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▶ Continuing care research: what we have learned and where we are going.

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Are alcohol and drug dependence best treated as chronic conditions needing extended care, or should we expect patients to recover and leave treatment? Whatever the answer, this review finds that generally the offer of long-term continuing care leads to better outcomes.

Abstract In the US context the review noted that virtually all addiction treatment is provided in time-limited specialist programmes which offer a single type of treatment. The limitations of this approach have led to calls for treatment protocols and systems which address the full continuum of care from detoxification to extended recovery monitoring, considered more appropriate to the patient-centred management of a chronic disorder. The review aimed to look back to analyse findings from continuing care evaluations done over the past 20 years, and then to look forward to how continuing care models might be developed, especially through collaborations between specialist care and other services, and through 'adaptive' treatment strategies which adjust the type and level of care to the patient's progress. The focus was on formal care services rather than self-help or mutual aid, which have already been comprehensively reviewed.

The review was based on 20 studies which allocated patients at random or in a quasi-random manner to treatment with or without a continuing care intervention, or to different types of continuing care. The dominant initial intervention was residential care, limiting the applicability of the findings to the more typical non-residential settings.

Eleven of the studies compared continuing care with minimal or no continuing care. In terms of each study's main substance use outcome measures, seven of the 11 found a clear and statistically significant advantage for continuing care. In contrast, of the nine studies which compared different types of continuing care, just three found a clear and statistically significant advantage for one type of care over another. When there were differences, they were large enough to be of clinical significance, but there was

considerable variability in how well patients responded, and room for improvements in participation rates and effectiveness. In most studies, about a third of patients had very good outcomes, another third had mixed outcomes, and a final third did poorly. Even among studies with significant effects favouring continuing care (or one type of continuing care), patients still varied in how well they responded to the more effective intervention.

Provided the interventions are capable of keeping patients engaged, longer durations of continuing care seem more consistently beneficial. All three studies offering at least 12 months recorded significant beneficial effects, four of nine when the duration was between three and 12 months, but just three of eight with shorter durations. However, randomised studies directly comparing different durations of the same intervention are needed to confirm this possibility. Also, the longer interventions all involved 'taking the treatment to the patient' rather than relying on them visiting a clinic. Other interventions featuring very active efforts to locate patients, to bring treatment to them, or to make it very easy and convenient to access (eg, over the phone), have also been effective. Finally, several studies show that that engagement and retention in continuing care can be increased with relatively low-cost, low-effort tactics which can be widely incorporated in virtually any continuing care protocol (1 2 3).

Looking forward, effectiveness might be enhanced and patient variability more adequately catered for by interventions which regularly and systematically monitor the patient's progress and in response to this progress, step up or down in the intensity of continuing care, or change the type of care. Such 'adaptive' models may be further enhanced by incorporating patient preference in the choice of continuing care options. Non-specialist settings for the provision of continuing care (and perhaps also initial treatments) may also be more acceptable to some patients and increase the proportion who participate. Primary care medical practices are a promising site and can forge links with specialist services for the times when patients need intensive or specialist inputs. Primary care services can also incorporate long-term medication-based continuing care. Internet-based provision may also be an option. Such alternatives to time-limited specialist care promise to extend effective treatment to the many individuals who do not want long-term contact with traditional, clinic-based specialist care.

FINDINGS The review is associated with a set of recommendations agreed by a panel of experts convened by the US Betty Ford Institute. Generally supportive of the conclusions of the featured review, the panel argued that extended and regular monitoring of the patient's progress was the key component of continuing care and one with the greatest evidence of effectiveness. Rather than minor alterations, they concluded that implementing their recommendations would require major changes in the way continuing care is conceptualised and delivered: "What has been the standard approach − provision of a few months of group counselling along with referral to self-help − clearly works well for some individuals but is ineffective with many others. Moreover, there is no 'plan B' for patients who do not succeed in this standard continuing care model".

These arguments go to the heart of the current debate in UK treatment circles about the appropriateness of the 'chronic and relapsing disorder' model of addiction, and of at least some forms of extended care predicated on this model, particularly methadone

maintenance. Without denying the need for long-term care for some patients, the English strategy on drug misuse argued that "Too many drug users relapse, do not complete treatment programmes, or stay in treatment for too long before re-establishing their lives ... In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment". In Scotland too the new 'recovery' strategy stressed the need for more patients to "move on from their addiction towards a drug-free life as a contributing member of society", implying a corresponding shift away from extended and/or indefinite treatment options. Perhaps because alcohol treatment services are relatively under-developed, neither the English alcohol strategy nor the Scottish equivalent saw any need to call for an accelerated and/or clearer movement through and out of treatment.

In both countries reintegration in to mainstream society and especially in to employment are seen as the bulwarks which can help prevent relapse and relieve the need for extended care. The model advanced in the featured review and the associated recommendations does not deny that short-term treatment can lead to lasting recovery, but argues that instead of there having been too much reliance on extended care options, there has in the US context been far too little. Given this shortfall, it places the stress not on moving patients out of treatment, but on retaining those who need it in continuing care. This difference in emphasis may partly be due to the prominence of alcohol dependent patients in the minds of the US experts, and partly also to the more marginalised position of long-term substitute prescribing in the US response to opiate addiction. From this starting point, the US experts saw a need for greater stress on extended care, while from the starting point of the balance of the current UK treatment system, some see the need to effectively call for the reverse.

In both cases, much will depend on the receptivity of the broader society to the relapse-preventing reintegration of problem substance users and especially problem drug users. Without sufficient receptivity in the form for example of routes in to suitable work opportunities, decent and stable housing, and social acceptance and support, extended care may be the most realistic way to prevent or intervene early in health- and life-threatening relapse.

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