

Continuing Care

Part 1 - Now What Happens?

Client progress in early recovery is often marked by episodes of perceived stress, resumed drug use or full-blown relapse, and multiple treatment admissions. Too often treatment episodes are brief, sometimes lasting only a few weeks. This approach to care has been based on the notion that a client who enters and completes a single episode of care should then be able to maintain abstinence and continue the recovery process independently. Although some individuals can successfully recover within this framework, more than half the clients entering substance abuse treatment today require multiple episodes of care over several years to achieve and sustain recovery (Dennis et al., 2005).

As a clinician you no doubt have urged clients to consider some sort of care that continues after they complete their initial treatment. The term “continuing care” has been used to define the stage of treatment that follows an episode of more intensive, usually inpatient/residential or intensive outpatient care. In days gone by, this stage of care was referred to as “aftercare” - a low-intensity outpatient service. The more contemporary term “continuing care” better conveys the message that active treatment should continue. In this Addiction Messenger series we will examine the role of continuing care and provide information on “adaptive continuing care” (McKay, 2009a) for individuals with substance use disorders.

Common Continuing Care Interventions

Generally, both residential and intensive outpatient services have offered continuing care comprised of “aftercare” group therapy sessions and referral to mutual-aid (self-help) programs, often based on the 12 Steps of Alcoholics Anonymous (AA). The goal of providing support for a client’s participation in a mutual-aid program is to facilitate the client’s positive transition back into the community environment. Typically that service has consisted of one contact per week, most often delivered in a group format. McKay’s (2009b) summary of the range of continuing care approaches includes both group and less readily available individual models.

Group Models

Self or Mutual Help Programs: McKay notes that clients who regularly attend self-help programs have better alcohol and drug use outcomes than those clients who did not participate on a continual basis. Clients who actively participate in self-help programs are often also involved with related activities such as talking with a sponsor, socializing with other program members outside of planned meetings, and becoming a sponsor.

12-Step-Oriented Group Counseling: This common form of continuing care is typically offered by treatment agencies once or twice a week for 60 to 90 minutes.

Group sessions typically examine one of the 12 Steps and provide opportunities for members to share their personal experiences.

Individual Models

Cognitive Behavioral Therapy: CBT often focuses on helping clients determine when they are most likely to use alcohol and/or drugs. After learning to recognize high-risk situations clients work to enhance their coping skills.

Twelve-Step Facilitation: TSF is designed to facilitate client engagement in 12-Step based self or mutual help programs. The counselor helps clients understand the traditions and principles that form the foundation of the 12-Step approach and encourages attendance at meetings.

Couple and Family Therapies: CFT supports both substance use reduction and improvement in relationships. Often behaviorally focused, participants learn to improve their communication and problem solving skills as well as their engagement in recovery-oriented activities.

Effective Continuing Care

An important goal of continuing care involves preparing and empowering clients to strengthen their recoveries when they are no longer in formal treatment. Effective continuing care can encourage clients to assume a greater responsibility for their recoveries and to make lifestyle changes that will support their continued abstinence.

McKay (2009c) points out several factors that may be associated with effective substance use disorder management and continuing care, including:

- ***Longer treatment interventions with sustained client engagement.*** Extending the duration of care allows the client the benefits of structure, social support, monitoring, skill building, problem solving, and developing connections to community resources and links to other services.
- ***Active outreach and retention efforts.*** Keeping clients engaged in continuing care may require taking an intervention directly to clients (placing a lower burden on them and their families) by visiting in their homes, involving their families, using phone calls to deliver an intervention, actively finding clients to get them back into treatment, and other strategies that are flexible and client-centered.
- ***Use of incentives.*** Retention in extended continuing care can be improved by providing incentives to clients for their participation. Providing service discounts, gift coupons, or other rewards may be a low-cost way of improving treatment outcomes.
- ***Community links to other sources of support.*** Linking clients with other community services can help them build a social network that is supportive of recovery, abstinence, and becoming engaged in new activities. That network can be very helpful during times of vulnerability to relapse. For more information see the table titled “Strategies to Link Clients to Sources of Support in the Community.”

Adaptive Continuing Care

New developments in treatment for addiction are shifting practice standards from an acute-care model to an extended continuing care approach. That shift is expected to lead to significant improvement in long term outcomes for clients with substance use disorders. The past decade has seen the appearance of adaptive models of continuing care that focus on flexible client-centered approaches to addiction management.

The effectiveness of continuing care might be improved by the use of these adaptive algorithms or sets of rules (McKay, 2009a). The goal of “adaptive continuing care” is to deliver treatment that is *most effective* for a *particular client* at a *particular time*.

Adaptive continuing care regularly adjusts treatment focus and intensity, based on changes and fluctuations in client symptoms, level of functioning and status.

Employing the use of flexible adaptive service delivery systems and care settings may lead to greater client engagement and retention in continuing care, especially among individuals who do not want traditional, clinic-based substance abuse treatment.

McKay’s concept of adaptive continuing care emphasizes the flexible use of formats and modalities, including group counseling, individual counseling, telephone counseling, brief checkups, and self-help meetings. Features of the model include:

- Long-term monitoring of client progress,
- Flexible treatment protocols, adaptable to changes in client status,
- Greater convenience for clients in accessing continuing care,
- Enhanced attention to client preferences and choices,
- Use of services and settings outside traditional substance abuse programs,
- Use of new technologies to communicate with clients, and
- Emphasis on the benefits of self-care

Awareness and implementation of adaptive approaches may, in addition to enhancing client engagement and outcomes, also reduce treatment costs to the community by reducing the frequency of acute-care treatment episodes and potentially reducing crimes that result in engagement with the criminal justice system. Just as important, they may also increase the quality of life for clients and their families over time. The next issue of the Addiction Messenger will highlight more detailed aspects of using an adaptive approach to continuing care.

Strategies to Link Clients to Sources of Support in the Community

1. Educate each patient about the importance and potential benefits of post treatment recovery support services.
2. Solicit each patient's past experiences with and perceptions (i.e., stereotypes) of recovery mutual-aid groups, and review the menu of post treatment recovery support options (e.g., family, social, occupational, formal support groups).
3. Identify important meeting characteristics (e.g., religious, spiritual, secular, smoking or non-smoking, gender, ethnicity, age, geographic access).
4. Use assertive rather than passive linkage procedures (e.g., orient each patient about what to expect in his or her first meeting).
5. Link each patient to a particular person to orient and guide the patient into a relationship with a local group, and link each patient to a specific meeting for his or her initial exposure.
6. Resolve obstacles to participation (e.g., day care, transportation).
7. Monitor and evaluate each patient's initial and ongoing responses to that person/meeting through follow-up phone calls, emails, or visits.
8. Link family members to support structures congruent with the recovery framework of the patient (e.g., referring spouses and children to Al-Anon and Alateen when the patient is participating in Alcoholics Anonymous).

White and Kurtz, (2006)

SOURCES

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