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Client incentives versus contracting and staff incentives: How care continuity interventions in substance abuse treatment can improve residential to outpatient transition

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ABSTRACT

Interventions for improving transition from short-term residential to outpatient treatment were examined. Usual care (UC; $n = 114$) was referral to a preferred outpatient program with advance appointment optional. Client incentive (CI; $n = 97$) offered up to $100 in gift cards for intake and attendance during the first 30 days of treatment. Contracting with staff incentives (CSI; $n = 49$) consisted of meeting with an outpatient counselor prior to residential discharge, signing an attendance contract, receiving an appointment and payment to staff if clients attended. CSI significantly improved rates of successful transition (84%) and admission (74%) compared to UC (64% contact; 49% admitted). CI did not result in significantly improved outcomes (74%; 60%). CSI was likely mediated by the reliability (92 versus 52% in UC) and immediacy (1.0 versus 3.9 days) of appointment scheduling. This study supports use of CSI for improving rates of transition between residential and outpatient continuing care treatment.

1. Introduction

In 2010, one million people received treatment for drug or alcohol abuse at an inpatient facility (Substance Abuse and Mental Health Services Administration, 2011). Typically, about half of the patients who receive treatment at a short-term (14–28 days) residential facility relapse to drug and alcohol use while half to two thirds remain abstinent or resume low levels of use (Alterman et al., 1994; Gossop, Stewart, Browne, & Marsden, 2002; Harrison & Asche, 1999; Lash et al., 2007; McKetin et al., 2012; Sannibale et al., 2003). Specific rates, of course, may depend on a number of factors including the type and severity of substance use disorder, the type and duration of residential treatment and the socioeconomic resources of the client. One factor that can increase rates of post-residential abstinence is participation in outpatient continuing care, which offers a continuation of the initial treatment episode at a step down in the intensity. Although it is well accepted among both researchers and treatment providers that continuing care is essential following brief residential treatment (Arbor, Hambley, & Ho, 2011; McKay 2005, 2009), service delivery systems are infrequently set up in a manner that facilitates the continuum of care (Lash, Timko, Curran, McKay, & Burden, 2011). About 40–50% of residential clients may make the initial transition into outpatient continuing care, although they frequently do not stay for the entire recommended duration of that care (Arbor et al., 2011; Lash, 1998; Sannibale et al., 2003; Stein, Kogan, & Sorbero, 2009). Further, there are a number of barriers that contribute to low rates of transition into continuing care that include inconvenience of treatment locations, lack of communication across agencies and financial and insurance barriers (Lash et al., 2011).

Several interventions have been developed and tested that can improve rates of transition from brief residential to outpatient continuing care treatment. Moreover, many of these are relatively simple, low-cost interventions that could be adopted within community treatment systems (Lash et al., 2011; McKay, 2009). For example, one study by Chutuape, Katz, and Stitzer (2001) found that only 24% of patients who completed a short-term medically assisted detoxification under usual care conditions made contact with a designated outpatient continuing care program versus 76% who were offered a ride to the program plus a $13 incentive payment upon completion of the intake assessment. The $13 payment alone increased rates of initial contact from 24 to 44%, although this was not a statistically significant increase. Since reinforcer magnitude has been identified as a feature of such interventions associated with outcomes (Lussier,

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Heil, Mongeon, Badger, & Higgins, 2006; Svikis, Lee, Haug, & Stitzer, 1997), it is possible that a larger payment would provide stronger motivation to attend an continuing care program.

Other interventions have been developed to help communication across agencies and improve treatment alliance. Lash (1998) studied transition interventions in 40 primarily alcohol dependent males at an inpatient 28-day substance abuse treatment program. Half received a 20-minute orientation session conducted by a therapist from the continuing care program who explained the benefits of continuing care, and asked the patients to sign an 8-week attendance contract. The remainder watched a video tape on motivation to reach goals. Participants who received the continuing care orientation were much more likely to attend the outpatient program at all (70 versus 40% in minimal intervention) and to attend subsequent sessions (37 versus 17% of scheduled sessions attended) over the first eight post-discharge weeks.

A similar therapeutic alliance (TA) intervention was studied by Campbell et al. (2009) in a multisite, randomized trial conducted within the National Drug Abuse Treatment Clinical Trials Network. A therapist from an outpatient program affiliated with the agency where the detoxification unit was located, conducted a single session that focused on treatment preparation, treatment goals, and treatment experiences, and ended with the opportunity for the participant to schedule an outpatient appointment. The study showed significantly higher rates of initial contact with the outpatient program for TA (21%) versus treatment as usual (14%) with no significant differences in subsequent retention.

Overall, there is an urgent need to improve continuum of care and specifically to improve rates of patient transition from residential to outpatient treatment. Within a complex community treatment system, short-term residential and outpatient continuing care services are often situated in different locations and run as independent agencies. Within this services configuration, there are evidence-based interventions that, if feasible for reliable implementation, could improve rates of transition from residential to outpatient care. The purpose of this study was to examine two such interventions with real world feasibility: (1) monetary incentives for clients designed to promote contact with and engagement in outpatient continuing care (client incentive) and (2) outpatient orientation via personal contact with a counselor from the program with staff incentives (contracting with staff incentives). The hypothesis was that rates of transition would be higher for both client incentive (CI) and contracting with staff incentives (CSI) interventions compared with those seen under a usual care referral procedure.

Table 1
Characteristics of the outpatient referral programs.

Clinic	Location	Size[a]	IOP[b]	Evening hours	Same day enrollment	Study *n*
A	Central	170	Y	N	Y	18
B	South east	60	Y	N	Y	10
C	South west	140	Y	Y	Y	16
D	South west	100	Y	N	Y	7
E	North east	150	N	Y	N	29
F	North west	165	Y	N	Y	25
G	North west	100	Y	N	Y	6
H	On-site	150	Y	N	N	149

[a] Number of clients served.
[b] Intensive outpatient program offered (9 hours per week or more).

2. Methods

2.1. Study setting

The study took place within an adult residential substance abuse treatment facility, located in west Baltimore, Maryland. The treatment facility offered inpatient, outpatient and halfway house services for individuals presenting voluntarily and via referral from the criminal justice system. The study recruited participants from the facility's 28-bed short-term (21–28 days) medically monitored intensive residential program.

2.2. Outpatient referral sites

Eight outpatient programs were selected for participation as referral sites. Primary criterion for selection was geographic dispersal around the Baltimore City area. Although serving a similar clientele, each program was unique in its organization, client eligibility criteria (e.g. insurance requirements) and operational characteristics. One of the outpatient referral sites was located at the substance abuse treatment facility where recruitment for the study occurred. Key features of the programs are shown in Table 1. All but one offered an IOP program which required that newly admitted patients attend 3–5 days per week.

2.3. Participant recruitment

Study participants were recruited between October 2009 and September 2011. Those eligible for outpatient referral through the study were 18 years or older, understood English and had been in the

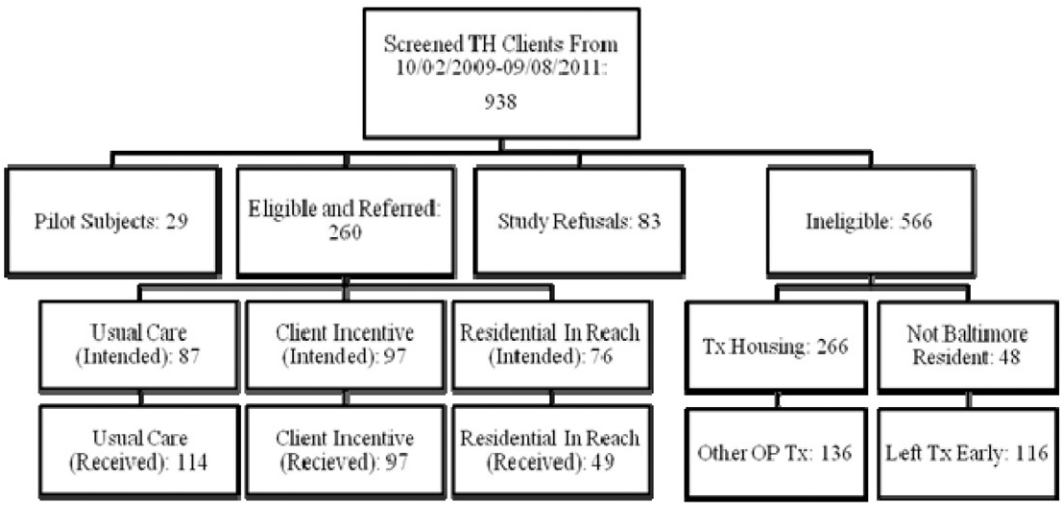

Fig. 1. Consort diagram.