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Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol

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ABSTRACT

There is increasing evidence that a chronic care model may be effective when treating substance use disorders. In 1996, the Betty Ford Center (BFC) began implementing a telephone-based continuing care intervention now called Focused Continuing Care (FCC) to assist and support patients in their transition from residential treatment to longer-term recovery in the "real world". This article reports on patient utilization and outcomes of FCC. FCC staff placed clinically directed telephone calls to patients (N=4094) throughout the first year after discharge. During each call, a short survey was administered to gauge patient recovery and guide the session. Patients completed an average of 5.5 (40%) of 14 scheduled calls, 58% completed 5 or more calls, and 85% were participating in FCC two months post-discharge or later. There was preliminary evidence that greater participation in FCC yielded more positive outcomes and that early post-discharge behaviors predict subsequent outcomes. FCC appears to be a feasible therapeutic option. Efforts to revise FCC to enhance its clinical and administrative value are described.

1. Introduction

Empirical evidence indicates that substance dependence disorders, while generally evaluated and treated as acute care problems, may better be considered chronic problems that warrant ongoing monitoring and care (McKay, 2005; McLellan, Lewis, O'Brien, & Kleber, 2000; McLellan, McKay, Forman, Cacciola, & Kemp, 2005). Addictions often develop insidiously over time, and heavy substance use and associated functional impairment often recur for many years after criteria for dependence had been met (Vaillant, 2003). Episodes often alternate with periods of less problematic use (Anglin, Hser, & Grella, 1997; McKay & Weiss, 2001; Vaillant, 2003). This alternating pattern is similar in other chronic medical illnesses (e.g., asthma, depression diabetes).

The case for conceptualizing substance dependence as a chronic medical disorder becomes more compelling when one considers vulnerability to relapse after treatment. Regardless of discharge status, patient characteristics, or substance(s) of abuse, most patients relapse within 6 months of treatment termination (Anglin et al., 1997; Finney, Hahn, & Moos, 1996; Hubbard et al., 1989; Hunt, Barnett, & Branch, 1971; Institute of Medicine, 1998; McKay et al., 1999; McKay et al., 2004; Simpson, Joe, & Brown, 1997). Moreover, evidence suggests that vulnerability to relapse remains high for significant periods of time even after treatment interventions of 3–6 months (Dennis, Scott, & Funk, 2003; McLellan et al., 2000). Thus, some have suggested that substance dependence for many patients constitutes a chronic, recurrent disorder requiring treatment conforming to an extended care model

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(McLellan et al., 2000). Such a model includes a full continuum of care, regular monitoring of progress during all phases of care, and needs-based movement throughout the continuum until long-term stable recovery is achieved (McKay, 2005).

Although treatment protocols for chronic illnesses such as asthma, cardiac disease, diabetes, and some psychiatric disorders already reflect an extended or continuing care model emphasizing monitoring and treatment during, between, and after acute episodes, treatment for substance dependence is just beginning to move in this direction (Bodenheimer, Wagner, & Grumbach, 2002; Jarrett et al., 2001; Look Ahead Research Group, 2003; McKay, 2001; McLellan et al., 2000; Whelton et al., 1998). Longer periods of continued therapeutic contact with patients with substance dependence are necessary to prevent relapse by: 1) dealing with issues such as decreased motivation and increased craving, 2) addressing compliance with pro-recovery lifestyle changes including self/mutual help participation, and 3) providing coping skills to deal with an ongoing vulnerability and the various other problems that arise after the more intensive phase of treatment ends (McKay, 2005; McLellan, Weinstein, Shen, Kendig, & Levine, 2005; Simpson, 2004). Unfortunately, few treatment programs are designed to provide this type of care (McLellan, McKay et al., 2005).

1.1. History of Focused Continuing Care (FCC)

Out of concern for the challenges patients experienced after discharge, the Betty Ford Center (BFC) made a decision to implement an economical form of continuing case management with in their standard provision of services. An extended, telephone-based continuing care intervention originally referred to as "Focused Aftercare" or FAC, was adopted to assist and support patients in their transition from residential treatment to "recovery in the real world." FAC was first implemented in March 1996 with 50% of BFC patients. Its popularity was evident immediately as many patients not selected for FAC complained to their counselors about not receiving this new, extra service. At this time, the FAC calls were made by the patient's continuing care counselor. Based on patient and staff feedback, FAC was modestly redesigned several times in its early years. Subsequently, BFC enhanced the visibility, responsibilities and goals for FAC by developing a specific program within BFC and hiring staff dedicated to conduct FAC as it was made available to all patients. The program was renamed "Focused Continuing Care" (FCC) to reflect that FCC is a level of treatment, and "aftercare" was a misnomer that downplays the importance of this phase.

Thus, FCC is an innovative, clinically distinct, and patient-focused level of care designed to: 1) sustain patient recovery and progress initiated during residential care, and 2) address the needs of patients once they re-enter their communities and are at heightened risk for relapse. In general, it is designed to provide an extended period of therapeutic contact with patients via a flexible, "user-friendly" format. Specifically, FCC assists patients who have successfully completed residential treatment at BFC with the transition home. To that end, FCC promotes involvement with AA/NA and other continuing care services including formal outpatient treatment, provides encouragement during the first year of recovery, and assists patients if relapse occurs. The primary purpose of FCC is clinical, to support patients in continued sobriety and recovery. This is accomplished by trained counselors querying patients in a semi-structured fashion about their status and, with this assessment as a guide, providing support and motivation, engaging in problem-solving, and assisting with service referral. In addition, the FCC counselor contacts provide information to BFC on how patients are doing after discharge, thereby facilitating ongoing quality improvement efforts.

The telephone has been used as a medium for therapeutic interventions in general medicine and psychiatry (Baer et al., 1995; Greist et al., 1998; Jerant, Azari, & Nesbitt, 2001; Ries, Kaplan, Myers, & Prewitt, 2003; Roter et al., 1998; Wasson et al., 1992). Telephone counseling has also been effective as a smoking cessation intervention (Lichtenstein, Glasgow, Lando, Ossip-Klein, & Boles, 1996; Wadland, Soffelmayr, & Ives, 2001). Few studies, however, have examined the use of telephone counseling for patients with alcohol or other drug use disorders. Thus, telephone-based continuing care such as FCC is still relatively novel, although there is mounting evidence for its effectiveness (McKay, Lynch, Shepard, & Pettinati, 2005), and it is a relatively low cost method to provide continuing care at a distance. Additionally, there is evidence of feasibility and efficacy in a more recent study of Telephone Enhancement of Long-term Engagement (TELE); (Hubbard et al., 2007), a 12-week intervention, modeled on FCC, designed to support compliance with the continuing care plan following short-term residential/inpatient substance abuse treatment.

1.2. Goals of the study

As an independent research organization, the Treatment Research Institute (TRI) was asked to evaluate the FCC program and to suggest ways of improving it. This article reports data on utilization of the FCC protocol in a large sample of BFC patients who received FCC services between 1998 and 2005. Levels of patient involvement/compliance with FCC are described, as are patient outcomes, at various time points using the information from the surveys administered as part of the intervention. The relationship of patient involvement with FCC to outcomes is also examined. Finally, within the 1-year period when patients participate in FCC, analyses explore the relationships between early post-discharge recovery related activities and later outcomes.

2. Methods

2.1. Participants

Between 1998 and 2005, 4094 Betty Ford Center (BFC) patients participated in Focused Continuing Care (FCC). Participation in FCC was defined as at least one completed FCC phone session. Additionally, all patients had successfully completed residential treatment at BFC (approximately 90% of BFC admissions), a condition of eligibility to FCC. Patients signed a "Consent to Participate in Focused Continuing Care Program" that included allowing their data to be used for program evaluation and research purposes.