Telephone Continuing Care Therapy for Adults

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Introduction

A GROWING INTEREST IN NEW MODELS OF TREATMENT is bringing the addictions field into a new era. These treatment protocols and systems address the full continuum of care, from detoxification to extended recovery monitoring (ASAM 2001; Dennis and Scott 2007; Dennis, Scott, and Funk 2003; Humphreys and Tucker 2002; McKay 2005; McLellan et al. 2000; Simpson 2004). In this new era, care will be provided in contemporary client-centered models designed to effectively manage chronic disorders (IOM 2006; Wagner et al. 2001).

Several factors are driving these changes, including progressive state and local leadership, more open-mindedness and pragmatism among treatment providers, increasing insistence from all stakeholders for better outcomes, and influential publications that have pointed out the similarities between addiction and other chronic disorders and the limitations of the current addiction treatment system (McLellan et al. 2000; McLellan, Carise, and Kleber 2003). In addition, research literature on continuing care has provided important information on the effectiveness of various interventions and management practices, ranging from more traditional Twelve Step–focused group counseling approaches to flexible extended care models (Dennis and Scott 2007; McKay 2005; McKay 2009a; McKay 2009b).

The term *continuing care* has been used to indicate the stage of treatment that follows an initial episode of more intensive care, usually inpatient/residential or intensive outpatient treatment. At one point, this phase of care was referred to as *aftercare*, but the

more common term is now *continuing care*, which better conveys the idea that active treatment continues in this phase (McKay 2005). Continuing care is provided in a variety of formats and modalities, including group counseling, individual therapy, telephone counseling, brief checkups, and peer-support meetings. This manual presents an approach to continuing care that relies primarily on telephone contacts.

A User-Friendly Intervention

Although there is now widespread agreement among clinicians, policy makers, and treatment researchers that continuing care is important, it is not always easy to deliver. Availability is a major problem. Some programs have provided little or no formal continuing care because insurance reimbursement has been limited. However, lack of availability is not the whole story. Some clients will not participate in continuing care when it *is* available and covered by insurance because they do not want to keep coming back to the clinic for further treatment sessions. This reluctance can reflect diminished motivation for treatment, but it can also be the result of other competing factors, such as the need to attend to work and parenting responsibilities.

This suggests that there is a need for a flexible, user-friendly continuing care intervention that can be provided for extended periods, if necessary. The challenge is to develop an effective intervention that is more appealing and less burdensome to clients than standard continuing care in order to promote higher participation rates. One possibility is to center the intervention on the use of regular, relatively brief telephone contacts, with provisions to "step up" the level of care when a client's status or symptoms indicate increased risk of relapse (Lavori, Dawson, and Rush 2000; McKay 2009a; Sobell and Sobell 2000).

Telephone-based continuing care is appealing to clients for a number of reasons. First, it is more convenient than standard, clinic-based care. Clients do not have to have access to transportation, take time off from work, or arrange for child care in order to travel to the clinic. Calls can be completed from home, work, or other locations where the client might be at the scheduled time of the session. Second, telephone-based interventions are provided via individual sessions. Conversely, most standard continuing care is provided in groups, a modality that many clients do not like. Third,

this approach provides support outside of conventional chemical-dependency treatment programs. Some clients are concerned about the perceived stigma associated with participation in such programs and wish to receive continuing care in some other setting.

A Useful Treatment Component

With regard to effectiveness, the telephone is considered to have a viable therapeutic role in the treatment of a number of physical and mental health problems (Roter et al. 1998; Wasson et al. 1992). Various studies have supported its use in the delivery of reactive and proactive counseling interventions, and in the therapeutic monitoring of health status, treatment compliance, and risk behavior. Telephone contact has been a useful component in the monitoring and treatment of depression (Baer et al. 1995; Osgood-Hynes et al. 1998) and obsessive-compulsive disorder (Baer et al. 1993; Greist et al. 1998).

Telephone counseling has been used most extensively as a component in smoking cessation programs. A meta-analysis has shown proactive calls made by clinicians to study clients have consistently produced better smoking outcomes than control conditions (Lichtenstein et al. 1996). There have been fewer studies of telephone continuing care in the treatment of alcohol and other drug disorders. In a study with problem drinkers, Connors, Tarbox, and Faillace (1992) reported no differences between group counseling, telephone calls, and a no-continuing-care control condition on drinking outcome measures, although the sample size in this study was small. Conversely, Foote and Erfurt (1991) reported that extended telephone contacts in an employee assistance program (EAP) produced better outcomes than standard follow-up care, as indicated by fewer subsequent hospitalizations and lower substance abuse treatment costs. More recently, Horng and Chueh (2004) reported that a three-month telephone continuing care intervention produced better alcohol use outcomes than a no-continuing-care comparison condition.

The telephone-based continuing care protocol presented in this manual was developed over the course of four randomized clinical trials conducted at the University of Pennsylvania. These studies are described in more detail later in the manual.

This manual consists of a detailed description of the program and outlines for the face-to-face orientation session and the subsequent telephone-based sessions. There are also guidelines for

administering the stepped-care component and maximizing adherence to the treatment protocols. The CD-ROM that accompanies the manual contains a client workbook, client handouts, forms for documenting treatment progress, and relevant journal articles.

Chapter 1

Understanding the Program

THIS PROGRAM IS DESIGNED TO PROVIDE continuing care for clients who have completed a residential treatment program or an intensive outpatient program for a substance use disorder. The majority of the sessions are provided via telephone contacts. However, we have found that some clients prefer to come into the clinic for some of their sessions. The program also includes a stepped-care component, which can include a return to clinic-based care, at least for brief periods of time. Therefore, some sessions will likely be provided in the clinic or office.

The sessions are usually offered on a weekly basis for eight weeks, twice monthly for another ten months, and, if desired, monthly after that for up to a total of two years. Each session is fifteen to thirty minutes in length and begins with a brief structured Progress Assessment of current symptoms and functioning. This assessment generates summary scores for relapse risk and protective factors, which can be used to monitor changes in these areas over time and to structure the rest of the session. These scores also provide guidance on possible increases or decreases in treatment intensity (that is, stepped care). The rest of the session is then focused on developing coping responses to risk factors identified in the assessment or expected over the period before the next session, primarily through the use of techniques from cognitive-behavioral

therapy (CBT). Motivational interviewing (MI) techniques are also used, particularly when the client appears to be losing motivation or becomes less involved with pro-recovery activities.

The stepped-care component has been included to adapt the program to the changing needs of the client over time. When a client's balance of risk and protective factors shifts sufficiently in the wrong direction, more frequent telephone calls are first offered. If this does not provide enough support and structure, an in-person evaluation session based on MI principles is recommended, to be followed by a course of face-to-face CBT sessions if the evaluation session finds that level of support is needed. Each component of the program is described in detail later in this manual.

Which Treatment Settings Can Use This Program?

This program can be used in a wide range of treatment settings and facilities. Residential or inpatient programs can use it to provide continuing care to clients after they leave the facility. In rural areas, where clients may travel some distance to attend either residential or outpatient treatment, the program can be used to provide continuing care following completion of a more intensive level of care, whether inpatient or outpatient. In such situations, the program may be limited primarily to telephone contact, with less opportunity for face-to-face stepped-care sessions.

The program can also be used by outpatient facilities to provide ongoing recovery support during and after intensive outpatient or standard outpatient treatment. For example, an intensive outpatient program (IOP) could start clients on the telephone program in their last month of IOP and continue it for some period of time after discharge. It is also possible to start the program earlier in the treatment process for higher-risk clients in order to provide additional individualized support and prevent early dropout. In our current research projects, for example, we begin providing the program to IOP clients in their third week of treatment. The city of Philadelphia recently began a pilot program with uninsured clients seeking treatment in the publicly funded system. This telephone recovery support protocol was provided at the very beginning of treatment, to prevent high-risk clients from falling through the cracks in the system.

How Is This Program Different from Other Outpatient/Continuing Care Programs?

An obvious difference is that this program is provided primarily via telephone contact, rather than face-to-face sessions. However, there are a number of other differences:

- The program is designed for one-to-one sessions rather than a group format.
- Each session begins with a structured Progress Assessment of risk and protective factors.
- The focus of the work in each session is guided by the assessment results.
- There is an emphasis on working on specific coping responses to risky situations.
- Progress on decreasing risk and increasing protective factors is monitored and tracked over time.
- Specific guidelines are provided for when and how to change level of care, based on changes in risk and protective factors over time.

Are Extra Staff Members Needed to Manage the Program?

Several factors determine whether additional staff members are needed to implement this program. Most clinicians have some time during the day when they would be available to deliver the telephone protocol. Given that each session is typically fifteen to twenty minutes long (although they can be up to thirty minutes long), a clinician could do three sessions in an hour, provided that clients were available at that time. Therefore, a program might be able to provide up to three months of telephone contact (that is, ten calls) to program graduates without needing much additional staffing. Often, clinicians who are providing IOP or residential care find it rewarding to be able to follow their graduates after they have completed an initial phase of treatment.

On the other hand, additional staff will clearly be needed if a treatment facility decides to implement the program earlier in the treatment process or to extend it over longer periods of time. For

example, the potential pool of program recipients is much larger if it is provided to all clients in an IOP, as opposed to only those clients who complete that phase of care. In addition, the stepped-care component of the program, which includes individual CBT sessions, can require additional staffing. However, it should be stressed that the version of the program that was evaluated and found to be effective in our first two studies did not include a stepped-care component. Therefore, treatment facilities could opt to try to reengage clients back into their standard programming should stepped care be required, rather than provide the individual CBT described here.

Finally, we have found that computerizing some aspects of the program, particularly the recording and tracking of risk and protective factor scores from the Progress Assessment at the start of each session, can be helpful to clinicians delivering the program. These data can be collected via paper and pencil, but it is more difficult to quickly review changes over time in the absence of a database. At this point, software that performs these functions is not available. Therefore, some staff time may be needed to set up a database if the facility desires to computerize the data collection process.

What Special Issues Might Arise When Dealing with Different Cultural Groups?

The majority of clients who have participated in our studies of telephone continuing care have been African Americans. We have looked at whether there are any differences in outcomes between African American and white clients, or between men and women, and have found no evidence that such differences are present (Lynch et al. 2009; McKay et al. 2003).

What about Clients with Co-occurring Disorders?

Clients who were currently exhibiting psychotic symptoms of sufficient strength to interfere with treatment have not participated in our studies of telephone continuing care, nor have clients with severe cognitive deficits. Therefore, it is not clear whether the intervention would be effective with such clients. However, we have included clients with other co-occurring psychiatric disorders in our studies, including schizophrenia-spectrum disorders, major depression, bipolar disorder, and anxiety disorders, including post-traumatic stress disorder (PTSD). Analyses indicate that neither a history of

major depression nor current severity of psychiatric symptoms at the beginning of the program predicts poorer substance use outcomes in telephone continuing care as compared to face-to-face interventions (McKay et al. 2005a). It should be noted that we have required clients with major psychiatric disorders, such as major depression or bipolar disorder, to have met with a psychiatrist and have been evaluated for medication in order to be in our studies. Some follow-up with a psychiatrist is also recommended for such clients.

Clients with a range of other co-occurring problems, such as poverty, poor social support, medical disorders, and criminal justice involvement, have participated in our studies. Procedures for addressing co-occurring problems are presented later in this manual. The Progress Assessment that is done at the beginning of each call includes information on factors such as psychiatric symptoms, work, and social support in order to monitor these areas and guide interventions.

Is the Program Evidence Based?

This program has been evaluated in four randomized research studies, all of which have provided evidence of its effectiveness. These studies have featured large sample sizes, two-year follow-ups, high follow-up rates, and confirmation of self-reported alcohol and drug use outcomes with biological tests or collateral reports. The studies were all conducted in publicly funded clinics in Philadelphia or in a Veterans Affairs Medical Center program, with clients who had extensive histories of alcohol and cocaine use, multiple prior treatment episodes, and high rates of co-occurring problems such as poverty, psychiatric disorders, and lack of social support for recovery.

The initial two studies (available on the CD-ROM) were conducted with clients who had completed four-week IOPs. A twelve-week version of the telephone-based continuing care intervention was found to be more effective than "treatment as usual" continuing care in the clinic (twelve weeks of group counseling) on most alcohol and drug use outcome measures. The intervention was also more effective than twelve weeks of cognitive-behavioral relapse prevention continuing care on some outcomes (McKay et al. 2004; McKay et al. 2005b). In the third study, we extended the intervention out to eighteen months and tested it in clients who had completed at least three weeks of more extended IOP. Once again, the intervention produced better alcohol and drug use outcomes than the comparison

conditions—in this case, IOP without telephone continuing care, and IOP with telephone calls that provided monitoring and very brief feedback but no counseling (McKay et al. 2009a; McKay 2009a). In the fourth study, which is currently under way, we are looking at the impact of providing small incentives for completing the telephone continuing care contacts.

The first two studies are completed and have been published in professional journals. The third study is completed, and data out to the eighteen-month follow-up for the complete sample have been presented at professional conferences. Two papers from this study are currently under review (Lynch et al. 2009; McKay et al. 2009b). The fourth study is still in process, although preliminary data out to the nine-month follow-up are positive as well.

How Should Clients Be Identified and Selected for Participation?

The telephone continuing care protocol can be offered to two groups:

- graduates of an initial, more intensive phase of care, such as residential treatment or IOP treatment
- clients who are still in OP or IOP treatment, but who may be at risk for dropout

If the goal is to offer the program to graduates of an initial phase of treatment, clients in residential or IOP treatment should be approached in the last week or two of treatment and told about the availability of the telephone continuing care program. It should be described as one of several options for continuing care, which also may include clinic-based care and/or peer-support programs. These options are not mutually exclusive; for example, clients could participate in the telephone program and attend AA or even group counseling. The important considerations are whether the client is motivated to participate in some form of continuing care and whether the telephone program is particularly appealing. Clients who anticipate difficulties attending standard clinic-based continuing care due to transportation problems, parental or work responsibilities, or a desire to "move on" with their recovery may be particularly good candidates for telephone-based continuing care.

If the goal of offering telephone continuing care is to provide additional recovery support to clients while they are attending an IOP, clients can be considered immediately for the program. In our studies, we have waited until clients have been in an IOP for at least two weeks before enrolling them in the research project. Therefore, it is not clear how effective the program is for clients who have not been in treatment that long. Although we would expect higher dropout rates among clients who are offered the program at or shortly after intake, there are likely to be some at-risk clients in this group who would benefit from the support provided by telephone contact.

If possible, we recommend that clients begin this protocol prior to graduating from their initial treatment program in order to increase the likelihood that they will make a successful transition to continuing care. Initial levels of care range considerably in duration; for example, some IOPs are only two weeks long, whereas others are three or four months in duration. Given the high rate of dropout in most outpatient programs, it is important to engage the client in the telephone protocol before he or she either graduates or drops out of the initial phase of care. During the period of overlap, when the client is still attending an IOP or OP and having telephone sessions, the calls place a greater emphasis on supporting continued engagement in that program. This is done by addressing barriers to attendance, such as problems with transportation, family roles, or employment; diminishing motivation for treatment or recovery; or problems with the IOP or OP itself.

Another important consideration in the selection of clients for the telephone program is what other continuing care options are available to the client. Our research indicates that some high-risk clients will do better if they receive twice-weekly clinic-based group counseling rather than telephone continuing care (McKay et al. 2005a). In this study, "high risk" was determined by failure to progress toward the main goals of the IOP along with whether the client was dependent on more than one substance at entrance to the IOP. The IOP goals, assessed over the past thirty days at the end of the IOP, were as follows:

- abstinence from cocaine
- abstinence from alcohol
- commitment to total abstinence
- attendance at three or more self-help group meetings per week

- at least 80-percent confidence in being able to use coping behaviors to avoid relapse
- some degree of social support for abstinence

Also added to this index was dependence on both alcohol and cocaine upon entrance to treatment. Clients who had *any combination* of four or more of these seven factors (that is, dependence on both alcohol and cocaine and failure to achieve three IOP goals, dependence on alcohol only but failure to achieve four IOP goals, and so on) did better in twice-weekly group counseling than in telephone continuing care. This effect was present through month twenty-one of the twenty-four-month follow-up. In our sample, only 20 percent of the clients were categorized in this high-risk group, quite probably because the sample was limited to those who completed a four-week IOP.

If clients have the option of participating in structured continuing care at the clinic after the IOP has ended, it makes sense to consider their progress in an IOP before recommending telephone continuing care. Clients who have done poorly in an IOP may be better served by remaining at that level of care for a few more weeks in order to achieve more of the goals listed here or starting off in clinic-based continuing care rather than moving directly to telephone continuing care only.

Chapter 2

Therapy Models

OUR TELEPHONE CONTINUING CARE MODEL is based on the principles of cognitive-behavioral therapy (CBT). According to the theories on which CBT is based, substance use is viewed as a learned habit that occurs in the context of environmental triggers, intra-individual thoughts and feelings, and short- and long-term consequences. Treatment involves identifying the client's unique triggers for substance use so that he or she can learn to avoid them or cope more effectively with them, and helping the client learn and practice more adaptive coping skills for managing risky situations (Carroll 1998).

It is important to emphasize that clinicians do not have to believe that addiction is a learned habit in order to use this program. Whatever the etiology of substance use disorders may be—learned habit, brain disease, self-medication, purely environmental, or some combination of any of these factors—clients can benefit by receiving help in monitoring their progress and developing improved coping behaviors for the stressful or high-risk situations they encounter in their daily lives. The program has been used successfully with clients who embrace the Alcoholics Anonymous view of the origins of substance use disorders and with clients who attribute their addiction to environmental factors such as family or the neighborhood they come from.

Intervention in CBT is based on a careful functional analysis of the client's alcohol and drug use. Substance use is viewed as a learned behavior that is associated with certain environmental

About the Authors

James R. McKay, Ph.D., is a professor of psychology in psychiatry at the University of Pennsylvania and the Director of the Penn Center on the Continuum of Care in the Addictions. He is also the Director of the Center of Excellence in Substance Abuse Treatment and Education at the Philadelphia Veterans Affairs Medical Center. Dr. McKay is the author or coauthor of more than 140 journal articles and book chapters. His work has focused on the evaluations of continuing care treatments for alcohol- and cocaine-use disorders, comparisons of outcomes following inpatient and outpatient rehabilitation treatments, the efficacy and cost-effectiveness of enhanced treatments for substance abuse, the impact of random assignment on outcomes, and the identification of factors over time that predict relapse following substance abuse treatment. His current work involves the development and evaluation of adaptive treatments for substance use disorders.

Deborah H. A. Van Horn, Ph.D., is an adjunct assistant professor of psychology in psychiatry at the University of Pennsylvania. She is also an independent consultant and trainer in counseling skills for lifestyle change. Her research has focused on evaluating new applications of cognitive-behavioral therapy and motivational interviewing in substance abuse treatment. Her training practice focuses on adapting empirically supported treatments for everyday clinical practice.

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Based on an integrated treatment model of motivational interviewing and cognitive-behavioral therapy, ***Telephone Continuing Care Therapy for Adults*** is an evidence-based program for adult clients who have recently completed a substance abuse treatment program. Research shows that those who follow a continuing care plan after finishing treatment report higher rates of abstinence compared to those who do not follow such a plan. Telephone-based therapy makes continuing care accessible for adults who cannot attend face-to-face appointments due to work or family obligations or transportation issues.

Created by James R. McKay, Ph.D., a renowned expert on continuing care, this program is ideal for adults who have completed a residential treatment program, including a program in a criminal justice setting, or an intensive outpatient program for a substance use disorder. ***Telephone Continuing Care Therapy for Adults*** includes a clinician's manual and a CD-ROM of essential resources that allows clinicians to print and copy materials at their convenience.

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