

Using Progress in Intensive Outpatient Treatment to Select Appropriate Continuing Care

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Blending Clinical Research and Practice

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Current Outpatient Treatment Models

- Many alcohol and/or drug dependent patients begin treatment in Intensive Outpatient Programs (IOP)
 - Typically 3 days/week, 9 hours of therapeutic contact
 - Length of programs vary, but most are 1-2 months in duration.

Current Outpatient Treatment Models

- Other patients may begin treatment in Standard Outpatient Programs (OP)
 - 1-2 sessions/week, 1-4 hours of therapeutic contact
 - Again, length of programs vary, but most are 2-4 months in duration

Continuing Care

- At some point, patients can be “stepped down” from IOP or OP to continuing care of some sort (ie, aftercare) on the basis of:
 - Completion of IOP or OP program of set duration
 - Achieving specified reductions in symptoms and related problems (as described in ASAM criteria)

Continuing Care

Greater interest now in continuing care due to:

- Recognition of the chronic nature of substance use disorders, at least for many patients who receive formal treatment
- Need to better manage these disorders over time, perhaps by shifting focus from “intensive” to “extensive” interventions

Approaches to Continuing Care

- “More of the Same” but at diminished intensity
- “Evidenced based” individualized therapy (e.g., CBT, Contingency Management)
- Couples therapy, and various wrap-around services
- Telephone-based monitoring and counseling

How Effective Is Continuing Care?

- Despite the obvious potential benefits of continuing care, research findings have not been as positive as one would expect:
 - High dropout rates
 - Significant treatment group effects found in about 50% of the studies
 - Little difference between active treatments
 - Some evidence that treatments of one year or longer are effective

Improving Continuing Care

- Develop empirically supported protocols to match patients to the most appropriate form of continuing care, on the basis of:
 - How they look when they enter treatment?
 - How they did while in IOP?
- Most research has focused on the former, with little evidence of success
 - Project MATCH

U Penn Continuing Care Research Program

- Investigating continuing care main effects and matching effects in 4 studies
- Present results from 2 studies that compared continuing care models in IOP graduates:
 - Cocaine dependent male patients in VA program
 - Cocaine and/or alcohol dependent patients in community and VA programs
- Briefly describe a new telephone-based disease management study

Continuing Care I

Adapting Treatment on the
Basis of Early Performance

Study Overview

- Patients all cocaine-dependent graduates of a 4-week intensive outpatient program (IOP) at a VAMC (N=132)
- Treatment conditions (5 months long)
 - Standard 12-step oriented group counseling (TAU)
 - Individualized relapse prevention (RP)
- Regular clinic counselors provided services
- Regular clinic patients participated

Study Features

- Follow-ups at 3, 6, 12, 18, 24 months
- High follow-up rate (>90% at 24 months)
- Corroboration of self-reports with urine toxicology
- Adequate control for therapist effects, monitoring of adherence, etc.

Sample Characteristics

- All participants had dx. lifetime cocaine dependence and recent use.
- All participants were male
- 86% African American
- 86% had lifetime dx of alcohol dependence

Continuing Care Conditions

- **12-step Based Group Counseling**
 - “Treatment as usual” in the clinics
 - Two 1-hour groups/week
 - Counselors facilitate discussions between patients that focus on working 12 step programs
 - Planning of leisure time and weekend activities
 - Generic approach to relapse prevention (“avoid people, places and things”)

Continuing Care Conditions

- **Relapse Prevention**

- One individual RP session and one group session/week
- Patients learn to recognize and anticipate high risk situations, and practice better coping behaviors
- Weekly between-session homework, including planned exposure to some risky situations

Main Effects over 24-Month Follow-Up

- **Cocaine use:**
 - No group differences on any self report measure
 - No group differences on urine toxicology
- **Other outcome areas:**
 - Alcohol outcomes in year 2 better in RP than STND
 - Little evidence of differences on any other measure
- *.....But what about matching effects???*

Predicted Matching Effects

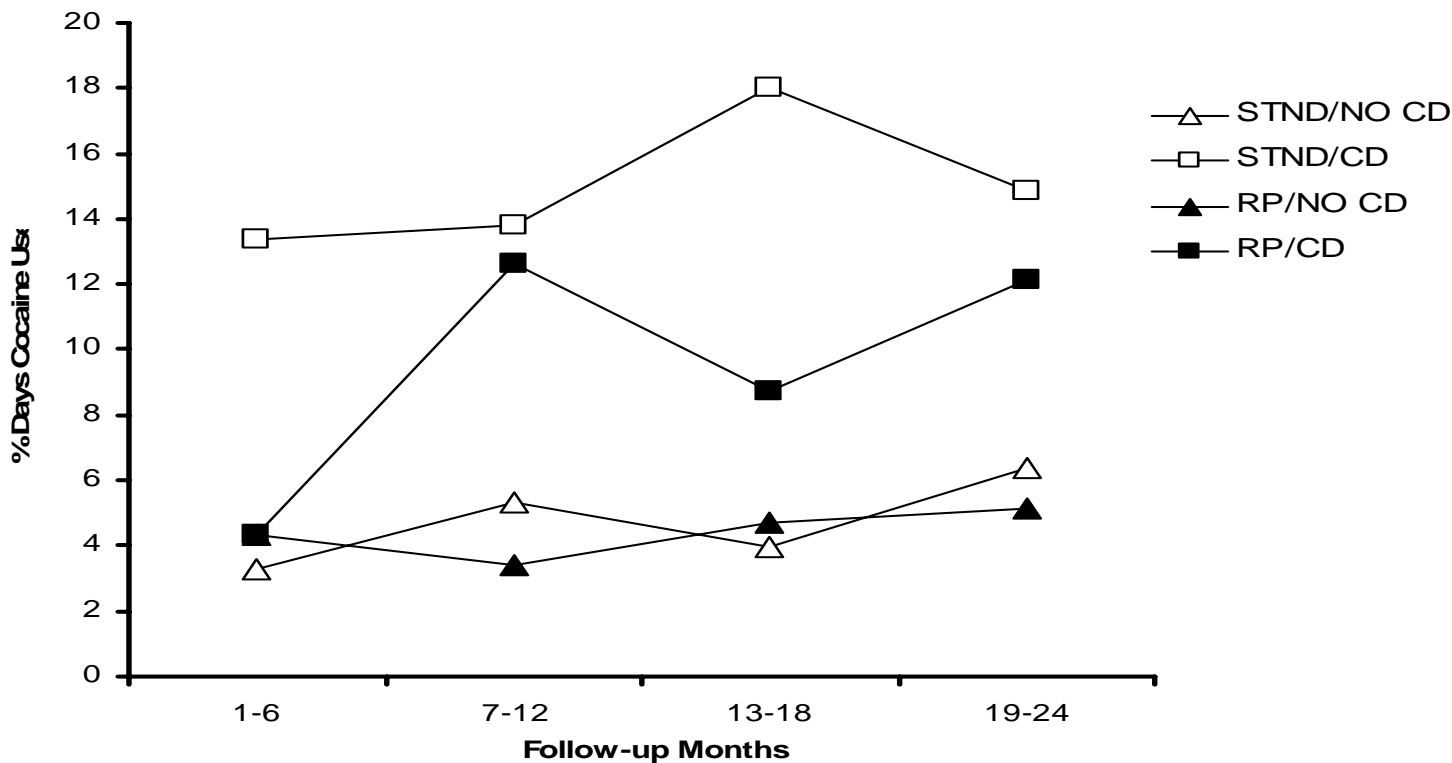
Based on Progress while in IOP:

Did the patient achieve remission from cocaine dependence?

Predictions:

- Patients who weren't able to stop using cocaine in IOP would do better in RP than STND.
- No difference in patients who did stop using cocaine.

IOP Cocaine Remission Status by Treatment Condition: Cocaine Use Frequency Outcomes



Continuing Care II

Identifying Patients Appropriate for
Telephone-Based Continuing Care

Advantages of the Telephone

- Convenient for client
- Reduces stigma of weekly trips to the treatment program
- Individualized attention
- Lower costs of ongoing care (?)
- Potential to be continued over a longer period of time

Evidence Supporting Therapeutic Use of the Telephone

- Studies suggest the telephone can be effective in delivering treatment:
 - Addiction (Foote & Erfurt, 1991)
 - Smoking (Lichtenstein et al., 1996)
 - Depression (Baer et al., 1995; Simon et al., 2004)
 - OCD (Greist et al., 1998)
 - Bulimia (Hugo et al., 1999)
 - Cardiac care (Jerant et al., 2001)

Models of Telephone-Based Continuing Care

- As an *alternative* to standard face-to-face continuing care approaches
- As an *extension* of standard care:
 - Monitor status and symptoms of clients
 - Provide brief ongoing treatment
 - Arrange for stepped up care when needed

Penn Telephone Continuing Care Study

- Patients:
 - 359 graduates of 4-week IOP programs
 - Alcohol and/or cocaine dependent
- Continuing care conditions (3 mo):
 - Standard group counseling (STND)
 - Individualized relapse prevention (RP)
 - brief telephone-based counseling (TEL)

Study Features

- High follow-up rate out to 24 mo. (>85%)
- Adequate control for therapist effects, monitoring of adherence, etc.
- Primary Outcomes
 - % days abstinent from alcohol and cocaine
 - total abstinence from alcohol and cocaine
 - Cocaine urine toxicology (cocaine pts)

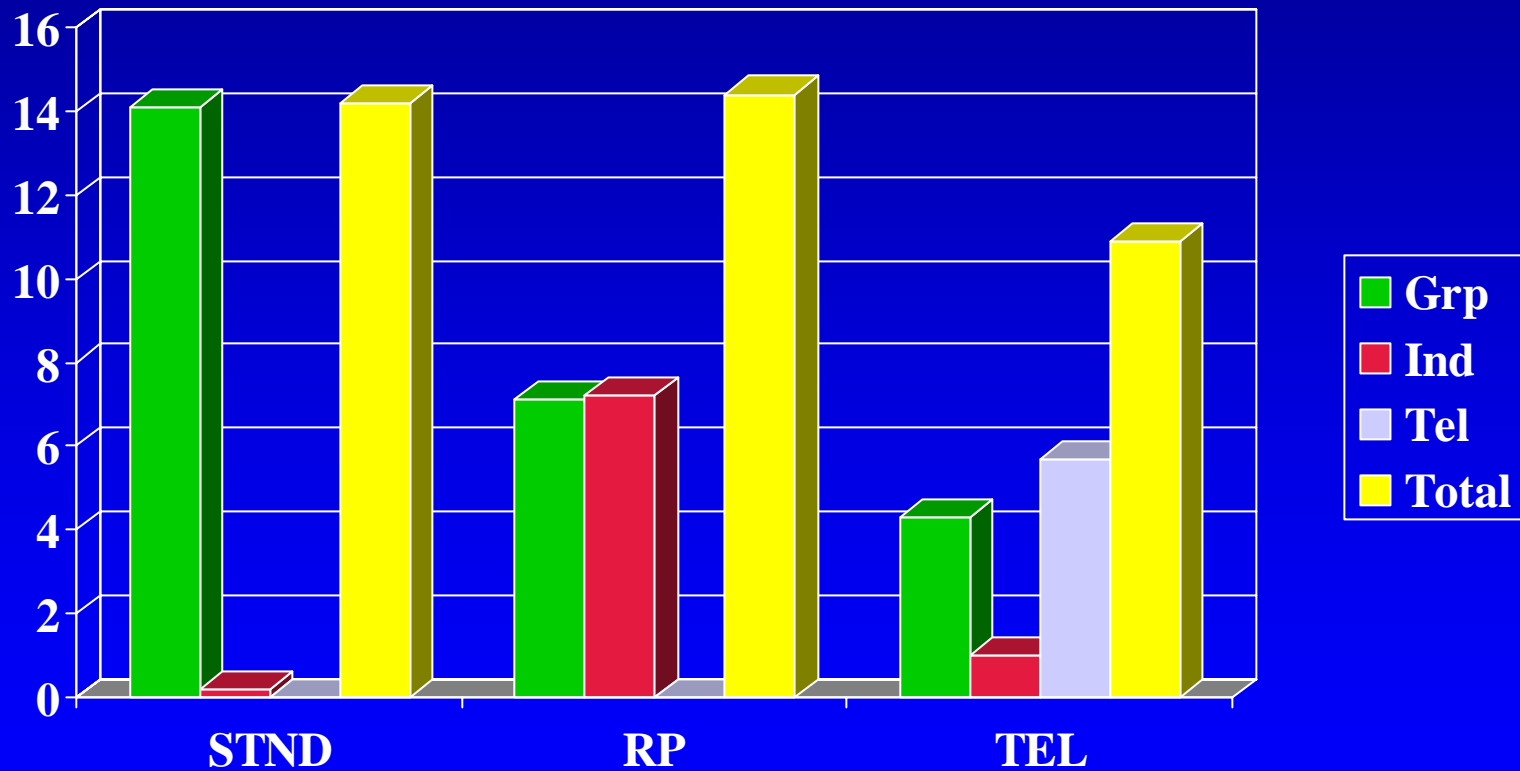
Characteristics of Participants

- Gender: 17% women
- Age: mean of 42 years
- Education: mean of 12.4 years
- Race: 77% African American, 21% White
- Years of cocaine use: 8.5
- Years of alcohol use: 18.6
- Prior drug treatments: 2.8
- Prior alcohol treatments: 3.5

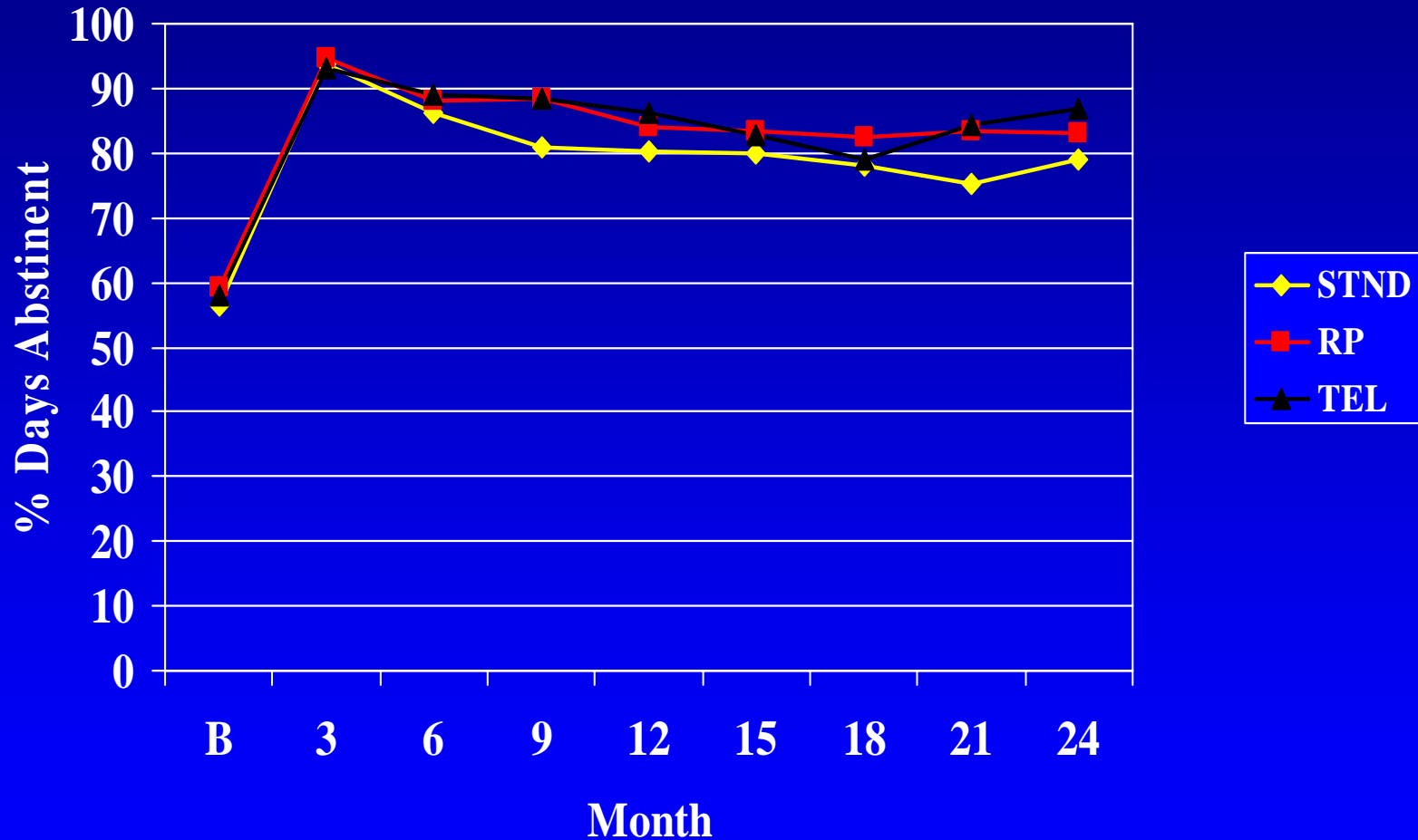
Continuing Care Conditions

- **Telephone Monitoring and Counseling**
 - Weeks 1-4, patients make a 15 minute call and attend a “transition” group (1x/week @)
 - Weeks 5-12, patients have telephone contact only (1x/week)
 - During calls, patients report on progress toward 1-2 goals, and plan goals for next week
 - Patients use a workbook that structures intervention for each week.

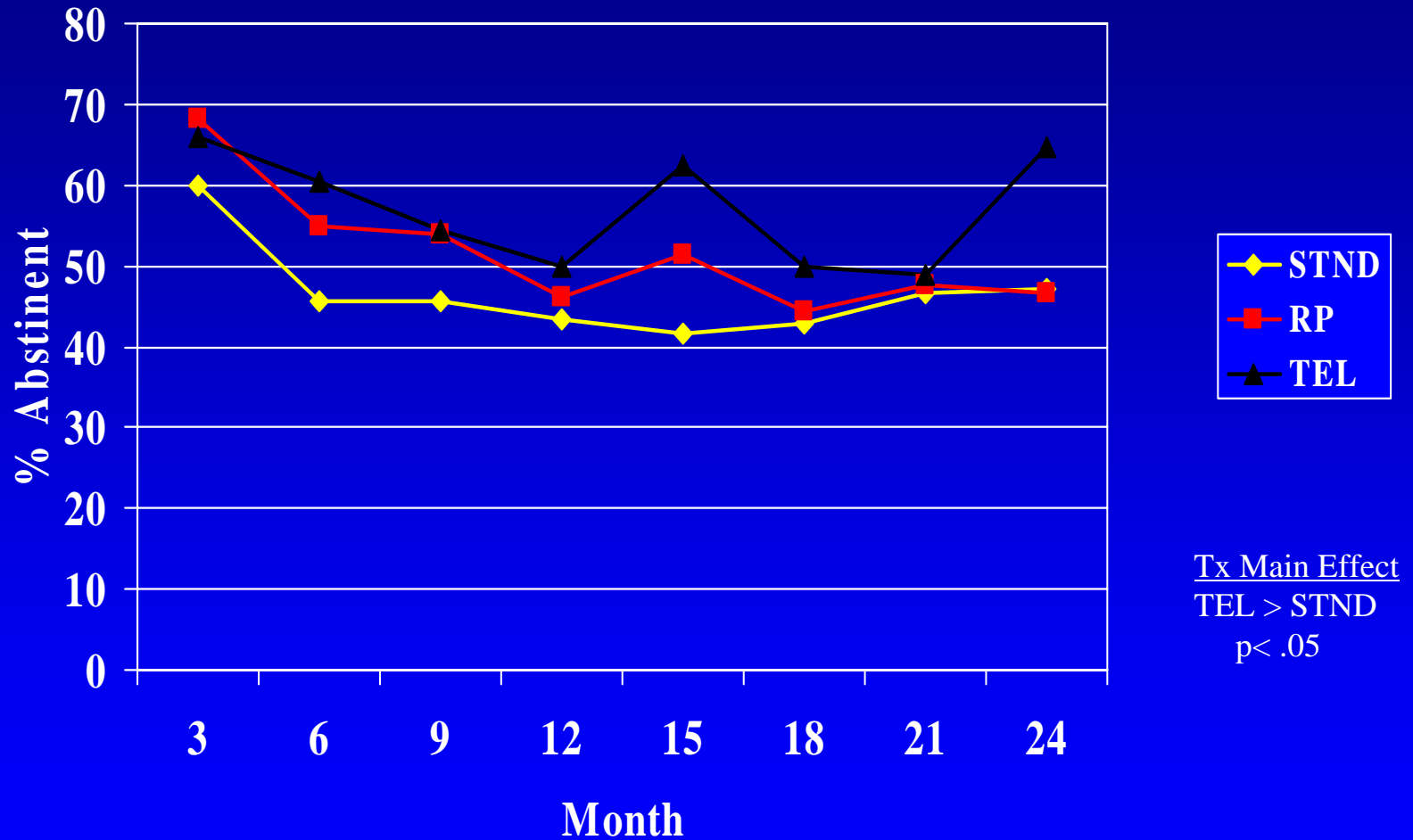
Number of Sessions Received



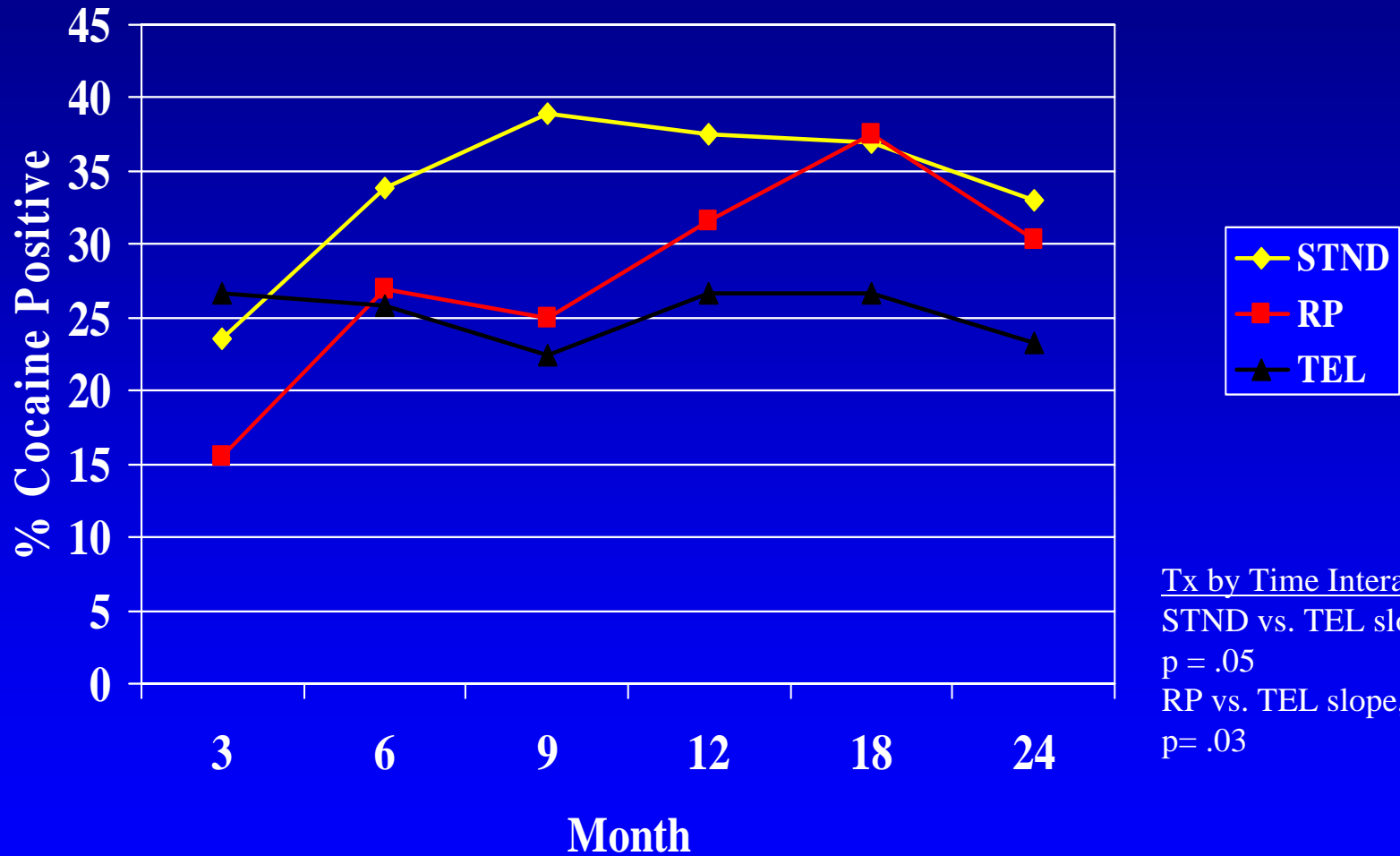
Percent Days Abstinent



Total Abstinence Rates



Cocaine Urine Toxicology



Identifying Patients Who Do Well in Telephone Based Continuing Care

(and those who do not!)

Working Hypothesis...

“Better prognosis” patients will be most appropriate for telephone continuing care

Determined by:

- Pretreatment factors
 - Dependence on both alcohol and cocaine
 - History of major depression
- Measures of progress during IOP

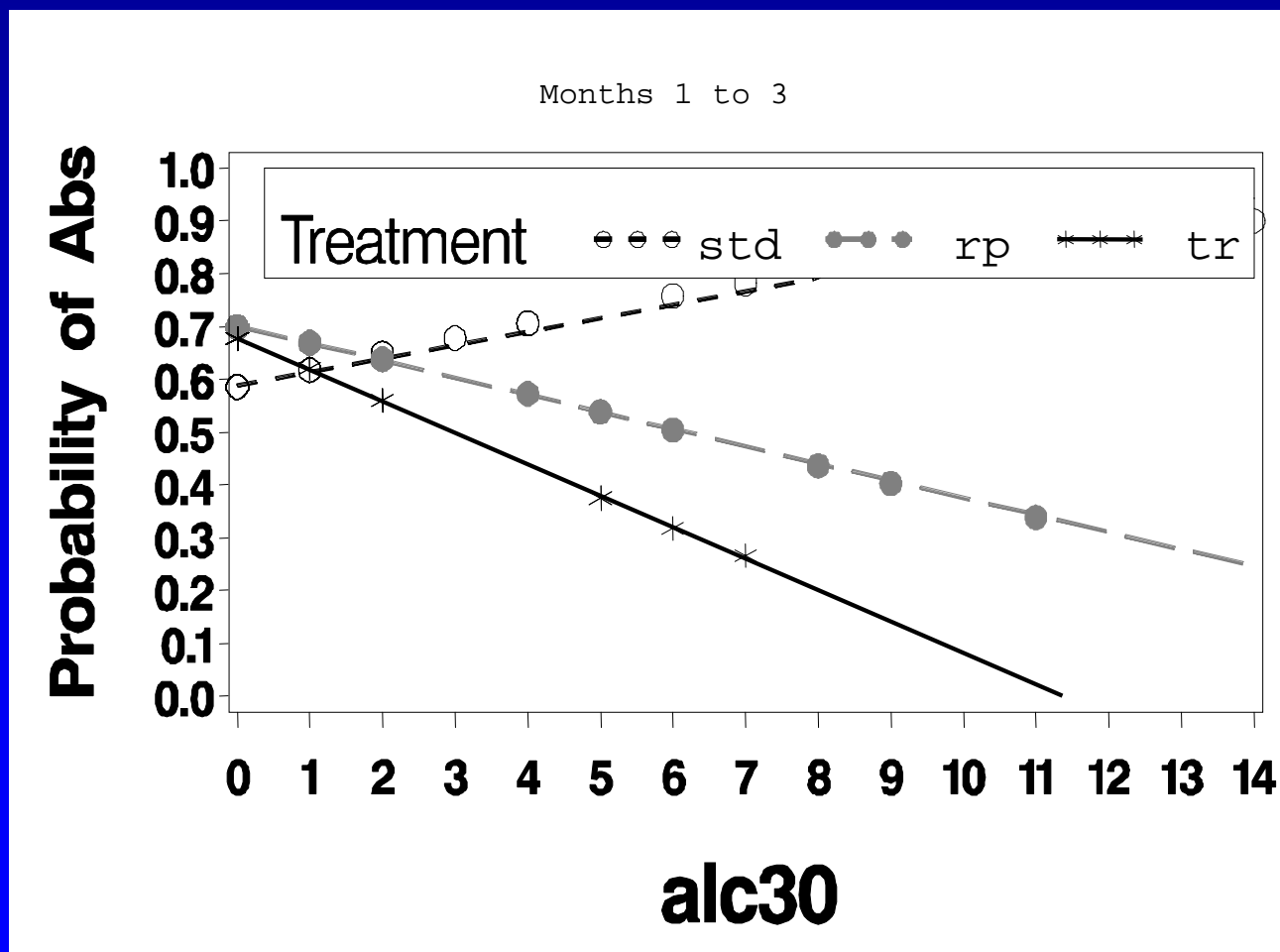
IOP Goals

- Stop using alcohol and drugs
- Become committed to abstinence
- Attend self-help regularly
- Increase motivation to change
- Increase social support
- Increase confidence in ability to cope with stressors without using (ie., self-efficacy)
- Decrease severity of psychiatric symptoms

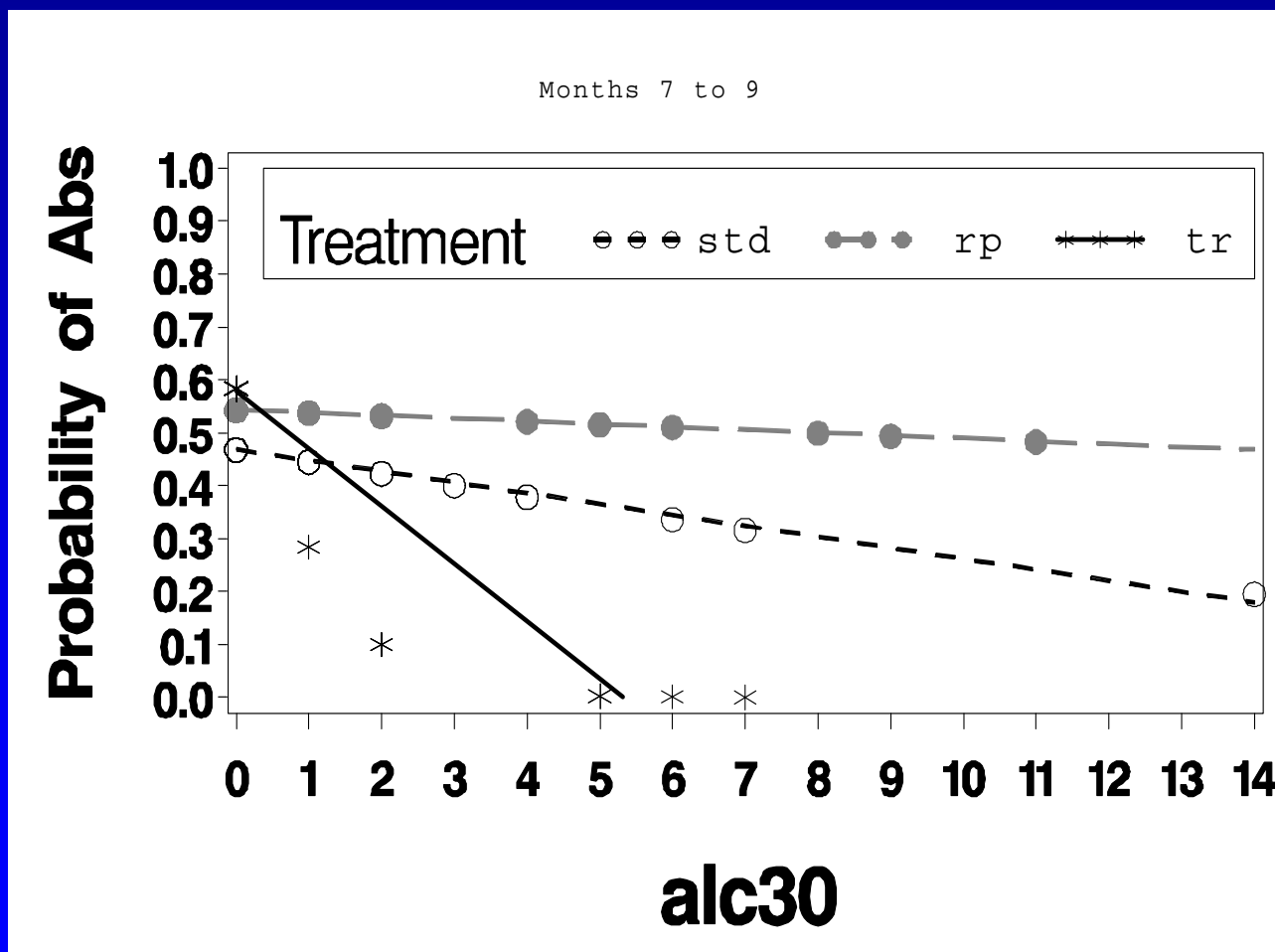
Matching Analyses

- Determine whether any of these measures interact with continuing care condition to predict main outcomes
 - Percent days abstinent
 - Total abstinence
- Results: Only interaction that was significant was alcohol use in IOP x the TEL vs. STND contrast ($p < .05$)

Relation of Days of Alcohol Use in IOP to Rates of Abstinence in Mo 1-3



Relation of Days of Alcohol Use in IOP to Rates of Abstinence in Mo 7-9



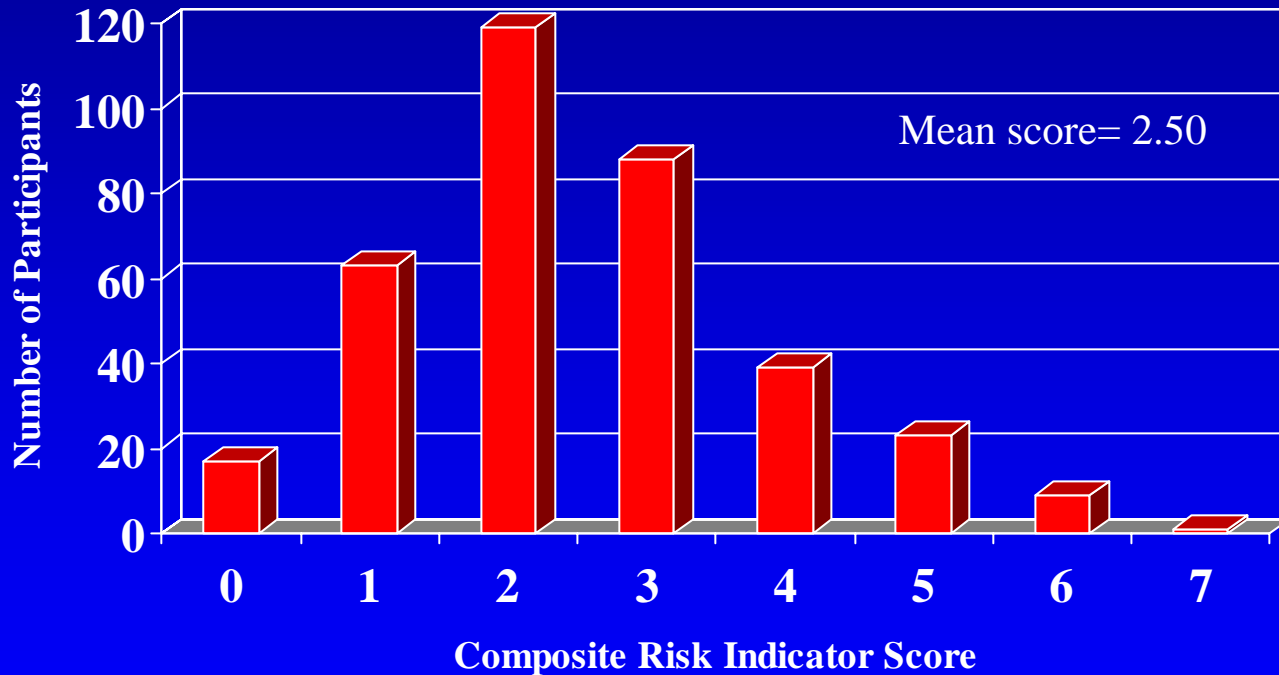
Limitations of Initial Findings

- Limited usefulness— only about 8% of Ss in TEL drank during IOP
- Did not indicated Ss for whom TEL was particularly *effective*
- Did not address possibility of stronger matching effect due to having a poor score on a number of goals (ie., think cardiac risk factors)

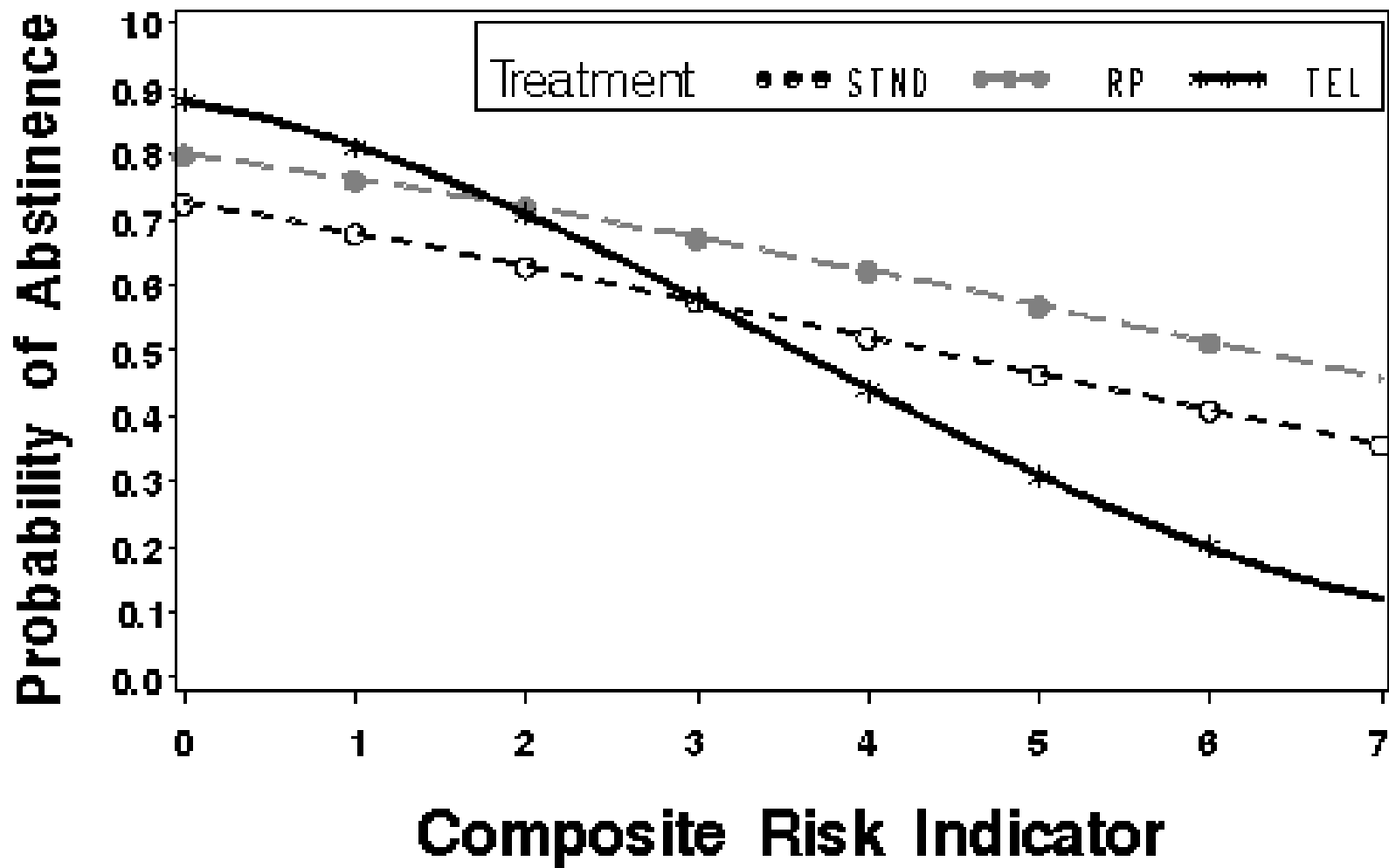
“High Risk” Clients

- Derived a 7-item “composite risk indicator” using sum of dichotomized indicators:
 - Dependence on both alcohol and cocaine, prior to IOP
 - Any alcohol use in prior 30 days
 - Any cocaine use in prior 30 days
 - Attendance at < 12 self-help meetings in prior 30 days
 - Does not have goal of absolute abstinence
 - Low social support (< median)
 - Low self-efficacy (< 80%)

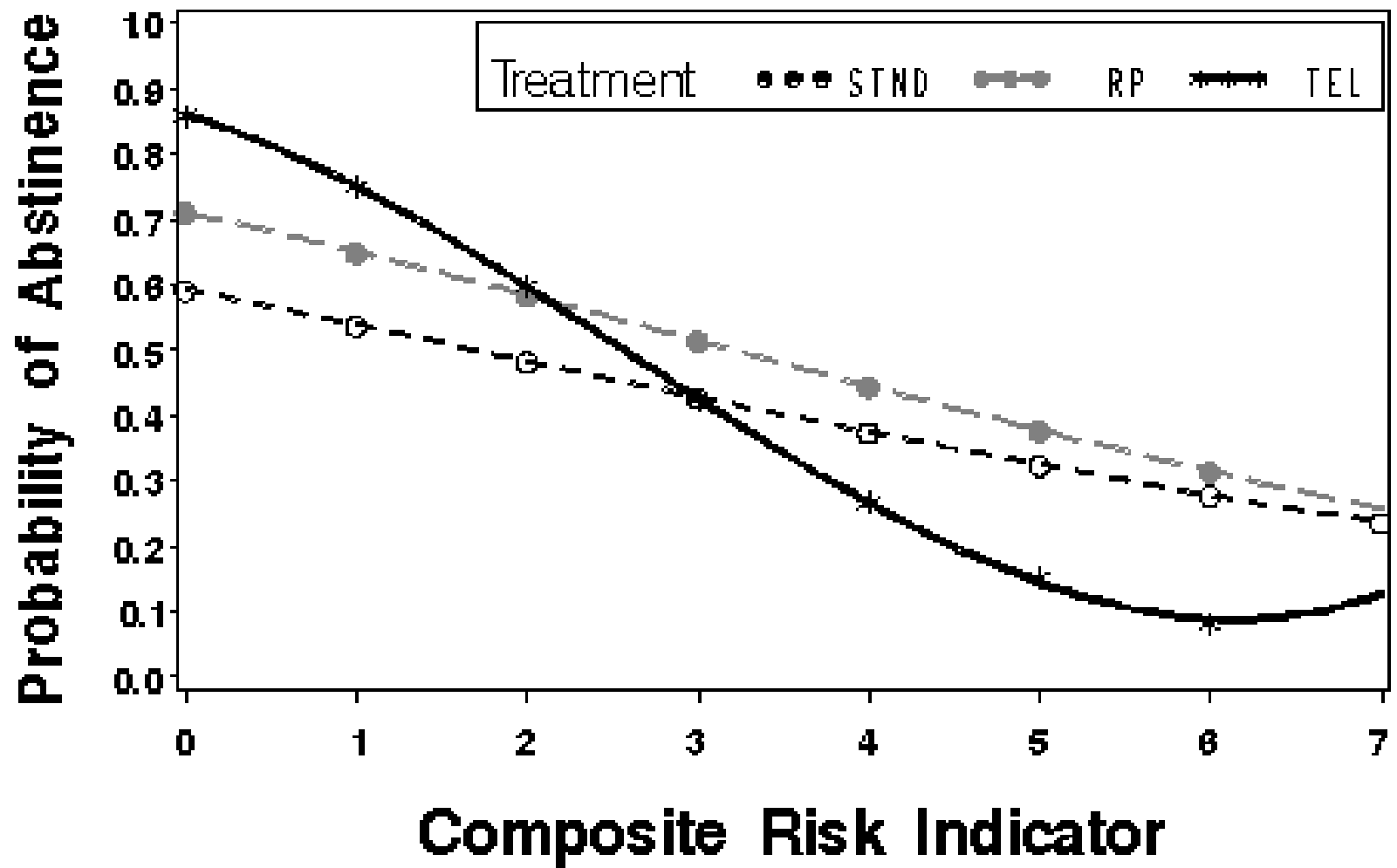
Distribution of Scores on the Composite Risk Indicator



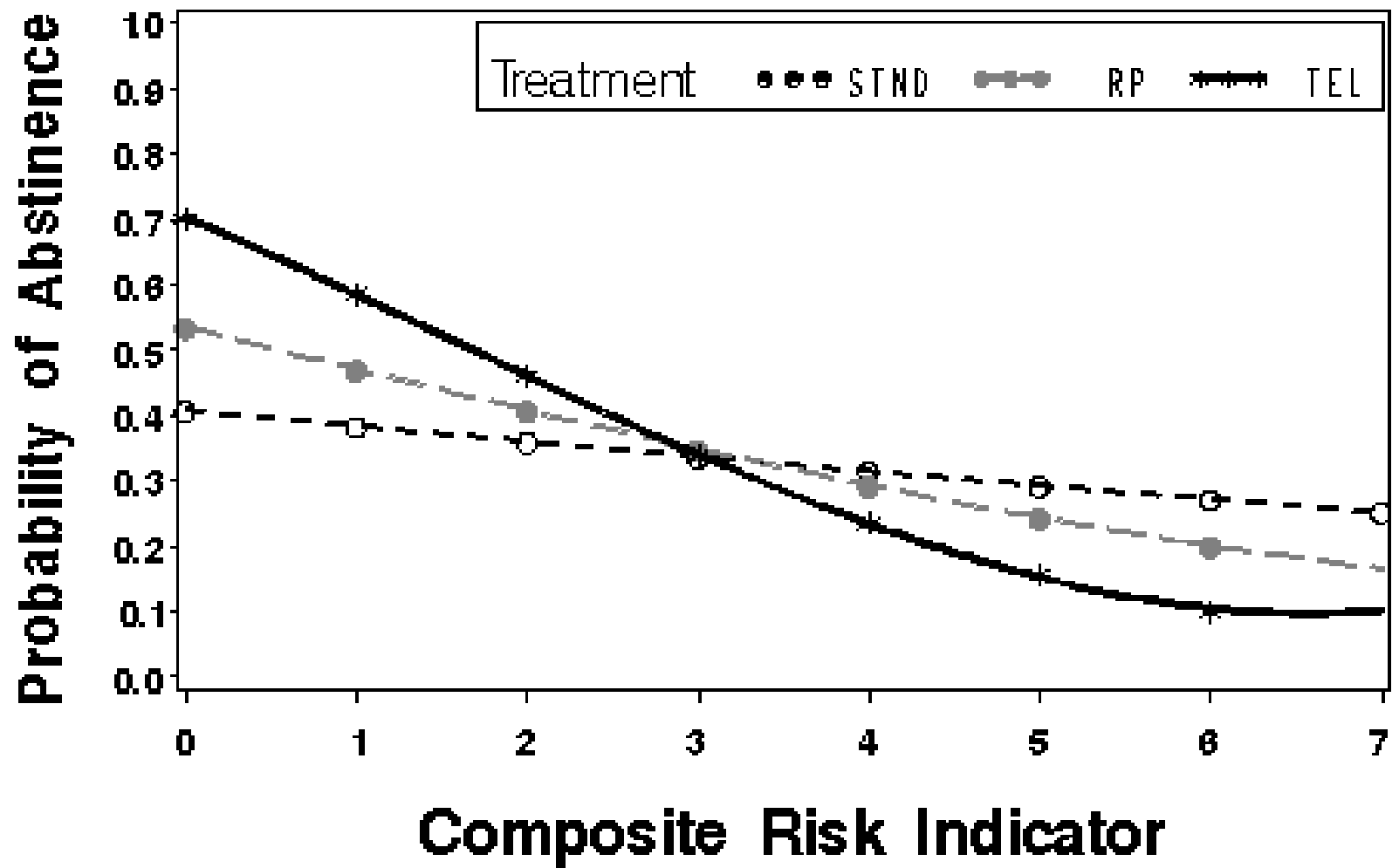
Months 1 to 3



Months 7 to 9



Months 13 to 15



Conclusions From Study II

- Assessing alcohol use in IOP identified 8% of TEL Ss who did better in STND continuing care.
- Adding five other indicators of progress in IOP plus dual vs. single dependence:
 - Identified 20% of Ss in TEL who did better in STND.
 - Identified Ss who actually did better in TEL than in STND or RP

Overall Conclusions

- Monitoring patient progress in the first phase of treatment appears to facilitate the selection of clinically appropriate continuing care:
 - Simply assessing substance use may be enough
 - However, factoring in a wider range of program goals seems to improve accuracy of the match
 - Requires programs to clearly operationalize the primary goals of treatment

Using the Telephone to Extend Standard Care

New Telephone-Based Disease Management Study

- Patients are monitored via telephone contacts after the 3 week of IOP
- Frequency of calls:
 - First two months: weekly
 - Next ten months: every other week
 - Final six months: monthly
- Each call starts with a “risk assessment”

Risk Assessment

- Negative Factors

- Recent alcohol or drug use
- Negative mood, strong cravings
- High level of concern about relapse
- Placing self in risky situations or spending time alone

- Protective Factors

- Participating in sober activities
- Talking to others about craving, urges to use
- Frequent attendance at and involvement in self-help
- Attending treatment

Three Levels of Risk

- ***“High Risk”***
 - Any use of alcohol or drugs since last call
 - Very low confidence for staying abstinent
 - Moderate scores on at least 4 negative factors, with no protective factors
- ***“Moderate Risk”***
- ***“Low Risk”***
 - Low scores on all negative factors plus at least one protective factor.

Telephone Protocol When Risk is Low

- Maintain usual schedule of phone sessions
- Focus call on a one or two issues
- Use CBT-like problem solving approach:
 - For any negative factors identified in risk assessment
 - For any anticipated risky situations in the coming week(s)

Adaptive Protocol

- Increases in services triggered when risk reaches moderate level
 - *First:* increase frequency of phone calls
 - *Second:* bring patient in for 1-2 face-to-face evaluation and motivational enhancement sessions
 - *Third:* provide 8 CBT relapse prevention sessions
 - *Fourth:* refer back to IOP

The Big Question.....

-*Will patients comply with increased level of care, when it is warranted?*
- “Recovery support persons”
 - Second randomization in two experimental conditions– enlisting acquaintance of patient to increase compliance with stepped-up treatment (vs. no RSP).

Final Take Home Message...

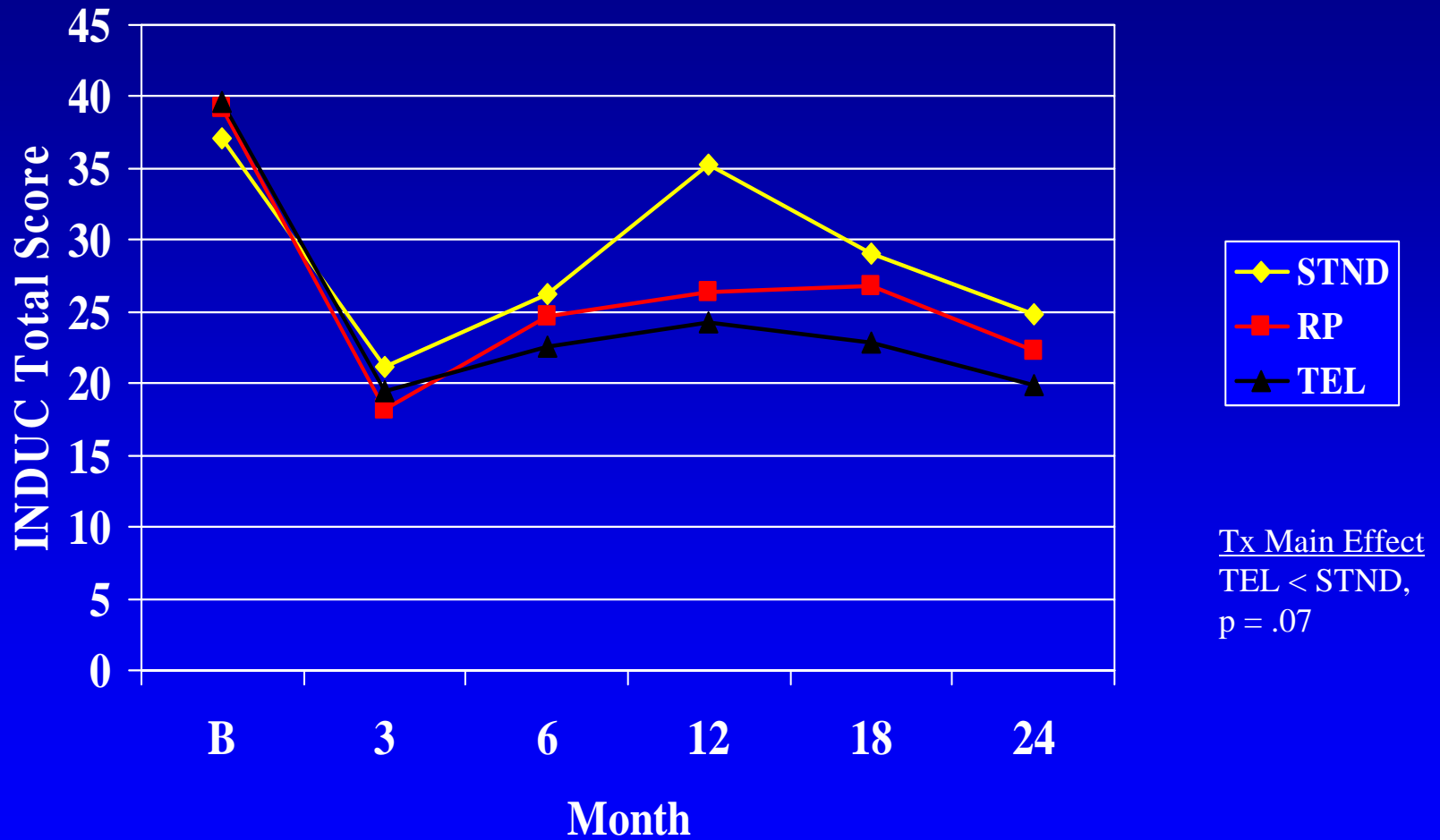
- Getting regular measurements of patients' progress toward treatment goals can:
 - Inform decisions about when patients are ready to move to lower levels of care
 - Provide information needed to evaluate effectiveness of treatment received to that point
 - Helps clinicians monitor their own performance

Can Treatment Programs Do This?

YES!!

- Identify key goals of first treatment phase
- Select measures of those goals
- Decide on what denotes good progress toward those goals
- Develop continuing care treatment options that differ with regard to intensity and burden
- See whether you can improve participation in continuing care and substance use outcomes by using summary measure of progress in IOP to assign patients to continuing care models.

Negative Consequences of Use

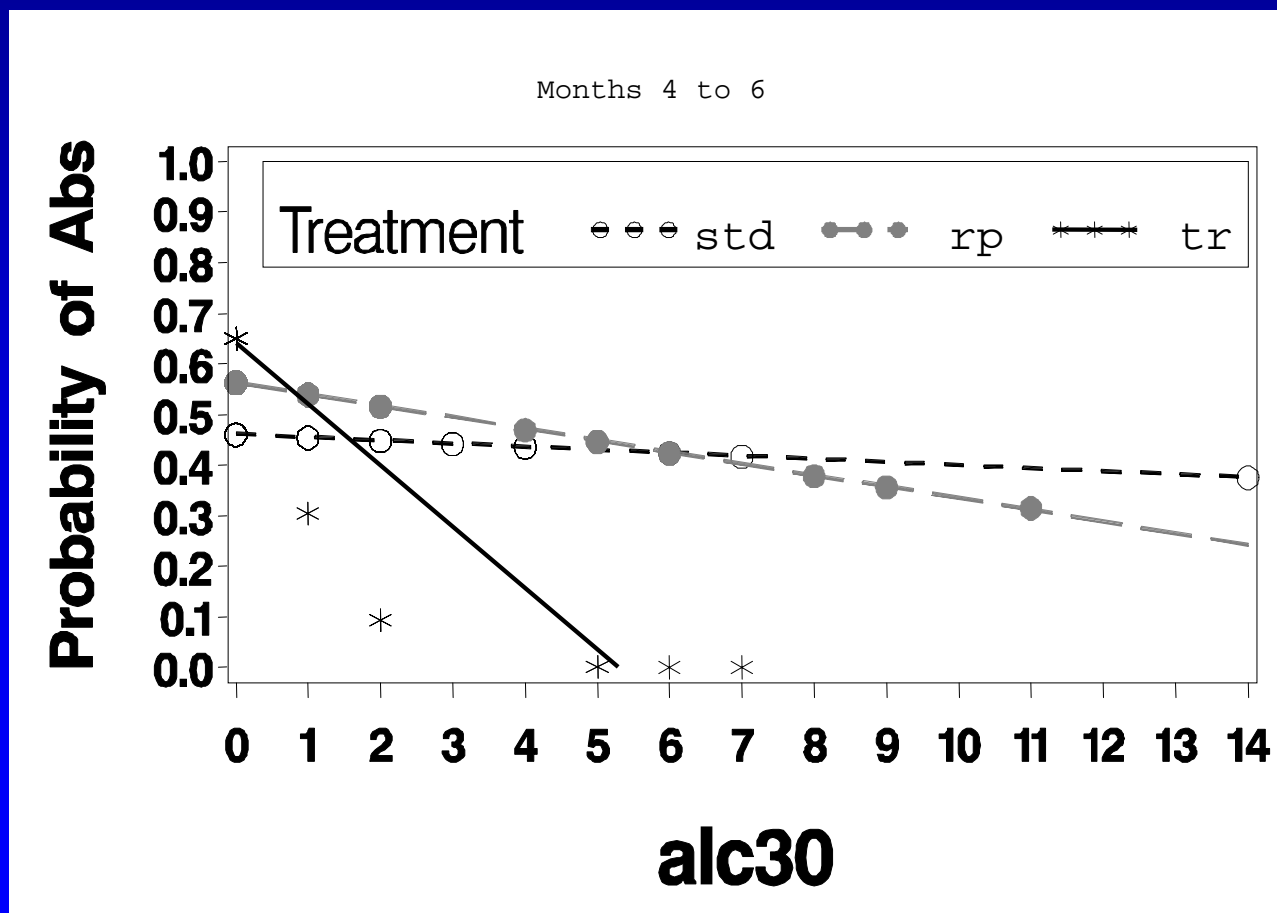


Endpoint Analyses: 24 months

Outcome	STND	RP	TEL	Contrast P Values	
				STND vs TEL	RP vs. TEL
Frequency Abst days	79.8	83.0	86.7	*	ns
% Total Abst	47.1	46.7	64.7	*	*
Neg Conseq	25.1	22.3	20.0	ns	ns
% Cocaine urine positiv	33.3	30.3	23.3	ns	ns
GGT (log)	3.69	3.86	3.47	+	**

+ p = .10; * p < .05; ** p = .005

Relation of Days of Alcohol Use in IOP to Rates of Abstinence in Mo 4-6



Relation of Days of Alcohol Use in IOP to Rates of Abstinence in Mo 9-12

