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▶ [Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users.](#)



Scott C,K., Dennis M.L.

Addiction: 2009, 104, p. 959–971.

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In the USA two studies have shown that quarterly check-ups on former patients help identify the need for and motivate further treatment, but gains in substance use/problem reductions only became evident when improved procedures were introduced, and even then remained modest.

Summary The featured report documents whether a promising post-treatment check-up and (if needed) treatment re-engagement protocol could be improved by taking on board the lessons of an [initial evaluation](#). 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, the intervention rests on the assumption that proactive, long-term monitoring through regular check-ups and early re-intervention will improve long-term outcomes by facilitating early detection of relapse and reducing time to treatment re-entry.

During a three-month period, the initial trial recruited [448 people](#) referred by a central assessment unit in Chicago for treatment at a [centre](#) specialising in the care of substance users who are new mothers or mothers-to-be, homeless, or mentally ill. Typically they were dependent on [cocaine](#) and three-quarters had serious mental health or behavioural problems. About half were women, most were black and out of work, and a substantial minority homeless. Generally they were referred to short-term residential treatment, the remainder mainly to short-term, intensive outpatient programmes. Three months later they were randomly assigned to 21 months of quarterly recovery management check-up

interviews, 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. 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. In contrast, during check-up interviews, the researcher went on to identify ex-patients in need of returning to treatment, indicated by a positive response one of six questions probing for a return to regular, 'binge', or problem substance use, and whether the client themselves felt in need. Patients screened as in need of treatment (usually about 30%) were referred immediately to a 'linkage manager' whose role was to **motivate** treatment re-entry and to offer practical assistance. As intended, the check-ups (details below) improved treatment re-entry rates, but the 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.

Later the study was replicated on **446 patients** recruited in the same way at the same centre. They were subject to the same intervention, except for three modifications suggested by the initial evaluation. 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**.

The first issue was whether and at what stage the modifications enhanced treatment access. Feedback countering denial of drug use helped increase the proportion of former patients identified as in need of treatment from an average 30% to 44% across all the follow-ups, giving the modified procedures a head start. This was extended when practically all the second set of 'in-need' participants agreed to see the linkage manager; previously a quarter had refused. However, it made virtually no difference to the proportion of in-need participants who agreed to attend a treatment intake assessment (44% study 1; 45% study 2), though more did complete it (30% versus 42%). This fed through to a slight but statistically significant advantage in the proportion who actually started treatment (25% versus 30%). Of these patients, many more in study 2 stayed for at least a fortnight (39% versus 58%), the study's engagement criterion.

Recalculating these figures as proportions of in-need participants, in study 1, 10% met the study's engagement criterion, in study 2, 17%.

Next was whether across the entire samples, these procedural improvements had translated in to better treatment re-entry and substance use outcomes compared to the respective control groups. A key statistic was the proportion who re-entered treatment at some time during the intervention period; in study 1, check-ups improved on control procedures by **9%**, in study 2, by **twice as much**. However, increases in the average time in treatment remained **modest**. The length of time patients in need of treatment failed to receive it also fell by a **greater amount** in study 2. 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.

The standard way to express these differences is as **effect sizes**. Except for average days in treatment, consistently effect sizes on the reported measures of treatment access and substance use or problems were greater in study 2, suggesting that the modified procedures had the **desired effects**.

The authors concluded that post-treatment monitoring leading (if needed) to treatment re-entry is feasible and effective for adults with chronic substance dependence, and that the modifications introduced for study 2 facilitated and improved the consistency with which the protocols were implemented. The result was fewer people in need of treatment and less time without help when it was needed. They argued that for such caseloads, ideally check-ups would be required as a condition of licensing, accrediting and funding treatment programmes, linked to a broader strategy of reorienting addiction treatment from an acute care model to a model which provides services ranging from brief intervention to long-term recovery management.

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The featured report derives from a well-constructed set of studies conducted most notably by the featured research team in Chicago and by another team in [Philadelphia](#). A [later report](#) on the replication study has documented outcomes for another two years (four years in all). As in the featured report, check-ups had substantially and more quickly helped re-engage patients with treatment, though still most did not meet the study's engagement criteria. Gains in respect of reduced substance use or problems were more modest but remained statistically significant in comparison the to the control group.

Both series of studies attempted to make a feasible reality of the common [understanding](#) of addiction 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 [later report](#) on the replication study found **hints** that patients more entrenched in crime and violence and who had started drug use early in life benefited most from 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.

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. Even without check-ups, levels of substance use and related problems were both low. 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. 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. 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. 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.

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 has found that most found 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, and that re-contacts can in themselves be therapeutic, even without leading to a return to treatment. In some studies the work was 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 improve service access more noticeably than they improve substance use outcomes.

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 long-term 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 contrast to the featured study's attempt to regularly check treatment need and (if needed) get patients back as soon as possible. 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, and determines part of the **financial allocation** to local areas for addiction treatment. 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.

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