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This is the abstract of a study selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the United Kingdom. It was not published by Drug and Alcohol Findings. Unless permission has been granted, we are unable to supply full text. Click on the Title to visit the publisher's or other document supplier's web site. Other links to source documents also in blue. Hover mouse over orange text for explanatory notes. Free reprints may be available from the authors - click Request reprint to send or adapt the pre-prepared e-mail message. The abstract is intended to summarise the findings and views expressed in the study. Below are some comments from Drug and Alcohol Findings.

▶ Promoting continuing care adherence among substance abusers with co-occurring psychiatric disorders following residential treatment.

DeMarce J.M., Lash S.J., Stephens R.S. et al. Request reprint

Addictive Behaviors: 2008, 33, p. 1104–1112.

Further analysis of findings from a US inpatient centre shows that systematically applying simple prompts and motivators especially and substantially improved aftercare attendance among patients with mental health problems, helping sustain progress made during initial treatment.

Abstract This entry provides new information from a study previously analysed by Findings. For more details see the earlier report.

The Salem Veterans Affairs medical centre offers a 28-day residential rehabilitation programme to its alcohol and/or drug dependent ex-military patients. To sustain sobriety, staff stressed the importance of aftercare, but attendance was poor. A series of studies had previously shown that attendance radically improved as step by step researchers added enhancements. A further study tested the impact of the entire package on aftercare attendance and assessed changes in substance use. 150 eligible patients agreed to join the study and were randomly allocated to the centre's standard procedure or to the enhanced package. During the final days of their stay, standard procedure patients were encouraged to attend the centre's aftercare groups and individual sessions, as well as mutual aid groups such as NA and AA. Initial appointments and/or attendance schedules were agreed and listed in an aftercare 'contract' handed to the patient, who was also shown a motivational video.

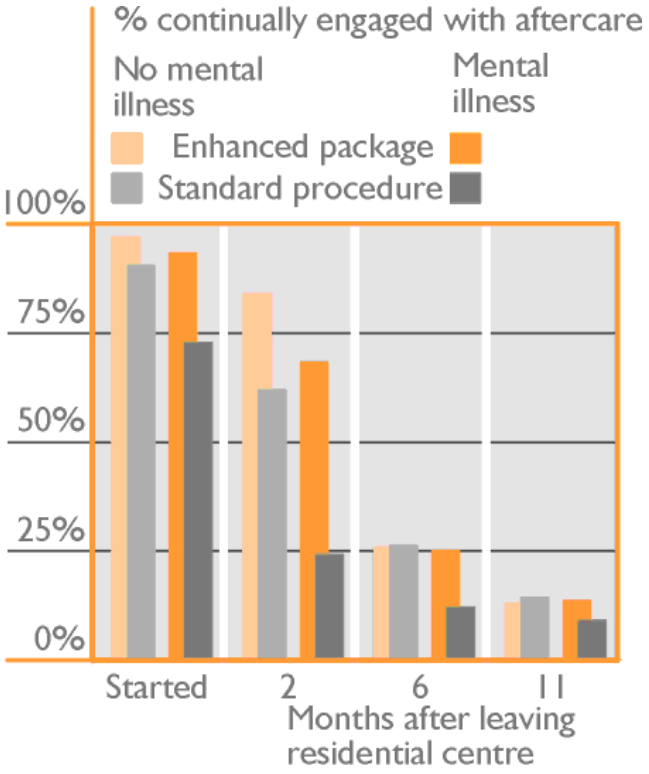
For the enhanced version, the contract was strengthened by asking patients to commit in writing (witnessed by the therapist) to over the next eight weeks attend weekly groups and AA/NA meetings and monthly individual sessions. Veterans Affairs' data showing that aftercare attendance was associated with abstinence was used to motivate agreement. Therapists also explained the reminder system and showed patients

Intervention manual and materials and related publications are available from Steven Lash.

the awards (see next paragraph) for attendance specified in the contract. After eight weeks patients were invited to re-contract to continue in aftercare for eleven months in total.

Letters from the therapist, appointment cards and automated telephone reminders prompted patients to attend the next session in a few days time. Non-attendance was followed by a letter and phone call from the therapist. Awards consisted of medallions and certificates handed out during individual aftercare sessions. Further reinforcement took the form of a handwritten letter congratulating the patient on initiating aftercare followed by another after three sessions.

Researchers were able to re-assess around 80% of patients two, five and 11 months after they left treatment, reassuring them that their responses were confidential. As documented in the earlier Findings analysis, compared to the standard procedure, the enhancements led more patients to initiate and continue in aftercare, and 11 months after leaving treatment, nearly 20% more (57% v. 37%) had been abstinent from alcohol and drugs for the past three months.



The featured report assessed whether these differences were related to the mental health status of the patients. Of these, 51% had been diagnosed by the unit's psychiatrist as suffering from a mental disorder, spread evenly across the standard and enhanced intervention groups. Personality disorders, depression, and schizophrenia were the most common diagnoses. Among patients without a psychiatric diagnosis, the enhanced protocol led slightly more to start (97% v. 91%) and to engage with aftercare for at least the first two months after leaving the centre (84% v. 62%). Following that until the study ended a year after treatment entry, participation was unaffected by the engagement enhancements. Impacts among patients with a psychiatric diagnosis were substantially greater and more persistent ▶ *chart*. Compared to the standard procedure, 20% more (93% v. 73%) started aftercare and at each time point until the study ended more remained engaged, the difference being greatest during the two months after

leaving treatment (68% v. 24%). Because they particularly increased engagement among patients with mental health disorders, the enhancements evened out the differences between these and the other patients. Without the enhancements the mentally ill patients engaged relatively poorly at each stage; with them, they did as well or almost as well. In terms both of statistical significance and size, these impacts were greatest during the first two months after patients left the residential centre.

In contrast, impacts in terms of abstinence from alcohol and drugs became apparent only in the last three months of the follow-up; without the enhancements, just 21% of patients with mental health disorders had sustained abstinence, with them, 50%, the sole statistically significant difference. Effects on abstinence were confined to patients with mental disorders. At no stage did the enhancements substantially affect abstinence rates among the other patients.

For the authors, the findings suggested that given the enhanced engagement interventions, participants with co-occurring psychiatric disorders were more likely than those receiving standard care to begin and remain in an aftercare programme for at least three months, and to be abstinent one year later. In general, the enhancements were more effective for individuals with co-occurring disorders than among those with substance use problems only.

FINDINGS As acknowledged by the authors, post-hoc subsample analyses of this kind are best seen as generating hypotheses for testing in a study specially designed for this purpose. For this reason, the analysis presented here focuses more on the size of the differences between the interventions' impacts than on their statistical significance.

While the difference in aftercare attendance was consistently substantial, the difference in abstinence rates in the last three months of the follow up must be treated more cautiously, since no such differences were seen at the previous two time points. An earlier report on the study found that across the full samples, the improved abstinence rate was largely due to more patients becoming abstinent in the previous six months, possibly because the enhancements made more willing to return for help after relapse. Though as defined by the study, aftercare engagement during the final three months was unaffected by the enhancements, following these nearly twice as many patients attended aftercare at some point during this period (40% v. 22%). This greater willingness to stay in touch to at least some degree partly accounted for why abstinence rates during this period showed a similar difference in favour of the enhancements. From the featured report it now seems that these processes were at work mainly if not exclusively among the patients with diagnosed psychiatric or personality disorders.

Because the centre served ex-military personnel there were very few women. All the studies excluded participants who would have had significant difficulty attending an aftercare centre. The greatest attendance gains were observed while contracting and rewarding procedures were also at their height (the first two months after leaving the centre) and for the type of aftercare provision (the centre's own sessions) most explicitly targeted. From the prior studies, we know that each of the elements in the enhanced package added to its impact. Gains from this package might have been greater still if awards had been made in front of peers at group therapy sessions and if it had replaced more typical procedures; even the standard comparator was an advance on the most basic procedure tested in an earlier study, and probably also on what typically happens to

encourage aftercare attendance.

If, as is being strongly argued in some quarters, Britain is to re-balance its treatment system to offer more residential treatment slots, aftercare provision and encouragement of the kind trialled in the study will be crucial to help patients avoid or overcome lapses or relapses, and to sustain support for services which might otherwise be seen as costly revolving doors. These settings radically alter the patient's social and physical environment, enabling residents who would otherwise be unable to do so to attain abstinence. By the same token, unless steps have been taken to alter this or sustainably alter how the patient reacts to it, they are likely to relapse when they return to the environments in which they were previously unable to stop using.

The enhancements in the featured study tried to meet this need by encouraging all former patients to return for aftercare, and seem to have made it easier for the more psychologically vulnerable to do so by adopting a welcoming, personal approach and implementing systematic reminders. Another approach is to check on whether former patients need to return to care, and then to focus efforts on them, a strategy tried with some success in Chicago. See the Findings analysis of that study for UK guidance on aftercare and information on the extent of implementation in Britain.

Earlier studies from Salem and related work were reviewed by Findings in parts one and two of the *Manners Matter* series. These concluded that treating the patient as an individual, being welcoming, and showing respect and caring persistence, are among the hallmarks of services which retain clients. The reviews argued that there is no conflict between these qualities and efficient administrative procedures of the kind used to deliver reminders in the featured study. Such procedures are needed to give practical expression to the qualities and values which motivate them. In turn, these procedures will not have the desired impact unless they express these qualities; a cold or standardised reminder letter signifies that the sender cares little about the individual and whether they turn up or not. Personal approaches are more effective.

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