Your selected document

▶ Four-year outcomes from the Early Re-Intervention (ERI) experiment using recovery management checkups (RMCs).

Dennis M.L., Scott C.K.

Drug and Alcohol Dependence: 2012, 121(1–2), p. 10–17.

Chicago studies have shown that quarterly check-ups on former patients can identify need and pave the way for treatment re-entry. Though extra substance use/problem reductions were modest, these remained significant four years after the patients started treatment. Issue for the UK: how does this square with the stress on lasting treatment exit?

Summary Post-treatment check-ups are one attempt to address the fact that rapid relapse is typical after short-term treatment of severe addiction, especially when complicated by social and psychiatric problems. Instead of leaving it to the patient to seek further help, check-ups assume that regular, proactive, long-term monitoring and early re-intervention will improve long-term outcomes by facilitating early detection of relapse and reducing time to treatment re-entry.

Over four years, the featured report documents outcomes from a post-treatment check-up and (if needed) treatment re-engagement protocol previously reported on up to two years after treatment entry. The two-year report was able to assess whether over the same time period promising results from an earlier version of the check-ups could be improved on by taking on board the lessons of that initial evaluation.

The trial of the earlier version had recruited 448 people referred by a central assessment unit in Chicago for treatment at a centre specialising in substance users who are new mothers or mothers-to-be, homeless, or mentally ill. Three months later when most had left initial treatment they were randomly assigned to 21 months of quarterly recovery management check-ups, or to a control group re-assessed according to the same schedule.

Questions put by researchers to both groups were designed to identify clients not already in treatment or custody, but who needed to return to treatment, indicated by a positive response to at least one of six questions probing for a return to regular, 'binge', or problem substance use, and whether the client themselves felt in need. For the control group, this was where the interviews ended; except rarely in an emergency, no attempt was made to re-connect them with treatment. During check-up interviews, instead the researcher immediately referred 'in-need' patients to a 'linkage manager' whose role was to motivate treatment re-entry and to offer practical assistance. As intended, the check-ups improved treatment re-entry rates, but results were far from perfect. For example, just a third of the people encouraged to return to treatment actually did so, the intervention did not improve retention once in treatment, and benefits did not become statistically significant until the end of the two-year follow-up.

For the study behind the featured report, this earlier study was replicated with 446 patients recruited in the same way at the same centre. As before, typically they were dependent on cocaine and most had serious mental health or behavioural problems. Just under half were women, 80% black, three quarters out of work, and about a quarter homeless. Eight in ten were referred to residential programmes, and (judging from the earlier trial) the remainder probably mainly to intensive outpatient programmes, in both cases usually lasting under three months.

They were subject to the same check-ups, except for three modifications suggested by the earlier study. To facilitate identification of treatment need, researchers countered the tendency of a small minority to deny drug use by reminding them of previous assessments and urine test results, and probing inconsistencies. To facilitate treatment entry, from the start there was a requirement to provide transport to treatment intake and initial sessions. To facilitate retention, linkage managers now maintained contact with patients in treatment, and treatment staff gave the managers a chance to intervene beforehand with patients about to leave prematurely.

As detailed in this analysis of results up to two years after treatment entry, the modifications enhanced treatment access by increasing the proportion of former patients identified as in need of treatment and also the proportion (now practically all) who agreed to see the linkage manager. However, the modifications made virtually no difference to the proportion of in-need participants who agreed to attend a treatment intake assessment, though more completed it and started and engaged with treatment and did so more quickly. By the end of two years, in both studies the check-ups had led to about 10% fewer people still being assessed as in need of treatment. Only in the second study was there an impact on substance use: a slight increase in days abstinent from on average 68% in the control group to 76%, and a further slight reduction in an already quite low index of substance abuse, dependence or related problems.

Main findings

Having established that at least over the first two years the modified procedures further improved treatment re-entry rates and modestly improved substance use outcomes, the featured report focused on whether the protocol had remained preferable to merely assessing patients (the control group) over a further two years, four years in all. Nearly all the patients completed at least two of the quarterly research re-assessments and

could be included in the analysis of treatment re-entry. Around 90% were assessed as at some stage in need of returning to treatment; again, nearly all could be included in an analysis of the time it took them at re-enter.

Compared to the control group, 19% more check-up patients (70% v. 51%) returned to treatment at some point after the first check-up point, they returned nearly twice as often (average of 1.9 v. 1 times), spent 42% more days in treatment (112 v. 79 days), and nearly twice as often engaged in outpatient treatment for at least a week or residential for at least a fortnight (2 v. 1.2 times). Those assessed as in need of returning to treatment did so much more quickly (13 v. 45 months) if they had been assigned to the check-ups. Check-up patients were also much more likely to return sooner than control patients after a range of severity and other variables had been taken in to account, and of these variables, being assigned to check-ups was the only significant influence. While access to treatment was enhanced by the check-ups, it remained far from universal; on just a fifth of occasions did being identified as in need of treatment result in engagement in treatment.

Enhanced access to treatment seems to have fed through to reduced substance use and problems. Check-up patients were less often assessed as in need of treatment (7.6 v. 8.9 of the 16 quarterly check-ups), stayed in need for a shorter time (5.9 v. 7.5 quarters in a row), reported fewer substance-related problems, and spent more days not drinking or using drugs (out of 1350 days, 1026 v. 932).

By the last three months of the four-year follow-up, check-up patients had used substances and/or used heavily or experienced problems related to that use on fewer days than control group participants (0.10 v. 0.13 on a scale of 0–1), they had more often been abstinent (70 v. 63 of 90 days), and over the final month of the follow-up they also experienced fewer (1.4 v. 2.3 on a scale of 0–16) problems related to substance use.

The authors' conclusions

Findings confirm that we are one step closer to effectively responding to addiction as a chronic illness. Recovery management check-ups were associated with reduced time to treatment readmission, more treatment, and reduced substance use and related problems. They offer a proactive approach to help substance abusers learn to identify their symptoms, resolve their ambivalence about their substance use, and support their choice to assume personal responsibility for the management of their long-term recovery.

The findings also demonstrate the need for such an approach; at some point during the study, 90% of the participants were in need of further treatment. High follow-up rates also show that quarterly monitoring is acceptable to patients and they can manage this despite often chaotic and highly mobile lifestyles.

It should be remembered however that the results derive from a mainly African American urban sample seen at one centre and with multiple problems. Implementing recovery management check-ups is also labour-intensive and financial considerations may be an obstacle. While the check-ups helped many and effects cumulated over time, each subsequent check-up reaped diminishing returns, and there was a subgroup of people for whom they may not have been the optimal intervention.

FINDINGS The featured report is the latest from a well-constructed set of studies

conducted most notably by the featured research team in Chicago and by another team in Philadelphia. Both attempted to make a feasible reality of the common understanding of addiction (at least of the kind experienced by people who seek treatment from public services) as a chronic condition.

Among dependent drinkers in Philadelphia, low readiness and/or motivation for curbing substance use, and lack of positive social support to do so, were markers of the need for more intensive continuing care. Additional markers were co-dependence on cocaine and poor outcomes or self-help attendance during initial treatment. Similarly, the featured study found hints that patients more entrenched in crime and violence and who had started drug use early in life benefited most from the recovery check-ups. The other side of the coin is that less vulnerable patients do as well with no or only minimal continuing care. However, these are not hard and fast rules. Securely identifying who is and is not at risk means keeping a check on how patients are actually doing after they leave treatment. A panel of experts convened by the US Betty Ford Institute saw such checks as the key component of continuing care and the one with the greatest evidence of effectiveness.

The featured Chicago studies sampled people with multiple problems and little stake in conventional society, the kind most likely to repeatedly relapse and need continuing care. Their primary substance use problem (cocaine) ruled out maintenance prescribing as a major long-term anti-relapse strategy. Check-ups helped re-engage patients with treatment, especially when for the second study assessment, transport and treatment engagement procedures had been improved, but the gains in respect of substance use or problems seem modest.

Presumably check-ups work best when there are adequate services for patients to re-engage with. In the face of the problems posed by these caseloads, brief episodes of resumed care focused on substance use perhaps for some missed the mark. Repeated access to episodic drug 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 was not matched by a similar degree of success in curbing substance use problems. Another reading of the results is that for many the check-ups were unnecessary; even without them, by the end of the four years of the study levels of substance use and related problems were low. Below some further considerations in respect of the study's methodology and context.

How well the criteria for 'need for treatment' identified people normally considered in need is questionable. They would have included someone who had spent just one day drunk in the past three months and never used any other drugs. Such patients may justifiably have seen themselves as not really in need, possibly why most did not re-engage with treatment.

Also questionable is whether in routine, real-world use, the check-ups would work as well as they did. As the authors acknowledged, such gains as there were resulted from specially trained staff using a standardised and supervised protocol; a substantial investment was required to reach required standards. While the patient was still in the initial treatment, the studies 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, for which these poor participants were financially reimbursed; presumably fewer would have attended without these incentives.

On the other hand, it could be that routinised check-ups would be more successful if familiar faces from the initial treatment agency were involved, and there was no burden of completing research assessments. Also, regular re-assessment of the control group participants may have raised their awareness of need for treatment, narrowing the gap with the check-up patients.

It is unclear whether the reduction in treatment need was due to remission of substance use problems, or because more recovery check-up patients were already in treatment, so could not be assessed as needing to return.

Other ways to keep in contact

A review of continuing care and aftercare studies found that most recorded clear and statistically significant advantages for continuing care versus no care or only standard care. Provided the interventions were capable of keeping patients engaged, longer durations of continuing care seemed more consistently beneficial. These longer interventions all involved 'taking the treatment to the patient' rather than relying on them visiting a clinic.

In particular, studies have shown that proactively re-contacting former patients can transform aftercare attendance, that re-contacts can in themselves be therapeutic, even without leading to a return to treatment, and that such work can be done by a service's routine staff. Approaches which evidence individualised concern for the patient work best, probably because they convey active caring rather than a bureaucratic reminder-mill. The more socially excluded and damaged the caseload, the more active and personal the follow-ups need to be, and the greater the help needed to re-establish aftercare contact.

Case management is a more common form of continuing care than featured study's check-ups, one which typically also tries to orchestrate multiple sources of help for multiply problematic caseloads. Despite some successes with US welfare applicants, like the check-ups, in general these interventions raise service access more noticeably than they improve substance use.

Another approach is to encourage all former patients to return for aftercare whether they need it or not, and to make it easier for them to do so by adopting a welcoming, personal approach and implementing systematic reminders. Especially among the more psychologically vulnerable patients, this proved effective in another US study.

UK policy stresses lasting treatment exit, not return

The check-up 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 treatment contact than in the pre-recovery era when guidance stressed the need for aftercare following residential rehabilitation and for continued post-detoxification treatment. However, on the ground 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 within which the patient lives and must fully return after treatment, and their entire life course, but at the same time the resources to commission services and forge 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 the greater stress was placed along with "planned exits" from treatment.

Policy levers reinforced the new stress on treatment completion and exit and at the same time tried to ensure this had represented lasting recovery by stipulating that the patient not return to treatment within six months or a year. A six-month non-return criterion was built in to the public health indicators by which local authorities (now responsible for addiction treatment) are held to account. It was also intended to determine part of the financial allocation to local areas for addiction treatment, though it now seems that will not happen. Pointing the way to the probable future, nationally agreed criteria for pilot payment-by-results schemes place a premium not on long-term contact, but on discharging dependence-free patients who then are not seen in treatment again for at least a year, one of a set of criteria services will find difficult to ignore because their financial survival depends on how well they do against these yardsticks. Gone entirely are the retention targets of previous years.

The probable intention was to encourage agencies and commissioners to offer the "recovery support interventions" provided for in the definitions used to record treatment entry and exit in England. These include the check-ups of the featured study and do not count as continuing treatment. Other interventions too can count as "recovery support" rather than "structured treatment", to the extent that a patient can be considered discharged yet be in regular contact with the treatment service, receiving the same types of interventions as before, for the same purpose, at the same location and with the same staff. But if before six months or a year these cross the unclear line to treatment re-entry, the service and/or the area stand to lose some of the credit and some of the money they would have gained from ensuring the patient stayed out of treatment, seemingly contrary to the featured study's stress on regularly checking treatment need and (if needed) getting patients back as soon as possible.

Thanks for their comments on this entry in draft to Michael L. Dennis of Chestnut Health Systems in the USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 15 May 2013. First uploaded 08 May 2013

▶ Comment on this entry
▶ Give us your feedback on the site (one-minute survey)
▶ Open home page and enter e-mail address to be alerted to new studies

---

Top 10 most closely related documents on this site. For more try a subject or free text search

Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users ABSTRACT 2009

Extended telephone-based continuing care for alcohol dependence: 24-month outcomes and subgroup analyses STUDY 2011

Check how your former patients are doing STUDY 2004

Continuing care research: what we have learned and where we are going REVIEW 2009

Improving continuity of care in a public addiction treatment system with clinical case management STUDY 2006

A practical clinical trial of coordinated care management to treat substance use disorders among public assistance beneficiaries STUDY 2009

Performance-based contracting within a state substance abuse treatment system: a preliminary exploration of differences in client access and client outcomes STUDY 2011

Gender differences in client-provider relationship as active ingredient in substance abuse treatment STUDY 2010

The Drug Treatment Outcomes Research Study (DTORS): final outcomes report STUDY 2009

Transitioning opioid-dependent patients from detoxification to long-term treatment: efficacy of intensive role induction STUDY 2011