

Telephone-Based Continuing Care Sustains Abstinence

By Lori Whitten, *NIDA NOTES* Staff Writer

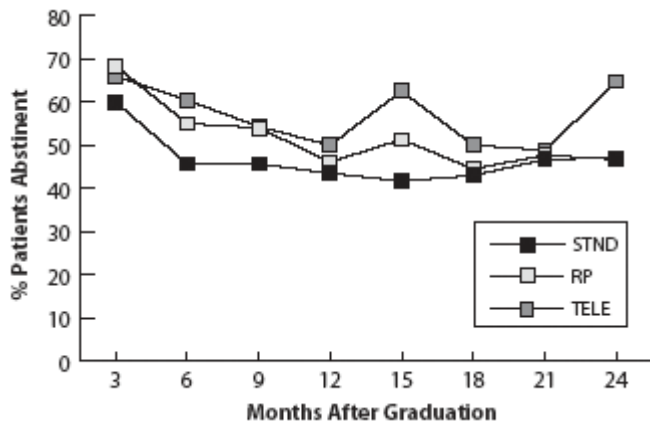
Telephone-based continuing care, in which an addiction counselor supports patient recovery with 15-minute calls once a week, can be as good as or better than face-to-face care at helping most patients maintain abstinence after intensive outpatient treatment (IOP). In a recent NIDA-funded study, the benefits of a telephone support protocol were evident nearly 2 years after the last call for all but the 20 percent of patients with severe addiction problems that did not resolve during IOP.

"Telephone-based continuing care does not require transportation or interfere much with work or childcare responsibilities, and this flexibility may help patients stay engaged in recovery and maintain the gains achieved during initial inpatient or outpatient treatment," says Dr. James McKay, lead researcher of the study.

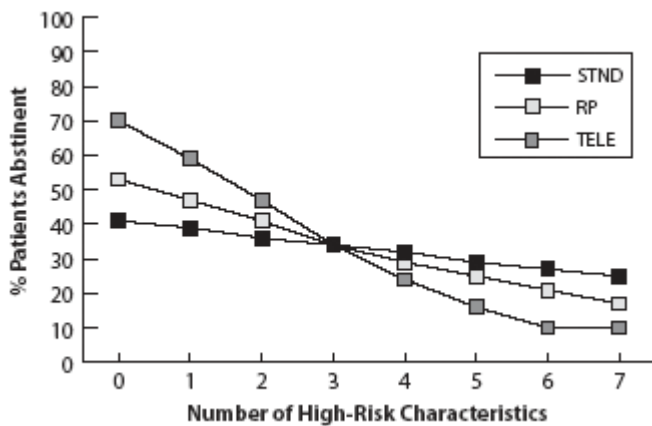
Dr. McKay and colleagues at the University of Pennsylvania, the Treatment Research Institute in Philadelphia, and Brandeis University worked with two Philadelphia-area outpatient addiction programs. Patients seeking treatment in these programs received about 9 hours of outpatient group therapy each week for 1 month, on average. The therapy concentrated on overcoming denial of substance abuse, learning about the addiction process and cues to relapse, and beginning self-help participation. Dr. McKay and colleagues recruited patients who "graduated" from therapy—that is, continued in the IOP and achieved abstinence in the last week—to receive 12 weeks of continuing care and follow-up for 2 years.

The patients, 359 men and women aged 18 to 65, were typical, in terms of demographics and problem severity, of individuals seeking treatment at publicly funded outpatient addiction programs. Half met the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV) criteria for co-occurring cocaine and alcohol dependence, 87 were dependent on cocaine only, and 91 were alcoholic. Thirty percent had met the criteria for a diagnosis of major depression at some time in their lives. When they began treatment, they reported 8 years of cocaine and 18 years of alcohol abuse, on average, and multiple attempts to quit.

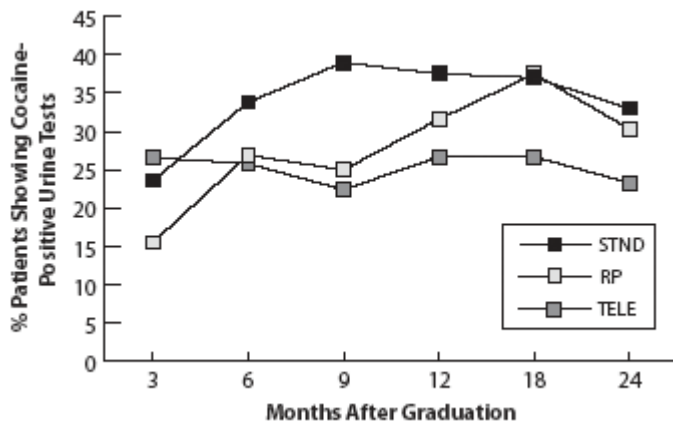
*Telephone Counseling Helps Outpatient Treatment
Graduates Stay Abstinent*



Two years after graduating from intensive outpatient treatment, more patients who participated in telephone-based continuing care (TELE) had maintained abstinence during the previous 3 months than those receiving standard group counseling (STND). The percentage of abstinent patients did not differ between TELE and relapse prevention (RP) continuing care.



Throughout the study, patients with four or more characteristics reflecting severe addiction were better able to maintain abstinence if they participated in STND compared with TELE.



The percentage of cocaine-positive urine samples did not increase as quickly during the follow-up for TELE patients as it did for those who participated in RP, with a similar trend for TELE compared with STND.

All patients participated in 12 weeks of continuing care after completing a month of intensive outpatient treatment, and reported outcomes every 3 months during the 2-year follow-up.

Regular Contact With a Therapist Is Crucial

The investigators randomly assigned each patient to one of three continuing care therapies: a face-to-face therapy, either standard group (STND) or relapse prevention (RP); or telephone-

based (TELE) counseling. In STND care, the most common approach to continuing care for addiction, 122 patients attended twice-weekly counseling sessions that emphasized overcoming denial and engaging in mutual and self-help activities. In RP therapy, 135 patients attended an individual session of cognitive-behavioral therapy and then group sessions once a week. In this approach, patients identify situations that prompt substance abuse and work to improve coping responses using structured activities and homework exercises.

In TELE care, 102 patients met with counselors in person the week before beginning the telephone phase to discuss the therapy and receive a workbook with exercises that structured subsequent calls. At a scheduled time each week, they telephoned counselors and talked for 15 to 20 minutes about progress during the previous week, any episodes of substance abuse, participation in self-help and other pro-recovery activities, plans for achieving the next week's goals, and any concerns. Counselors contacted patients who did not call and discussed in a supportive way their reasons for not doing so. To ease the transition from outpatient to continuing care, therapists offered the TELE patients group counseling once a week for a month. Patients struggling with relapse at that point could continue with group sessions; more than a third (35 percent) exercised this option.

The researchers followed up with patients every 3 months throughout the study and contacted 86 percent 2 years after graduation from IOP. At this point, about two-thirds of TELE patients reported abstinence during the previous 3 months, compared with about half of those who had participated in STND. An analysis of urine samples from the cocaine-addicted patients showed an overall increase in the percentage of cocaine-positive samples during the follow-up period, but the increase was more rapid among RP participants than TELE participants. The TELE group had higher abstinence rates than STND throughout follow-up. Patients who participated in TELE maintained the gains of IOP even though they received about half as much therapeutic contact (428 minutes) as those receiving STND or RP (845 and 861 minutes, respectively).

"Continuing care benefits people in recovery in several ways, but regular contact with a therapist is crucial for patients with a chronic condition, and especially helps patients who have relapsed get back into treatment," says Dr. Dorynne Czechowicz of NIDA's Division of Clinical Neurosciences, Development and Behavioral Treatments. Although larger studies with more diverse patients are needed, Dr. McKay and his colleagues laid important groundwork, she says.

Face-to-Face Care for Severe Problems

Some patients need more contact with a counselor than telephone-based continuing care affords to maintain recovery. To identify these patients, Dr. McKay and his colleagues examined the link between outcomes and seven patient characteristics: co-occurring addiction to alcohol and cocaine at the beginning of IOP; any alcohol use, any abuse of cocaine, minimal attendance at self-help meetings, below-average social support during IOP; and a lack of commitment to complete abstinence, and low self-efficacy for recovery at the end of IOP.

Patients who demonstrated three or fewer of the characteristics—about 80 percent of the study population—did at least as well with TELE continuing care as with the other two approaches. But the remaining patients, those who met the criteria for co-occurring addiction at the beginning of treatment and did not achieve the main goals of IOP—abstinence from cocaine and alcohol during treatment, commitment to abstinence, and participation in self-help programs—were at high risk for relapse and showed better outcomes with STND continuing care, relative to TELE, during most of the follow-up. The findings suggest that TELE may be inappropriate for patients with more severe addiction problems until they demonstrate stable abstinence from drugs and alcohol, says Dr. McKay.

Flexible Continuing Care

"Some practitioners are developing flexible arrangements to engage and retain more patients in continuing care," says Dr. McKay. Flexibility in the practical sense—the ability to call one's counselor from any location—extends participation in continuing care, not only to busy people, but also to those living in rural areas or who have lost driver's licenses.

Telephone-based care is one way that a treatment intervention can respond to each patient's progress during recovery; it gives counselors the flexibility to intensify care if the patient is struggling to maintain abstinence. "Clinicians managing other chronic disorders—for example, hypertension and cancer—are using progress during initial treatment to determine subsequent care. It's not a new therapeutic approach, but it is novel to addiction treatment," Dr. McKay says.

Sources

- McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry* 62(2):199-207, 2005. [[Abstract](#)]
- McKay, J.R., et al. Do patient characteristics and initial progress in treatment moderate the effectiveness of telephone-based continuing care for substance use disorders? *Addiction* 100(2):216-226, 2005. [[Abstract](#)]