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The first 90 days following release from jail: Findings from the Recovery Management Checkups for Women Offenders (RMCWO) experiment.

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Drug and Alcohol Dependence: 2012, 125, p. 110–118.

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For the first time regular checkups to promote treatment re-entry have been tried with an all-female problem substance user caseload, and one leaving prison rather than community-based treatment. Over the first three months more returned to treatment more promptly. Previous studies suggest this will lead to reduced substance use, crime and HIV infections.

SUMMARY Most of the vulnerable population of women held in local US jails engage in a range of activities that put them at high risk of relapse to problem drug and alcohol use and of contracting or spreading HIV. As a result, female offenders are twice as likely to have HIV/AIDS as male offenders and over seven times more likely than women in the community. They are also at high risk of relapse to substance use, HIV infection, and re-incarceration on release from prison. Studies mainly involving men show that post-release participation in community-based substance use treatment can help avoid these problems. But the vast array of competing needs faced by women leaving prison often prevent access to and retention in community-based treatment, resulting in relapse and poor outcomes.

Other chronic medical conditions are managed by ongoing monitoring and early re-intervention techniques to bring patients back in to active treatment as needed. In response to calls to move to a similar model for substance use, the research team responsible for the featured study developed and tested the 'Recovery Management Checkup Model'. Rather than relying on participants to identify their symptoms and return to treatment, pro-active quarterly assessments offer them personal feedback on the status of their condition, and motivational interviewing techniques involve them in decision-making about their care, helping resolve ambivalence about substance use and promoting commitment to change through treatment or some other recovery support.

Key points

The US 'Recovery Management Checkup Model' uses regular proactively arranged assessments to promote treatment re-entry among problem substance users.

For the first time this trial tested the system with an all-women problem substance user caseload and one leaving prison rather than community-based treatment.

Over the first three months after release more returned to treatment more promptly; past trials suggest continued checkups will lead to reductions in substance use and related problems.

However, these reductions have previously been modest and achieved via a system which may be difficult to implement outside the context of a well controlled and resourced research trial.

The checkups have been tested as a follow-up to community-based treatment in two clinical trials (1 2 3), which found they promoted treatment re-entry, and after two years led to significantly more days of abstinence and fewer past-month symptoms of abuse/dependence.

The featured study extended this work to an all-female caseload leaving not community-based treatment, but a prison which specialises in substance use treatment for female offenders. Given a high potential for relapse and recidivism during the 90 days after release, checkups were scheduled for 30, 60, and 90 days post-release, the period covered by this study. Further checkups were planned every three months. The high risk of HIV infection led to the inclusion of HIV intervention component.

After being assessed by researchers at release from prison and then re-assessed at the times set for the checkups, the 238 women randomly assigned to the checkups were scheduled to met with their 'linkage managers' for feedback on their progress, discussion of ways to promote recovery and reduce risk and related barriers, and motivation for change. At the post-release meetings, women who reported substance use were scheduled treatment appointments to which the linkage manager accompanied them and which they attended. Linkage managers also sought to promote retention – for women entering detoxification, by calling or visiting them daily until they moved to the next level of care, and after treatment entry, through phone calls and face-to-face visits during the first 14 days. Linkage managers were notified by treatment staff if a woman threatened to leave or missed an appointment, and arranged an intervention to re-engage the woman in treatment. Alternative action plans were developed for women who refused treatment. Women doing well were led to consider how their lives had improved and how in the next 30 or 60 days to maintain their recovery.

The remaining 242 women were randomly allocated to usual care and research assessments only, which were not followed by checkups.

All 480 women in the study had symptoms of abuse or dependence before being imprisoned, 94% had previously been treated for addiction, and 80% met criteria for dependence, most often on opioids and/or cocaine. Typically they were unmarried black women with children who had been in prison before and were now imprisoned for substance use offences. All but a few agreed to join the study and nearly

all could be followed up by researchers at the final 90-day assessment. The analysis of outcomes was based on the 462 women with at least one follow-up re-assessment.

Main findings

Only 2% of the women allocated to these did not attend any post-release checkups and 83% attended all three. During 48% of the 885 linkage meetings, women were identified as in need of treatment, and on 63% of these 429 occasions they agreed to go, resulting in 149 treatment intakes and 48 treatment episodes lasting at least two weeks.

Overall 77% of the women had returned to alcohol or drug use during the 90 days of the follow-up period, the vast majority within the first month. At each follow-up, proportions shown by urine test or self-report to have used drugs or alcohol were virtually identical whether or not the women had been allocated to checkups, and neither were there statistically significant differences in the proportions abstinent from each of the drugs assessed by the study, who engaged in behaviours which risked HIV infection, or who returned to crime or prison.

However, the checkups did significantly promote treatment uptake, which was in turn significantly associated with better outcomes. During the 90 days after their release, 55% of women allocated to checkups entered treatment compared to 45% without checkups. On average women allocated to checkups returned to treatment 60 days after release, the usual-care group, 90 days. Women who received any treatment during this period were more likely than those who did not to be abstinent from any alcohol or drug use (34% v. 12%) and more likely to have avoided using alcohol, cannabis, cocaine or (non-significantly) opioids. They were also less likely to have injected but no less likely to have engaged in unprotected sex.

The authors' conclusions

The high follow-up and intervention participation rates observed in this trial demonstrate the feasibility of engaging female offenders in monthly checkups following release from jail. Women who received checkups were more likely to participate in community-based substance use treatment and did so sooner than women not offered checkups. These findings provide support for using the Recovery Management Checkup Model as an intervention which neither threatens punishment nor involves criminal justice pressure, but which nevertheless successfully links female problem drug users to community-based treatment on release from prison.

Lack of significant effects of the checkups on substance use, crime and HIV risk is in line with previous trials of the approach, which found it required multiple exposures to checkups over 12–18 months before they were associated with increased abstinence. The featured study will continue to offer checkups for three years after release and may in future see improved outcomes. However, it may also be that additional or different types of treatments are needed.

It should be acknowledged that these results derive from just one large urban jail with a predominately minority female population, and needs to be replicated with more diverse sites and populations.

COMMENTARY See this analysis of one of the earlier trials of the same checkup system for a commentary on the methodology of the trials and the checkups, probably also relevant to this new application of the approach.

Among the comments made were that the checkups did (as in the featured study) help re-engage patients with treatment, especially when in the second of the two previous trials assessment, transport and treatment engagement procedures had been improved, but the gains in respect of substance use or problems seemed modest. In the second trial, by the last three months of the four-year follow-up, checkup patients had used substances and/or used heavily or experienced problems related to that use on fewer days than control group participants, but the difference was just 0.10 v. 0.13 on a scale of 0–1. They had also more often been abstinent, but just on seven more out of the 90 days, and over the final month of the follow-up had experienced fewer problems related to substance use, a difference of 1.4 v. 2.3 on a scale which reached up to 16.

Presumably checkups work best when there are adequate services for patients to re-engage with. In the featured study it seems disappointing that the 429 times women were assessed as needing treatment resulted in just 48 treatment episodes lasting at least a fortnight. Two-thirds of the women's tries at treatment lasted less than two weeks – given their daunting and multiple problems, likely to be entirely inadequate. In the face of such problems, brief episodes of resumed care focused on substance use perhaps for some missed the mark. Repeated access to episodic substance use treatment is in these circumstances more a sign of the intractability of the patient's situation than a way to lastingly resolve it, perhaps why success in encouraging treatment re-uptake has not in any of the trials to date been matched by a similar degree of success in curbing substance use problems.

Also questionable is whether in routine, real-world use, the check-ups would work as well as they did. Such gains as there were resulted from specially trained staff using a standardised and supervised protocol who in the featured study reached a high degree of competence in motivational interviewing. In this trial as in previous trials, research staff paved for the way for later follow-ups by verifying potential contact points and carefully preparing the patient, their nominated associates, and the agencies they were likely to be in touch with, so they would respond to later re-contact attempts. Also the interventions took place during visits when research data was collected. Again as in previous trials, these poor participants were paid for the research interviews and could earn up to 845 US dollars, a considerable incentive; presumably fewer would have attended either the research assessments or the following checkups without these incentives.

The intervention in the featured study has been costed. The research-related costs of tracking and interviewing participants amounted to 81 US dollars (2010 prices) per quarter per participant, and the checkups themselves added another 56 dollars – in total a fraction of the cost of probation- or parole-based follow-up, and figures which even small gains in crime reductions and HIV infections would easily match.

UK policy stresses lasting treatment exit, not return

The checkup system in the featured report was intended to move (in a way feasible for patients and services) towards matching the chronicity of the vulnerability of patients with an equally long-term support system. Though advocated by the researchers in the name of 'recovery' from addiction, in

Britain policy based on the same overarching concept is less encouraging of extended treatment contact than in the pre-recovery era when guidance stressed the need for aftercare following residential rehabilitation and for continued post-detoxification treatment. Even then, in practice long-term continuing care or aftercare was patchy and post-residential care plans relied mainly on mutual aid groups. With the encouragement of national caseload and retention targets, opiate substitute prescribing based largely on oral methadone was the mainstay of longer term care.

From the late 2000s, in theory the recovery vision and associated understandings of addiction extended the horizon beyond treatment episodes restricted in space (as at a clinic) and time to the world the patient must return to after treatment, but at the same time the resources to forge and maintain those extended links became more restricted. New commissioning guidance continued to mention "aftercare support services" but as a "supplement" to mutual aid groups and recovery networks, on which greater stress was placed along with "planned exits" from treatment.

However, in the criminal justice context, the seemingly low cost of the Recovery Management Checkup Model might commend it as a template for community rehabilitation companies which share responsibility with the probation service for the rehabilitation of offenders leaving prison, including substance misusers serving short sentences and now subject to the extended period of licence supervision under the 2014 Offender Rehabilitation Act.

Thanks for their comments on this entry in draft to Tim McSweeney of HM Inspectorate of Prisons in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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