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

McKay J.R., Van Horn D., Oslin D.W. et al.

Addiction: 2011, 106(10), p. 1760–1769.

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At Philadelphia clinics seeing alcohol- (and often cocaine-) dependent patients, spending on average another nine minutes to offer counselling as well as progress checks during aftercare phone calls made the difference between a programme which did rather than did not consistently improve on usual arrangements, at least while it was operative.

Summary Set in Philadelphia in the USA, the featured study tested whether over the two years after intensive outpatient treatment, monitoring alcohol-dependent patients' progress over the phone and feeding the results back to them improved outcomes, and whether adding counselling to the monitoring made any further difference. This account draws on an earlier report of outcomes during the 18 months when aftercare was made available, and another of whether over the same period certain types of patients benefited more from this aftercare than others.

Alcohol-dependent adult patients at two publicly funded outpatient addiction treatment centres who had completed at least three weeks of the initial intensive treatment phase (intended to last three to four months) were asked to join the study. The 252 who did so were randomly allocated to the centres' usual three to four months of standard aftercare – an offer of weekly group counselling sessions – or additionally to one of two phone contact options lasting 18 months. Typically they were black, unmarried men in their late 30s and 40s; half were also dependent on cocaine.

One phone contact option consisted of "progress assessments" lasting five to ten minutes, during which the counsellor asked 10 questions to assess whether the patient had relapsed or was at risk of doing so. Patients were told whether their responses meant they were at low, medium or high risk of relapse, and to call back if they felt that they were suddenly at heightened risk or had used drugs or alcohol. No formal counselling was offered, but patients who were relapsing or experiencing other crises were advised to re-

enter treatment or find other sources of support, and in a few cases, to call back before their next scheduled contact. The aftercare counsellor met face-to-face with the patient usually in week four of the intensive treatment phase to explain the programme. Calls were then made weekly for the first eight weeks, every other week for the next 44 weeks, and monthly for the final six months.

The more intensive phone intervention followed the same initial meeting and calls schedule, but in this case the risk assessment was used to inform the counselling and services offered during the remainder of the call. Patients at low risk were led to review their goals and the milestones that needed to be accomplished to reach each goal. Problems identified in the risk assessment were also addressed and positive activities encouraged. For patients at moderate or high risk, greater attention was devoted to identifying and rehearsing better coping responses to existing or anticipated relapse-provoking situations. Patients at high risk were also called more often for the next several weeks and if still at high risk, were offered face-to-face assessments based on motivational interviewing followed by cognitive-behavioural therapy sessions.

Assessments of the patients for research purposes were conducted while they were in their third or fourth week of the intensive phase of treatment (the baseline) and then every three months for two years. Proportions reassessed ranged from 90% at three months to 77% at two years.

Main findings

On average each patient completed 36 sessions of the basic treatment across both the intensive and aftercare phases, a retention record unaffected by the addition of telephone contacts. Just over three quarters of the patients allocated to phone contacts attended the initial face-to-face session. In the progress check option, these starters completed nearly 12 of 36 possible calls and when counselling was also offered, nine of 36. Calls lasted on average eight and 17 minutes respectively.

Whatever aftercare patients had been allocated to, on average the proportion of days on which they drank fell dramatically over the first three months and remained more or less at this lower level for the remainder of the follow-up. The same was true of the proportion of patients who had drunk heavily. At the first follow-up, over half the patients were assessed as having a good clinical outcome over the past three months, meaning only occasional light drinking at most, no self-reported cocaine use and no urine tests positive for cocaine, methamphetamine, barbiturates or heroin, and no inpatient admissions for psychiatric, alcohol or drug problems. Again these gains were more less sustained over the two years.

Against this background of substantial overall improvements, over the two-year follow-up, on none of these outcome measures had adding progress checks significantly improved on the centres' usual aftercare. In contrast, improvements among those allocated to checks plus counselling were greater and either near statistically significant or (in respect of proportion of days drinking) actually significant. This advantage was largely due to the initial 18 months when the counselling was available. After it had been withdrawn, among these patients drinking days and the proportion drinking heavily deteriorated slightly, while among patients offered only usual aftercare they improved, until the two sets of patients were on average virtually identical. The proportion assessed as experiencing a good clinical outcome remained higher even after counselling was

withdrawn, but not much and not to a statistically significant degree. From an earlier report it is known that during the 18 months aftercare period the average frequency of heavy drinking was also significantly lower among patients offered progress checks plus counselling.

Women generally benefited from both phone contact options and did relatively poorly without them, while men did relatively poorly when offered progress checks in the absence of counselling. Patients in social circles supportive of drinking benefited more when counselling was added to progress checks. Those whose social networks did not support drinking did equally well with or without counselling or progress check calls. Across all three outcome measures, patients who at baseline were less ready to change their drinking or had previously been treated for their drinking problems benefited from the counselling option. In no case were these differential impacts sustained at the final follow-up.

The authors' conclusions

The beneficial effects of telephone-based continuing care dissipated after the end of the 18-month intervention. While these were on offer, the benefits of progress checks plus counselling were particularly impressive, given that patients averaged 36 usual-care treatment sessions over the first six months of the follow-up, a relatively intensive intervention in its own right. Possibly extending the phone intervention might also have extended the benefits, an option made more feasible by ease of delivery.

Though designed to be a low-burden, user-friendly approach to continuing care, about a quarter of the patients offered phone-based contacts never met their counsellor to initiate them, and those who did averaged about 10 out of 36 possible contacts. On the other hand, 38% of those who initiated had at least one contact in the final six months of the follow-up.

Some of the larger effects for the two continuing care interventions were found among women, due in part to their particularly poor outcomes when offered usual care only. Why this was the case is unclear, as is why men did relatively poorly when the contacts consisted only of progress checks.

Progress checks plus counselling were particularly helpful for higher risk patients – those less ready to change their drinking, who had previously been treated for their drinking problems, or whose social circles supported drinking. Extended support may have helped counteract low motivation while facilitating the development of strategies to deal with friends or relatives who encouraged continued drinking. In addition, the extended relationship with the counsellor provided further social support for recovery.

It should be borne in mind that some findings which were not statistically significant might have been with a larger sample. The analyses which segmented the sample to assess which patients benefited most from continuing care suffered particularly from small samples. These analyses were not planned in advance, so need confirmation in a study intended for this purpose. Only about a quarter of the patients screened for the study were enrolled in it, raising questions about the representativeness of the sample.

FINDINGS An important message from this study is that patients most vulnerable to relapse benefited from being offered continuing counselling as well as progress checks. A

similar message emerged from the same research team and a similar set of patients also in treatment in Philadelphia. In that study, largely telephone-based continuing care was best overall, but entirely face-to-face aftercare was best for high-risk patients. As in the featured study, 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 both alcohol and cocaine and poor outcomes or self-help attendance during the initial treatment phase. Since both studies admitted only patients who had either successfully completed or sustained several weeks of the initial treatment, it seems possible that yet more intensive contacts might have been needed for the drop-outs, but whether they could be contacted and would be open to this is questionable.

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. Studies have shown that proactively re-contacting former patients can in itself be therapeutic, even without leading to a return to treatment. 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.

The two Philadelphia studies and others in Chicago suggest that check-ups are best combined with the ability to offer counselling over the phone or to initiate face-to-face care or treatment re-entry if the checks reveal things are not going well. Initiating face-to-face contact with the aftercare counsellor during the initial treatment phase may help in promoting later aftercare engagement. During those engagements, more patients will be identified as at risk of relapse if steps are taken to counter the tendency to say all is well when it is not. In the Chicago studies this took the form of reminding patients of previous assessments and urine test results, and probing inconsistencies.

Reviewing continuing care and aftercare studies, the lead author of the featured study found that most identified 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.

Thanks for their comments on this entry to James McKay of the University of Pennsylvania in the USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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