DRUG & ALCOHOL FINDINGS *Research analysis*

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BENEFITS OF RESIDENTIAL CARE PRESERVED BY SYSTEMATIC, PERSISTENT AND WELCOMING AFTERCARE PROMPTS

A US inpatient treatment centre has shown that systematically applying simple prompts and motivators can substantially improve aftercare attendance and help sustain progress made during initial treatment. The findings offer a way to preserve the benefits of the investment made by patients, services, and funders. This account remains as published in 2008 except for the addition of a later study published in 2013.

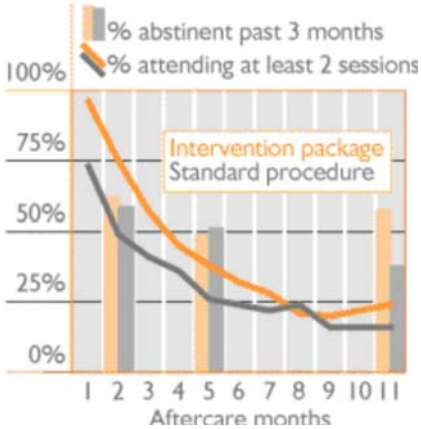
FINDINGS The Salem Veterans Affairs medical centre offers a 28-day residential rehabilitation programme to its alcohol and/or drug dependent ex-military patients. To sustain sobriety, staff stressed the importance of aftercare but attendance was poor. A unique series of studies[1] had previously shown that attendance radically improved as step by step researchers added enhancements, culminating in a report which suggested that there were consequent reductions in drinking and related problems.

A further study[2] has now tested the impact of the entire package on aftercare attendance and more robustly 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 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. Compared to the standard procedure, the enhancements led 12% (95% v. 83%) more patients to initiate aftercare and nearly 30% more (75% v. 45%) to attend at least two sessions a month over the first two months. Attendance tailed off until after five months just 20–25% remained continuously in aftercare and after 11 months 12–13%. Nevertheless, nearly twice as many intervention patients attended aftercare at some time during the last three months of the follow-up (40% v. 22%).



This persisting attendance advantage appeared to account in part for impacts on substance use. Eleven months after leaving treatment, nearly 20% more (57% v. 37%) enhanced patients had been abstinent from alcohol and drugs for the past three months. The difference had grown over the preceding six months as more of these patients stopped using.

IN CONTEXT 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 highest attendance gains were observed while contracting and rewarding procedures were also at their height (the first two months) 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 package added to its impact. Involving the patients themselves in formulating the contract seems likely to have deepened their commitment to fulfilling it. By signing it they acknowledged research indicating that aftercare tripled the chances of staying sober. Refusing would have meant admitting to themselves and to their therapist that they did not wish to improve their chances in this way. Phone calls and personal, handwritten letters from therapists signified individual attention and that someone cared enough to notice the patient's achievements and to bother when they went missing.

The pattern of abstinence outcomes suggests that intervention patients, systematically encouraged and prompted to stay in or return to aftercare, felt more inclined to seek help after they lapsed or relapsed. A welcoming, non-punitive ('Come back – we'd like to see you.') attitude would have made it easier. The result it seemed was that more resumed abstinence over the last months of the follow-up.

Gains from the enhanced package might have been greater still if awards had been made in front of peers at group therapy sessions and if it had replaced 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.

In a study published in 2013,[9] for the first time the intervention package was tested not only at its home at the Salem centre, but also at another Veterans Affairs medical centre. The package was strengthened by providing more frequent and immediate reinforcement of aftercare attendance, especially between the fourth and twelfth months. In addition, contracting of participation at mutual aid groups was modified to include specific attendance and participation goals (such as obtaining a sponsor), and the prompting component added feedback on mutual aid group attendance. Abstinence-based contingency management was incorporated in the form of social reinforcement of abstinence with the goal of establishing longer periods of continuous abstinence during early treatment. The programme to which the intervention was added was similar to that in the featured study, with the notable exception that weekly substance use testing was conducted with all patients in aftercare and they were seen for additional counselling if substance use was detected. A high follow-up rate during the year following completion of the initial treatment phase means the findings from the 183 participants can be considered applicable to patients who met the criterion of being within reach of the aftercare centres and able to travel there; few simply refused to join the study.

The aftercare-promoting intervention extended throughout the 12-month follow-up and its effects were expected to cumulate to more patients abstinent by the end. This was not, however, the case; with or without the intervention, about half the followed-up patients were abstinent from drink and drugs at the 12-month follow-up. Other measures of substance use or those taken at earlier follow-ups were generally not significantly improved by the intervention. Intensity of drinking by the 12-month follow-up was a partial exception, suggesting along with other indicators a small effect on drinking even if not on other drug use. There were no significant effects on measures presumed to reflect the negative consequences of substance use, such as hospitalisation or imprisonment. Outcomes were substantially unaltered when it was assumed that patients unable to be followed up were continuing to use alcohol or drugs. These generally non-significant findings emerged despite the fact that the intervention had modestly increased attendance at aftercare sessions, though not at mutual aid groups like NA or AA.

Extension of the intervention to another centre did not seem the reason for findings less impressive than those in prior studies. Instead the authors highlighted the fact that a much larger proportion of the sample was required to attend aftercare as a condition of parole, probation, housing or employment (62%) than in the featured trial (40%). As the authors commented, “For veterans … whose housing, employment, or freedom were contingent on attending aftercare, the … intervention may have added little to their motivation or incentives to attend aftercare.’ Supporting this interpretation, among those not required to attend, impacts on attendance were much greater. Also, the core programme which the intervention supplemented was stronger, and though enhanced in several ways compared to previous studies, the intervention did not systematically promote attendance at one-to-one aftercare therapy sessions. For whatever reason, across the entire sample the extra cost of adding the intervention to usual care of $98 per participant per year did not net extra gains in abstinence.

Earlier studies from Salem and related work were reviewed by *Drug and Alcohol Findings* in parts one[3] and two[1] 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.

PRACTICE IMPLICATIONS The interventions are practical and probably also widely acceptable because they involve neither material rewards nor material or other sanctions. Behind them is the principle of prompting and rewarding attendance directly and immediately rather than expecting this to be motivated entirely by the patient's interest in their long-term recovery.

Intervention manual and materials and related publications are available free of charge from the lead author.

If (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 avoid or overcome relapse and to sustain support for services which might otherwise be seen as costly revolving doors. Residential settings radically alter the patient's environment, enabling residents who would otherwise be unable to do so to attain abstinence. By the same token, relapse is likely when they return to the environment in which they were previously unable to stop using, unless steps have been taken to alter this, or to sustainably alter how the patient reacts to it. For heroin dependent patients in particular, aftercare is needed to reduce the risk of overdose due to relapse at a time when the patient has lost their tolerance to opiate-type drugs. In the English NTORS study,[4] within a fortnight of leaving residential or inpatient care, half the former heroin users had returned to the drug. In other[5] studies[6] the consequence has been extremely high post-discharge death rates.

Guidance[7] for England stresses the need for aftercare following residential rehabilitation and continued treatment following detoxification. Arrangements are often complicated by the fact that residents return to their home areas, beyond the reach of direct aftercare provision by the initial service. However, the principles behind the featured intervention could be applied in the home area. Most services do make some arrangements, but in a survey[8] 4 in 10 residents were at best unclear who was to coordinate their aftercare, and care plans appeared to rely on mutual aid groups for ongoing support. Valuable as they are, arranging and monitoring attendance and responding to missed meetings is less feasible than with formal aftercare arrangements.

Thanks for their comments on the original entry in draft to research author Steven Lash of the Salem Veterans Affairs Medical Center and Bill Puddicombe, Chair of the European Association for the Treatment of Addiction (EATA). Commentators bear no responsibility for the text including the interpretations and any remaining errors.

1 Ashton M. Can we help? Drug and Alcohol Findings: 2005, 12, p. 4–7, 16–19. For an analysis of the entire series see the panel on p. 17.

2 **FEATURED STUDY** Lash S.J. et al. Contracting, prompting, and reinforcing substance use disorder continuing care: a randomized clinical trial. Psychology of Addictive Behaviors: 2007, 21(3), p. 387–397.

3 Ashton M. et al. The power of the welcoming reminder. Drug and Alcohol Findings: 2004, 11, p. 4–7, 16–18.

4 Gossop M. et al. Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: protective effect of coping responses. Addiction: 2002, 97, p. 1259–1267.

5 Best D. et al. Overdosing on opiates parts I and II. Drug and Alcohol Findings: 2000, issues 4 and 5.

6 Davoli M. et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study. Addiction: 2007, 102, p. 1954–1959.

7 Bradbury C. et al. Improving the quality and provision of tier 4 interventions as part of client treatment journeys: a best practice guide. National Treatment Agency for Substance Misuse, September 2008.

8 Abdulrahim D. et al. The 2007 user satisfaction survey of tier 4 service users in England. National Treatment Agency for Substance Misuse, May 2008.

9 Lash S.J. et al. Contracting, prompting and reinforcing substance use disorder continuing care. Journal of Substance Abuse Treatment: 2013, 44, p. 449–456.

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