Published in final edited form as:

J Subst Abuse Treat. 2009 March ; 36(2): 127–130. doi:10.1016/j.jsat.2008.10.005.

Second Betty Ford Institute Conference Extending the Benefits of Addiction Treatment: Practical Strategies for Continuing Care and Recovery

James R. McKay, Deni Carise, Michael L. Dennis, Robert Dupont, Keith Humphreys, Jack Kemp, Debra Reynolds, William White, Ron Armstrong, Mady Chalk, Beverly Haberle, Thomas McLellan, Garret O'Connor, Barton Pakull, and John Schwartzlose

Position Statements

One of the primary goals of the conference was to arrive at position statements regarding continuing care. By the end of the conference, the participants produced position statements concerning three issues: (1) what is currently known about the components of effective continuing care, (2) factors that are likely to improve continuing care, and (3) key questions that require additional research.

Position Statement on Effective Continuing Care

The conference participants agreed that research studies have consistently indicated that effective continuing care interventions are likely to include some or all of the following components: extended monitoring; incentives and consequences for performance at the level of the patient, counselor, and program; alternative forms of service delivery; and utilization of community supports.

1. Extended Monitoring

The continuing care treatment component with the greatest evidence of effectiveness was extended monitoring of substance use status and recovery oriented behaviors. As one participant put it, "Monitoring is necessary to develop a system of accountability, which provides the structure and encouragement for behavioral and lifestyle changes." The "gold standard" in monitoring of substance use is the frequent collection of biological data (e.g., urine samples), which provide the most objective indicator of recent substance use status. The likely availability in the near future of biological tests that can detect the presence of alcohol for up to 5–7 days should improve the accuracy, and consequently the effectiveness, of monitoring in patients with alcohol use disorders. Biological data are not needed for those substances which patients report having used recently, which can reduce the cost of such testing. The reports of others in the patient's recovery support circle can also be used to monitor substance use, but are likely to vary in accuracy depending on how much contact the collateral source has with the patient.

The duration of monitoring appears to be related to the overall effectiveness of continuing care. For example, programs for physicians and airline pilots, which feature regular monitoring for

up to five years, have produced very high rates of continuous abstinence. Therefore, extended monitoring of substance use, with some form of objective data such as biological tests or collateral reports, is strongly recommended, with durations of at least one year and preferably longer.

2. Use of Incentives and Consequences for Performance

Establishing contingencies for behavior is important. Rates of sustained participation in treatment can be increased by providing incentives to patients for sessions attended. Incentives for drug-free urine samples have also been shown to reliably produce better substance use outcomes. Such incentives do not need to be costly, particularly if an intermittent reinforcement schedule is used. Physician health plans and programs for airline pilots have shown that frequent monitoring coupled with potentially severe career-related consequences for non-compliance can be extremely effective in promoting sustained abstinence, as was noted above. Several recent studies have also suggested that providing incentives to individual counselors or programs for greater utilization of treatment and retention by clinic patients can also improve attendance rates.

There is still some resistance in the treatment field to the use of incentives for behaviors such as attendance at treatment and abstinence from alcohol and drugs. The resistance is in part due to philosophical opposition to rewarding substance abusers for something they should be doing anyway, and lack of resources to pay for the incentives. This highlights that need to think creatively about the possible use of naturally occurring incentives and negative consequences that could be linked to performance in continuing care.

3. Alternative Forms of Service Delivery

Extended interventions that in some way actively bring the therapeutic components of the treatment to the patient are more likely to demonstrate effectiveness than interventions that rely on the patient to return to the treatment facility week after week to receive care. Examples of interventions with active outreach include Recovery Management Checkups, telephone-based continuing care, case management, recovery coaching, home visits, and web-based interventions. Therefore, continuing care interventions should include treatment components that can be delivered via active outreach efforts. However, because most of these interventions are less intensive than more standard, clinic-based interventions, protocols need to be developed and included that can increase level of care if the alternative form of service delivery is not sufficient to address deteriorations in symptoms or functioning.

4. Utilization of Community Support

People in recovery need more than formal treatment—they need a community of family members, friends, employers, and peers from mutual help organizations who will provide ongoing support and monitoring of progress. Such individuals could be termed a “recovery circle” or as the “stakeholders” in a person’s recovery. There was also agreement that there needs to be open communication between these individuals—the phrase “total transparency” was used. Such transparency makes it possible for the support community to rapidly respond in helpful ways when the person in recovery begins to have trouble. Without such transparency, the substance abuser can hide slips and relapses from some or all members of the recovery circle. Of course, it is necessary for the patient and members of the recovery circle to all formally agree to these terms, to avoid accusations at later points of inappropriate sharing of private information. To that end, contracts can be signed at the beginning of treatment or the continuing care phase that authorize treatment providers, family, and other members of the recovery circle to talk to each other and share information when the patient is having trouble.

Position Statement on Factors Likely to Improve Continuing Care

The conference participants also identified a number of clinical and organizational factors that were strongly believed to contribute to better outcomes in continuing care, but for which there is currently less research evidence. These factors included case management and recovery coaching, thoughtful integration of continuing care with standard addiction treatment, improved funding mechanisms, and collaborations with other treatment systems.

1. Use of Case Management and Recovery Coaching

The research literature on the effectiveness of active case management or “coaching” is still limited, particularly with regard to the latter. However, there is good reason to believe that case management and coaching can be used effectively to monitor progress, coordinate circles of recovery, and arrange for additional treatment for co-occurring problems as needed. One of the major issues for the field is developing models of coaching that are more widely affordable or that are eligible for third party payments.

2. Integration of Continuing Care with Standard Treatment Approaches

At this point, most of the models of extended continuing care that have demonstrated effectiveness have been implemented by clinicians who were not part of the regular staff of the treatment program where the study took place. Moreover, some of these models were considered “add-ons” and were not well-integrated with standard care at the facility. For the addiction treatment system to truly move into a continuing care model, better integration of the continuing care phase with the initial phase of treatment is required. For example, a recent study has shown that more use of what were labeled “continuity of care practices” in outpatient treatment resulted in better retention in subsequent continuing care. These practices included greater efforts to coordinate care, connect the patient to resources, and maintain provider continuity (i.e., retain same counselors or case managers in continuing care).

3. Better Funding Mechanisms

The issue of how to better fund continuing care received considerable attention during the conference. Some of the approaches that were discussed included incentives to providers, other forms of connecting payments to performance, focusing on “high cost” patients, shifting funding from other treatment services to continuing care, and demonstrating that provision of better continuing care reduces costs for welfare and criminal justice systems with the hope of receiving some support from these other agencies. More efforts to educate benefits managers and managed mental health care companies about the potential economic advantages to their businesses of effective continuing care were also recommended. On a positive note, information presented also indicated that there are now billing codes in some systems for ongoing continuing care.

4. Collaborating with other Service Delivery Systems to Provide Continuing Care

There was acknowledgement that continuing care should be available through other medically-oriented service delivery systems, such as primary care or community mental health centers. At this point, there is only limited evidence of the effectiveness of continuing care provided in such facilities. However, given the reluctance of some patients to continue in specialty care beyond the initial phase of treatment, it may be possible to reach a greater number of patients by making greater use of these other treatment systems.

Position Statement on Questions in Need of Further Research

The conference participants agreed that a number of issues and questions regarding continuing care still need to be addressed through additional research. These include questions about

monitoring, appropriate participants, social support for recovery, economic factors, staffing of programs, development of new interventions, and long-term recovery rates.

1. Monitoring

- Is it best to focus on substance use, or other factors such as social support, attendance at self-help, mood, cognitions, and so forth?
- How long should monitoring (and treatment) last? How frequent should contact with patients be?
- Can Physician Health Plan style interventions be successfully implemented in other populations?
- How can ongoing treatment and monitoring be made more attractive to patients?
- What sorts of positive and negative consequences should be linked to monitoring results?

2. Selection of Appropriate Continuing Care Participants

- Should programs and systems focus on delivery continuing care to high cost patients rather than to all patients, as is done in the management of other disorders?
- Can other patient subgroups be identified that are likely to benefit to a greater degree from extended care models?

3. Staffing Models for Continuing Care

- Should staff members who deliver continuing care also provide other services in the clinic or program? Or, should they constitute a separate unit devoted only to continuing care?
- What combination of personal characteristics, experience, and training makes for a highly effective recovery coach or counselor?
- Who has clinical and legal responsibility for patients in extended monitoring or other forms of continuing care?

4. Development of New Interventions

- Are continuing care models that integrate potentially complimentary approaches, such as telephone continuing care and in-person recovery management checkups, more effective than current approaches?
- Do adaptive interventions improve long-term outcomes for patients who have poor initial outcomes in standard continuing care or do not want to continue in such treatment?
- Can effective alternative disease management approaches be developed for the very large numbers of people with substance use disorders who never come to standard specialty care treatment at all?

5. Strengthening Community/Family/Peer Supports

- Which coaching or counseling approaches best equip families to support a member's recovery?
- What are the most effective methods to stimulate and support community recovery supports?

- Can optimal combinations of community/peer supports and formal treatment, and methods to increase synergy and collaboration between these factors be identified?
- Is it possible to replicate practices that were more common in the early years of AA, in which more senior members used to take a much more active role in assisting and working with people new in the program (i.e., “classic” AA)? This could include increased efforts on the part of senior members to help newcomers with various issues in early recovery, such as housing, employment, and recreation, as well as more active outreach following relapse.

6. Developing a Stronger Economic Rationale for Extended Continuing Care

- Which extended models of care demonstrate cost-offset/benefit-cost advantages in economic studies?
- Can effective performance contracting models be developed and implemented?
- What are the effects on overall recovery rates of cost-shifting from other phases or types of treatment to cover more comprehensive or extended continuing care?
- Are payment models that charge patients or employers at higher rates at the onset of continuing care episodes but provide refunds for sustained participation in the intervention attractive to patients and providers, and do they in fact promote better adherence?

Final Conclusions

The key conclusion from this conference is that major changes are needed in the way continuing care is conceptualized and delivered. What has been the standard approach—provision of a few months of group counseling along with referral to self-help—clearly works well for some individuals, but is ineffective with many others. Moreover, there is no “plan B” for patients who do not succeed in this standard continuing care model. Although further tinkering may bring about small improvements in effectiveness with this approach, there are a number of effective alternatives that are available now and could be used to replace or augment our existing continuing care system. Although effective interventions such as extended monitoring and incentives for good performance often come with an increased price tag, some programs and state systems have been able to implement innovative continuing care interventions by obtaining grant funding, shifting costs from other phases of care, or making use of performance-based contracting. We urge providers to consider implementing the interventions recommended here and to collaborate with researchers to address the important questions that have been raised. Further research in the areas recommended here will no doubt increase the acceptability, effectiveness, flexibility, and economic feasibility of innovative approaches to continuing care.