption to daily life),
- cost (no travel or child care),
- safety (for patients in high-risk environments),
- accessibility (reaching patients in remote areas or who face transportation challenges),

- adaptability (varying length of contact based on patient need at moment of contact),
- timing (either patient or support worker can initiate calls at or around high-risk times or places if GPS-enabled smartphones are used), and
- amplification effects (e.g., combining telephone-based support with face-to-face meetings to strengthen therapeutic alliance, lower dropout rates, and enhance recovery outcomes).

A recently published study tested the potential effectiveness of telephone-based continuing care following addiction treatment (Godley, Coleman-Cowger, Titus, Funk, & Orndorff, 2010). In this study, 104 adult patients were randomly assigned to either usual continuing care (UCC) consisting of weekly outpatient gender-specific group counseling facilitated by a master's level clinician, or telephone continuing care (TCC) consisting of weekly telephone support provided for a 90-day period by a paraprofessional staff member or volunteer with a bachelor's degree in a human service field. To make sure that those who left residential treatment prior to program completion had the opportunity to participate in continuing care, informed consents to participate in the study and random assignment to condition were completed during the first week of residential treatment.

The study participants averaged 31.6 years of age, were predominately male (60%) and Caucasian (76%), with high problem severity (85% meeting criteria for alcohol, cannabis, cocaine, or opioid dependence), high problem complexity (78% reporting symptoms consistent with one or more co-occurring mental disorders) and chronicity (63% reporting use before age 15; 64% reporting prior addiction treatment). The average length of treatment for the study population was 24 days and 86.5% successfully completed residential treatment. The only significant difference between those assigned to UCC and TCC was a higher rate of use and physiological dependence by the TCC group. Paraprofessional staff and volunteers working within the TCC condition made weekly 10- 20-minute calls following a standard protocol that prescribed both the content (review of recovery status and recovery support activities, problem solving, and recovery planning) and tone/style (supportive, non-confrontational) of the call. Fidelity to the TCC protocol was monitored through audio-recording of calls and a review of random tape recordings during weekly supervision.

Outcomes across the two conditions were measured by use of the Global Appraisal of Individual Needs (GAIN), self-reported days abstinent and substance problem behaviors at 3 and 6 months post-discharge, as well

as urine screening and patient satisfaction with the TCC condition. There were three major findings from this study.

1. Those assigned to the telephone continuing care group were significantly more likely to receive continuing care sessions compared to those in the usual continuing care, face-to-face, group-based format.
2. At the 3-month follow-up, the TCC condition had significantly fewer substance-related problems, and a comparison of lower severity patients showed even more improvement in both increased days of abstinence and decreased substance-related problems. Because this was a short-term feasibility trial, the continuing care support calls were stopped after 3 months and statistically significant improvements for the TCC condition were no longer present at the 6-month follow-up. These findings are encouraging but suggest the need for longer duration of continuing care calls.
3. Most (89%) of the patients participating in the TCC condition liked receiving the calls from their telephone support counselor and felt the time spent on each call was "just right" (91%). Most importantly, patients felt the calls should be extended beyond 3 months (72%).

The Future of Continuing Care Following Addiction Treatment

If there is a new frontier of addiction treatment, it is in extending the effects of treatment through assertive and other innovative approaches to sustained recovery management for months and years following recovery initiation. There seems to be unlimited potential in the use of new technologies of recovery support to achieve this goal. We anticipate the dramatic growth of telephone- and internet-based recovery support services in the near future. For example, there are already continuing care/recovery support applications for smartphones that will link patients to a listserv, allow them to assess their risk and protective factors in real time, and to request a call from a recovery support counselor (Gustafson et al., 2011). Another recent innovation is to hold continuing care groups on Second Life where both patients and therapist come together at a designated time via their personal avatar (Dillon, 2010). It is important that these and future developments are guided by methodologically sophisticated studies that can evaluate their degree of effectiveness across demographic and clinical populations, with an emphasis on understanding which subgroups of patients may benefit from which approaches. For example, in the present study, we

found that lower severity patients may have benefitted more than those with higher severity. Future studies should also focus on whether telephone and other technologically sophisticated approaches remove known service access disparities for special populations (e.g., rural and remote populations).

In this shift from acute stabilization to recovery maintenance and enhanced quality of personal/family life in long-term recovery, there are a number of very important unanswered questions, including:

- How can the "active ingredients" of these recovery support services be isolated, amplified, and combined or sequenced to enhance long-term recovery outcomes?
- How can the emerging recovery support technology be individualized to respect patient preferences and optimize clinical effectiveness?
- How long should such services be provided, can we reliably maintain longer-term contact with most patients, and what role do patient preferences play in successfully achieving optimal duration of service?
- By whom are these services best provided (professional versus peer models) and through what type of organizational settings (e.g., addiction treatment organizations, managed behavioral health care organizations, grassroots recovery community organizations)?
- What financing models will support the growing emphasis on sustained recovery management services?

Answering such questions will require the deep involvement of addiction professionals, addiction researchers, and listening carefully to the voices of individuals and families spanning multiple stages of long-term recovery. Many addiction professionals are stepping forward to explore this new frontier, and their practice and research will define the future direction of long-term addiction recovery management and support.

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Acknowledgement: The research for this paper was supported in part by the National Institute on Alcohol Abuse and Alcoholism grant 2 R01 AA010368. This paper was supported in part by SAMHSA contract HHSS283200700061 Westat Subcontract s8440, Recovery Supports for Adolescents and Families. The views expressed in this paper are the authors

and do not necessarily reflect the views or policies of the Department of Health and Human Services.

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