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Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment

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Abstract

In many treatment systems, adolescents referred to residential treatment have the most serious alcohol or other substance use disorders and are at high risk of relapse. Upon discharge, these adolescents are typically referred to continuing care services, however, linkage to these services is often problematic. In this study, 114 adolescents (76% male) who stayed at least 7 days in residential treatment were randomly assigned to receive either usual continuing care (UCC) or UCC plus an assertive continuing care protocol (ACC) involving case management and the adolescent community reinforcement approach. ACC participants were significantly more likely to initiate and receive more continuing care services, to be abstinent from marijuana at 3 months postdischarge, and to reduce their 3-month postdischarge days of alcohol use. Preliminary findings demonstrate an ACC approach designed for adolescents can increase linkage and retention in continuing care and improve short-term substance use outcomes.

Keywords: Adolescents; Substance use disorders; Continuing care; Preliminary outcomes; Experiment

1. Introduction

Alcohol and marijuana continue to be the major drugs of abuse among youth in the US, and the examination of relevant datasets reveals the level of use is strongly associated with other illicit drug and tobacco use, fatal motor vehicle crashes, risky sexual behavior, delinquent behaviors, externalizing disorders (e.g., conduct or attention deficit disorder), and Posttraumatic Stress Disorder (Clark, Lesnick, & Hegedus,1997; Dennis, Godley, & Titus, 1999; Deykin & Buka, 1997; Hser et al., 2001; Komro et al., 1999). The number of drug-using adolescents (age 12–17) accessing treatment increased 45% from 1993 to 1998 (Office of Applied Studies, 2000). Options for treatment vary based on the resources available in an adolescent's community. The least invasive forms of treatment are student assistance programs located in schools, followed by outpatient programs of various intensities and then residential treatment. Experts recommend that placement in a level of care should be based on a number of presenting characteristics including: the adolescent's substance use diagnosis/severity; intoxication and withdrawal risk; biomedical issues; psychological problems; treatment acceptance and resistence; relapse potential; environmental risk; legal pressure; and vocational pressure (American Society of Addiction Medicine [ASAM], 1996; Schoenberg, 1995).

To be assigned to residential treatment (Level III care) under American Society of Addiction Medicine's (1996) patient placement criteria, patients must exhibit significant deficits in their willingness to accept treatment, recovery environment, and have high relapse potential. Studies of treatment systems have shown adolescents placed in residential treatment do, in fact, have higher rates of substance, psychological, behavioral, motivational, environmental, legal and vocational problems (Dennis, Dawud-Noursi, Muck, & McDermeit, in press; Dennis, Scott, Godley, & Funk, 2000). The length of residential treatment varies based on a number of variables (e.g., need, funding, willingness, and cooperation), but generally averages about 1–3 months in the public treatment system. After residential treatment, adolescents are typically referred to continuing care, which

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usually includes outpatient treatment services and encouragement to attend self-help groups. It is also common for these adolescents to develop a personalized recovery plan with the goal of maintaining a substance-free lifestyle.

Outside of major cities, residential treatment programs draw from many communities and counties. Complicating matters further, referring communities often are lacking in adolescent outpatient treatment services or adolescent specific self-help groups. Even though referrals are made to continuing care treatment, many adolescent clients do not link to, or only participate minimally in, postresidential continuing care treatment (Alford, Koehler, & Leonard, 1991; Hoffman & Kaplan, 1991). In a study of adolescent clients discharged from two residential programs, Godley, Godley, and Dennis (2001) found only 36% of the clients discharged from residential treatment attended one or more continuing care sessions at community clinics. Poor linkage to continuing care services may contribute to high relapse rates for adolescents after residential treatment. Indeed, follow-up studies of standard practice report relapse rates of 60% during the first 90 days after discharge from treatment (Catalano, Hawkins, Wells, Miller, & Brewer, 1991; Brown, Vik, & Creamer, 1989; Kennedy & Minami, 1993; Dennis et al., in press; Godley, Godley, and Dennis, 2001). Investigators have recommended increasing treatment attendance during the first 90 days of continuing care (Kaminer, 2001; McKay, 1999).

Models of continuing care monitoring and reintervention occupy a central role in the long-term management of other chronic diseases and researchers have recently supported adapting the disease management model to the management of substance use disorders (e.g., McLellan, Lewis, O'Brien, & Kleber, 2000). Several investigators have recommended common approaches to continuing care (Bukstein, 1994; Catalano et al., 1991; Center for Substance Abuse Treatment, 1993; Donovan, 1998; McKay, 2001; Myers, Brown, & Mott, 1995; Richter, Brown, & Mott, 1991; Vik, Grizzle, & Brown, 1992). They recommend programs: (a) offer sufficient intensity and duration of contact; (b) target multiple life-health domains (e.g., educational, emotional, physical health, vocational, legal, psychiatric); c) be sensitive to the cultural and socioeconomic realities of the client; (d) encourage family involvement; (e) increase prosocial leisure habits; (f) encourage compliance with a wide range of social services to provide additional support; (g) focus on relapse prevention; and (h) provide cognitive behavior and problem solving skill training to help reduce cravings and to cope with anger, depression and anxiety.

Research on family involvement in treatment has shown it can further improve adolescent engagement, retention, substance use, and other problems (Bry, Conboy, & Bisgay, 1986; Henggeler et al., 1991; Joanning, Quinn, Thomas, & Mullen, 1992; Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle, Dakof, & Diamond, 1991; Santisteban et al., 1996; Szapoznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983) and should facilitate reentry to home and community after residential treatment. In a study of self-help group attendance following residential treatment, Kelly, Myers, and Brown (2000) found greater attendance was associated with improved outcomes even when controlling for pretreatment and treatment differences. Empirically, several longitudinal studies with both adults and adolescents have concluded participation in formal continuing care and/or self-help group meetings is a significant predictor of improvement at follow-up (Alford et al., 1991; Donovan, 1998; Hoffman & Kaplan, 1991; Kelly et al., 2000).

An intervention that includes many of the features recommended for continuing care intervention is the Community Reinforcement Approach (CRA) (Azrin, Sisson, Meyers, & Godley, 1982; Meyers & Smith, 1995). CRA is a behavioral intervention that helps clients restructure their environment with prosocial activities that compete against continued substance use. In addition, CRA examines the relationship between using behavior and other behaviors and teaches the client skills to improve daily communication and problem solving as well as overcoming resistance and obstacles to participating in prosocial activities. Over the past 30 years, CRA has proven effective in several outpatient clinical trials with adult alcoholics and other drug abusers (Miller, Meyers, & Hiller-Sturmhofel, 1999). Although untested as a continuing care strategy for adolescents, it is well-suited to follow residential treatment and was, in fact, used this way in its first two trials with adults (Azrin, 1976; Hunt & Azrin, 1973). The present study seeks to augment CRA with a component designed to assist the caregivers and improve problem solving and communication between caregivers and the client. In addition, since adolescent clients are frequently involved in the education, criminal justice, mental health and/or child welfare service systems, the addition of case management services (Godley, Godley, Pratt, & Wallace, 1994) was deemed necessary to help them access and negotiate complex services systems.

Though a review of the published literature did not find experimental studies of continuing care with adolescents, McKay's (2001) review of 12 experimental and two quasi-experimental continuing care studies with adults revealed mixed results. Findings from four of the 14 studies indicated adults with more intensive continuing care did significantly better than those with no ($n = 3$) or some ($n = 1$) continuing care, while the remaining 10 studies showed slight improvement or no difference between continuing care conditions. Research on continuing care strategies for adolescents is an outstanding need in the treatment effectiveness literature.

The purpose of the present study was to develop and experimentally evaluate an Assertive Continuing Care (ACC) protocol for adolescents after their discharge from residential treatment. Specifically, this study evaluates the extent to which ACC is more effective than usual continuing care (UCC) in terms of 1) increasing the likelihood, amount and content of continuing care, and 2) reducing the time until, amount of, and problems related to relapse. Since this study grew out of a need identified by treatment providers, the findings should be relevant to other adolescent treatment