

Continuing Care Groups: Long Term Treatment of Substance Use Disorders

by

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A Graduate Research Project Submitted to the

University of Alaska Fairbanks

In Partial Fulfillment of the Requirements of the Degree of

Masters of Education in Counseling

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Spring 2014

### Abstract

Substance use disorders are chronic diseases that affect individuals, families, and communities. These illnesses frequently require several courses of treatment to achieve abstinence. Inpatient chemical dependency treatment, followed by continuing care, increases abstinence rates regardless of the interventions used within the continuing care program. The largest barrier to successful continuing care programs appears to be patients' attendance and participation. This project aims to create a continuing care program that focuses on increasing patients' attendance adherence in order to support them through their first year of recovery.

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### Continuing Care Groups: Long Term Treatment of Substance Use Disorders

This research paper aims to aid program directors in developing effective continuing care groups to treat individuals with substance use disorders. Many studies have shown the importance of long-term continuing care programs to maintain recovery from drug and alcohol addiction (Lash & Blosser, 1999; McKay, 2009a; McKay, 2009b). However, patients' adherence to continuing care programs has proven to be a problem (Lash, Burden, Monteleone, & Lehmann, 2004).

Continuing care or aftercare is defined as a continuation of treatment for substance use disorders, characterized by regular care without hiatus, following a higher intensity of treatment such as inpatient or outpatient substance abuse treatment (McKay, 2001; Vanderplasschen, Bloor, & McKeganey, 2010). According to McKay (2009b), continuing care groups are created to ease transition from a higher intensity of care as well as support patients' reentry into their communities. Often patients are achieving sobriety in safe environments, such as inpatient treatment facilities. Inpatient treatment offers the unique opportunity for patients to recover with limited external triggers to use drugs and alcohol. Once patients reenter their communities, they must face more triggers, with less support. Having a continuation of care to aid in this process is beneficial. Continuing care groups are also available to teach new relapse prevention skills to patients as high-risk situations arise. For example, patients may not realize that something as simple as grocery shopping is a trigger, until they have reentered their community. Continuing care groups are able to support and teach patients the necessary skills to remain sober throughout difficult endeavors (McKay, 2009b). Continuing care groups also aspire to support the maintenance of gains achieved in higher intensity treatments (McKay, 2009b). These gains vary, including abstinence from drugs and alcohol, setting firm boundaries with friends and family, or

proper medication management. Continuing care groups also act as a forum to provide social support during a critical time in patients' recovery (McKay, 2009b). Lastly, continuing care groups can help patients find other available resources within their communities. This may be 12-step programs, additional counseling, or psychiatry. With the many benefits that continuing care groups provide, it is disappointing that many patients do not continue with any form of care following inpatient services (Cacciola et al., 2008).

This project answers the following research question, "What will encourage patients with substance use disorders to become engaged in the continuing care treatment process, and increase their likelihood of maintaining long-term recovery?" The information gathered through this project was used to develop a continuing care program that aims to assist those who struggle with drug and alcohol addiction through long-term treatment.

### **Theoretical Framework**

The theoretical framework for this project is based on Cognitive Behavioral Principles. Cognitive Behavioral Therapy interventions have been successful in preventing relapse in this population (Brown, Seraganian, Tremblay, & Annis, 2002). Cognitive Behavioral Therapy assumes that individuals' maladaptive thinking patterns are the root of their psychological disorders, with the premise that counseling will help to adjust current thinking patterns (Corey, Corey, & Corey, 2014). Relapse prevention aftercare interventions use a modified thinking process to target positive changes in the individual's environment, and to assess the individual's relationships and evaluate the individual's emotions (Brown et al., 2002). An examination of these mentioned areas yields relevant information to maintaining sobriety through high-risk situations and potential triggers. Strategies developed to aid in coping with identified high-risk

situations allow individuals to be prepared once they leave residential and outpatient treatments (Brown et al., 2002).

Individuals who are addicted to drugs and alcohol often exhibit defense mechanisms, are not rational, and appear to ignore reality (Doukas & Cullen, 2010). Defense mechanisms seen in individuals with substance use disorders include minimization (distorting reality to make things appear smaller or better), rationalization (creating excuses for behavior), and denial (refusing to accept or experience reality) (Perkinson, 2008). These are common and protect individuals' continued use of drugs and alcohol (Doukas & Cullen, 2010). Cognitive Behavioral Therapy provides individuals who are enrolled in aftercare programs the opportunity to analyze, challenge, and modify their thinking, feelings, and behavior. This is an important process for patients transitioning from a structured environment, such as residential chemical dependency treatment, to outpatient treatment (McKay, 2009b). Individuals returning to their home environment encounter high-risk situations and social contexts such as re-exposure to drugs or alcohol (Dingle, Gleadhill, & Baker, 2008). By analyzing thought and behavioral patterns in a safe environment, such as during a continuing care treatment program, patients are able to identify existing thinking errors and high-risk behavior that may indicate that they are in danger of relapse. Through this process, patients who are a part of an aftercare group are able to find social support in the early stages of recovery (Dingle et al., 2008).

### **Literature Review**

The literature review discusses the following: (a) current attitudes regarding treatment of substance use disorders, (b) the importance of continuing care, (c) program development, and (c) effective continuing care programs.

#### **Current Attitudes Regarding Treatment of Substance Use Disorders**

Substance use disorders are mental illnesses that are progressive and chronic (Vanderplasshen et al., 2010). Chronic mental disorders hold an inherent risk of relapsing over a long period (Bhugra, 2006). The characteristics that qualify substance use disorders as chronic are cycles of abstinence followed by relapses back into use of drugs and alcohol that can potentially require readmission to treatment services (McKay & Hiller-Sturmhofel, 2011).

Despite the label as a chronic and lifelong disorder, typical substance abuse treatment is brief, with the standard duration of care at 28 days (Cacciola et al., 2008; Lash, Peterson, O'Connor Lehmann, 2001). Ershoff, Radcliffe, and Gregory (1996) evaluated a large HMO treatment facility that offered detoxification services, inpatient chemical dependency treatment, day treatment, as well as outpatient services, and found that only 22% of patients retained services for longer than three months. Peterson, Swindle, Phibbs, Recine, & Moos (1994) evaluated the National Veterans Affairs substance abuse treatment program, which offers inpatient chemical dependency treatment, and found that only 20% of patients retained services for longer than three months. McKay, Foltz, Leahy, and Stephens (2004) tracked patients after they completed 28 days in an inpatient treatment facility. The recommendation to patients was to step-down their care, meaning to divide treatment into distinct phases that lessen in frequency and intensity over time (McKay, 2009b). In order to successfully step-down care, clinicians recommended patients follow inpatient treatment with an intensive outpatient treatment program (three days a week) or a standard outpatient care (one day a week). Within this study, only 36% adhered to the step-down care treatment recommendation. This low rate of continuing care concern for treatment outcomes given that the highest rates of relapse in substance use disorders occur within the first three to six months of abstinence regardless of intensity of treatment (Gossop, Stewart, & Marsden, 2008).

McKay et al. (2004) stated that patients in residential settings did not follow through with continuing care because (a) they did not believe they needed additional treatment to remain abstinent, (b) the cost of continuing care was too high, (c) too many responsibilities at home or work, or (d) they returned to substance use. The authors found that patients who were more likely to step-down their care from inpatient, to some form of continuing care had adequate social support, were older, had steady employment, and higher self-efficacy. From these findings, the authors conclude that patients who have more stability, support, and self-assurance in their ability to handle stressful situations without returning to drug and alcohol use are typically receiving continuing care services. Unfortunately, McKay et al. states that it appears that the patients that would benefit most from continuing care are not the population receiving continuing care services.

In order for substance abuse treatment to be effective, it should last for a minimum of three months and follow a step-down care model (Lash et al., 2004; Simpson, Joe, & Brown, 1997). Treatment offers the highest rates of abstinence at seven months, making continuing care an effective means to provide support during this crucial phase in patients' lives (Ouimette et al., 1998; Ritsher, Moos, & Finney, 2002). Often inpatient and outpatient programs last a month or less (Lash et al., 2004). Ekendahl (2007) proposes that with this information, the attitude towards aftercare or continuing care services needs to shift. Ekendahl states that patients perceive continuing care groups as an "add-on" to services. A more appropriate perception should be that continuing care is a central component to treating substance use disorders. Currently, patients and many professionals use 30 day inpatient treatment programs as the preferred intervention for treating substance use, and all treatment following is aftercare (Ekendahl, 2007). Ekendahl



suggests that the preferred intervention for treatment should include aftercare, for it teaches individuals with substance use disorders how to stay abstinent in their home environment.

Rates of relapse for individuals who receive inpatient chemical dependency treatment is currently around 40-60% (Clarke & Myers, 2012). In addition, the average patient attends treatment 2-3 times before remaining abstinent (McKay et al., 2004). Patients discharged before three months are vulnerable during a high-risk period. This alludes to the significance of long-term continuing care programs, which support patients through their first year of recovery.

### **Importance of Continuing Care**

There are 20.8 million adults in the United States with substance use disorders (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). The cost of services created by substance use disorders to the US is around \$360 billion every year (Office of National Drug Control Policy, 2004). The economic cost, coupled with the immeasurable pain and suffering of patients, friends, families, and communities shows the significance of effective treatment for substance use disorders (McKay & Hiller-Sturmhofel, 2011).

Research indicates that continuing care following inpatient or outpatient substance abuse treatment is a promising method to increase the likelihood of recovery (Brown et al., 2002; DeMarce, Lash, Stephens, Grambow, & Burden, 2008; Ekendahl, 2007; Lash & Blosser, 1999; Lash et al, 2004). In several studies, patients who participated in an aftercare or continuing care program demonstrated higher rates of abstinence at six month and one-year follow-ups, compared to patients who did not receive aftercare services (DeMarce et al., 2008; Lash et al., 2004; Shaefer, Cronkite, & Hu, 2011; Schaefer, Harris, Cronkite, & Turrubiarres, 2008). Aftercare also correlates with longer time between relapses (Sannibale et al. 2003), and less readmissions to inpatient treatment facilities (Moos & Moos, 2004). This indicates that if

attendance rates in aftercare programs were increased, positive treatment outcomes would likely increase as well.

Schaefer et al. (2011) recruited research participants from 10 residential and 18 intensive outpatient treatment programs affiliated with the Department of Veterans Affairs, with varying continuing care program procedures. The sample population was divided into four subgroups. Two subgroups were based on psychiatric severity and two were based on patients' self reported substance use, to see if these factors mitigated continuing care outcomes. The population used within this study was primarily men (98%), with an average age of 47.22. About half the participants were of a minority racial/ethnic identity (48%), and the other half reported as European American (52%). Schaefer et al. (2011) found that engagement in continuing care was a strong predictor of abstinence at a six-month follow-up in all subgroup categories. Schaefer et al. also found that the odds of abstinence increased 20% for every consecutive month that the patient participated in continuing care services within all four subgroups. Regardless of severity of co-occurring psychiatric symptoms or substances abused, the study by Schaefer et al. demonstrated the potential importance of continuing care treatment services for all patients who are struggling with a substance use disorder.

### **Program Development**

Corey et al. (2014) suggest that when treatment facilities are developing a program involving a group, they consider recruitment of members, group facilitation, and group development.

**Recruitment of members.** When recruiting patients, it is important to consider the appropriate level of care (McKay, 2009b). The American Society of Addiction's Medicine (ASAM) placement criteria describe the system developed to match patients who have substance

use disorders with an appropriate level of care (McKay, 2009b). ASAM takes into consideration six problem areas or dimensions. Two of the six dimensions are medical problem areas for clients, and acute intoxication or withdrawal (American Society of Addiction's Medicine [ASAM], 2001). The other four problem areas that ASAM considers when recommending treatment intensity level are psychosocial dimensions (ASAM, 2001). These are emotional/psychiatric complications, readiness to change, relapse potential, and recovery environment (ASAM, 2001). Through these dimensions, patients can be placed at five different levels of care: Level 0.5 early intervention, level I outpatient treatment, level II intensive outpatient treatment/partial hospitalization, level III residential/intensive inpatient treatment, and level IV medically managed intensive inpatient treatment (ASAM, 2001). According to ASAM placement criteria, patients must maintain within all six dimensions at a higher level of care to qualify them for a lower intensity of care (ASAM, 2001). It appears, regardless of the criteria used to decide appropriate level of care, the interventions utilized within continuing care programs are applicable to encouraging abstinence from drugs and alcohol.

**Group facilitators.** Potential facilitators for groups are evaluated by their personal and professional characteristics gained through work and personal experiences (Corey et al., 2014). However, Perkinson (2008) states that good clinicians who work with patients with substance use disorders are born and not made. Finding effective, talented, empathetic facilitators is important because their role within the group is crucial. They act as a catalyst to begin the process of change that occurs within the group atmosphere.

Facilitators are present to encourage participation and empower patients within continuing care groups (Topor, Grosso, Burt, & Falcon, 2013). Through this process, facilitators create a therapeutic alliance with patients, supporting them through their recovery process and

helping them succeed in completing and maintaining goals (Topor et al., 2013). If facilitators are able to build strong therapeutic alliances with patients, group members will follow facilitators' examples, eventually creating strong bonds among one another (Topor et al., 2013). Within the continuing care groups, clinicians utilize skills such as active listening, empathizing, reflecting, clarifying, linking, and confronting patients when necessary (Corey et al., 2014). These are skills group members will learn within the group process if successfully modeled by facilitators (Corey et al., 2014).

Co-facilitation is an effective approach within group counseling, allowing clinicians to focus on several patients within the group simultaneously (Corey et al., 2014). Clinicians are then able to share their perspectives with one another to form a broader, more accurate description of group dynamics (Corey et al., 2014). Co-facilitation is also beneficial because it reduces burnout among counselors, as they share their stressors and burdens (Corey et al., 2014). Recovering addicts working as counselors in the field of substance abuse are an asset to treatment facilities (Doukas & Cullen, 2010). Doukas and Cullen (2010) reported that patients viewed treatment centers that employ recovered addicts as having more creditability. In addition, patients surveyed reported they were able to form closer therapeutic bonds with counselors who were in recovery versus non-addicted counselors (Doukas & Cullen, 2010). Lastly, counselors who are in recovery were able to identify current drug use in patients more accurately than counselors who are not in recovery (Doukas & Cullen, 2010). Doukas and Cullen suggest that having recovered addicts working as counselors creates a more comfortable, understanding environment for the patients.

While there are benefits to employing counselors in recovery from substance use disorders, there are also ethical considerations. Counselors who are in recovery are found to over

involve themselves in patients' treatment (Doukas & Cullen, 2010). Another issue that is common within this population is over identification with patients. Identification with patients can be helpful, but over identification can lead counselors to inappropriately self disclose, as well as pass wrongful assumptions and judgments based on their own past experiences (Doukas & Cullen, 2010). In addition, there remains a chance the counselor could relapse and cause potential harm to their patients (Doukas & Cullen, 2010).

Doukas and Cullen (2010) suggest that recovering addicts who are considering entering the field of substance abuse counseling consider their motives for pursuing this career choice. The authors also urge this population to investigate their support network once they join the field. This can be an issue because many recovering addicts use the 12-step program as their primary support system, and once working in the community, patients will likely be attending the same meetings. This can become an issue due to the development of dual relationships (Doukas & Cullen, 2010).

**Group Development.** When developing a program such as a continuing care group, there are practical components that require consideration such as an open versus a closed group (Corey et al., 2014). Closed groups have a start and end date, with the group meeting for a predetermined number of sessions, and without change in members (Corey et al., 2014). An open group has no start or end date, and a constant change in members with patients continuously entering and completing services (Corey et al., 2014; Perkinson, 2008). Having a closed group may facilitate a better sense of cohesion among group members; however, an open group allows patients to become comfortable with entering and exiting relationships as well as meeting a larger variety of people (Corey et al., 2014).

Confidentiality is the most important group component in creating a safe, working group (Kottler & Shepard, 2011). Clinicians, held accountable by strict ethical guidelines, promote safety within groups. Patients are not held by this ethical code, making it crucial to stress the importance of confidentiality within the group process (Corey et al., 2014). Clinicians must contemplate how they are going to enforce confidentiality within the group in order to create safety within the group (Corey et al., 2014).

### **Effective Continuing Care Programs**

The continuing care stage of treatment is important to maintain lifestyle changes, especially if the changes were made in a different environment than the patient's home, such as a residential facility (Ekendahl, 2007). A typical example of a continuing care program is a weekly or monthly group psychotherapy session (Lash, Timko, Curran, McKay, & Burden, 2011). Facilities also incorporate specific interventions as necessary to meet patients' treatment needs, such as individual psychotherapy sessions, case management, home visits, incentives, and telephone calls (Lash et al., 2011). This phase of treatment is used to step patients down from higher intensity treatment (McKay, 2009b). For example, a patient typically will attend an inpatient chemical dependency facility for 30 days or less, step down care into an intensive outpatient program meeting anywhere from 3-5 days, then transition to a continuing care group meeting once a week.

**Patient incentives.** Lash et al. (2001) created a continuing care program that exhibited the strong effects of social reinforcement on patients' attendance rates. The authors created two different aftercare groups following a 28-day substance abuse residential treatment program at the Veterans Affairs Medical Center (VAMC). The sample had 4 females and 77 males with a mean age of 44.25. The racial composition of the participants was 52% European American,

47% African American, and 1% Hispanic. The two aftercare groups were kept as similar as possible, not differing in age, racial composition, or substance use diagnosis. Both groups received a continuing care orientation session along with an attendance contract. However, one group received social reinforcement in the form of recognition within the group when attending one group, three groups, six groups, and eight groups. Patients also received medallions and certificates for achieving these attendance milestones. The effects of the social reinforcement on the continuing care groups' attendance rates were dramatic. The social reinforcement group attended 68.8% of their weekly aftercare groups within the first eight weeks of the program. The aftercare group that did not receive social reinforcement attended 49.4% of their weekly sessions (Lash et al., 2001).

Lash et al. (2004) was curious if the social reinforcement and increased attendance rates affected rates of abstinence within these participants. The authors followed the same research participants from their 2001 study to learn of any further effects. Lash et al. found that the continuing care group that received social reinforcement had an abstinent rate of 76% at a six-month follow-up, whereas the group that did not receive social reinforcement had an abstinence rate of 40%. The social reinforcement group correlated to higher attendance rates as well as nearly doubled abstinence rates at a six-month follow-up, compared to the standard continuing care treatment group. This study shows the potential power of simple interventions to greatly affect patients' treatment outcomes.

Individuals with a substance abuse disorder as well as co-occurring psychiatric disorders, typically have lower treatment success rates (DeMarce et al., 2008). In order to try to create better treatment outcomes DeMarce et al. (2008) looked at the affects of contracting, prompting, and reinforcing (CPR) interventions within a continuing care program with patients who had a

co-occurring diagnosis. Patients were recruited from the Veterans Affairs Medical Center, an inpatient substance abuse disorder treatment facility in Salem, Virginia. DeMarce et al. recruited 150 participants, who were assigned to either the CPR continuing care treatment or the standard continuing care treatment (STX). The standard care program started within the last week of inpatient treatment and consisted of one individual counseling session, one weekly group session, and choosing one NA or AA meeting to attend weekly. The CPR treatment group met with their primary counselor during their last week of inpatient care and signed a behavioral contract committing to attend continuing care. This contract also provided patients with important information regarding continuing care, such as abstinence rates of those who utilize an aftercare program. The CPR group was given attendance prompts in the form of emails, phone calls, and appointment cards. In addition, members of the CPR were given social reinforcement in the form of certificates and medallions after attending a specific number of sessions (DeMarce et al., 2008). Ninety-three percent of patients assigned the CPR treatment followed through with the continuing care group, compared to 73% of the STX patients. The CPR continuing group also increased adherence to attendance, with 68% attending at a three-month follow-up, whereas only 24% of the STX aftercare group were still attending. One year into the continuing care program, 50% of the CPR group was abstinent and 21% of the STX group was abstinent (DeMarce et al., 2008). This demonstrates the strong effect these interventions potentially have on continuing care attendance, as well as the effects of attendance on treatment outcomes. The authors reported the findings did not differ significantly between patients who have a diagnosis of substance use disorder and those who have a substance use disorder as well as another co-occurring psychiatric disorder.



McKay et al. (2010) recruited 252 participants from two different facilities who were enrolled in IOP programs. Patients were between the ages of 18 and 65, with an average age of 43 years old. They were predominately single (91.3%), African-American (88.9%), males (64.3%), and met criteria for a diagnosis of Alcohol Dependence (McKay et al., 2010). Upon completion of the IOP program participants were split into three groups; no aftercare (TAU), telephone monitoring (TM), or telephone monitoring with counseling (TMC). The TM group received 5-10 minute phone calls, consisting of a brief assessment on progress, for a total of 18 months. The TMC group utilized this same assessment, but in addition created projected goals. McKay et al. found that the TMC group yielded the best results in regard to overall alcohol use, with the TM group resulting in better results than the TAU group (McKay et al., 2010).

**Alternative forms of delivery.** According to McClure, Acquavita, Harding, and Stitzer (2013) 90% of patients who completed an outpatient treatment program had access to a cell phone. This shows that participating in continuing care programs via telephone is a feasible option for patients who may be unable to attend in person on a regular basis. McClure et al. found that 39-45% of patients who had completed treatment also had private access to a computer with internet access. Although not feasible for all patients, video conferencing within individual substance abuse counseling sessions is an increasing option for patients (King et al., 2009). In addition, patients reported they felt safer and believed their confidentiality was better protected when participating via video conferencing versus in person (King et al., 2009). With an increase in internet access availability, online forums for continuing care programs are being developed (McKay, 2009b).

If patients live rurally and do not have access to treatment facilities, participation in continuing care services becomes difficult, resulting in a decrease in attendance rates. Schmit,

Phibbs, & Pipette (2003) found that only 40% of individuals who live 25 miles or more away from a treatment facility engaged in any continuing care following residential treatment. In areas that have outlying rural communities, incorporating interventions for this population is difficult and important. The Betty Ford Center has implemented a continuing care program, The Focused Continuing Care (FCC) conducts telephone calls to rural patients who are unable to attend physically due to distance, with the goal of maintaining long-term monitoring of patients (Cacciola et al., 2008). Counselors from the FCC program met with patients before their discharge to introduce themselves, build rapport, and encourage the patients' participation. Once discharged, a counselor called patients twice monthly for the first three months and once monthly for the next 12 months. Patients completed an average of 40% of scheduled phone calls. Although this attendance rate is less than optimal, as Sannibale et al. (2003) suggested, any continuing care correlates with higher abstinence rates versus no continuing care. Cacciola et al. (2008) found that patients who had higher participation rates in the FCC program (completing more than five phone conversations) were more likely to engage in recovery related behavior. This behavior included attendance of 12-step meetings, meeting with a sponsor, staying in contact with treatment alumni, and abstinence from drugs and alcohol (Cacciola et al., 2008).

Kenney (2008) reported that Hazelden's, a 28-day Minnesota model treatment program, created an online continuing care program termed My Ongoing Recovery Experience (MORE). The MORE program is offered to patients who have completed the 28 day inpatient chemical dependency treatment program. This web-based continuing care program includes a home page for each patient, intermittent check-ins that evaluate progress, space for patients to journal privately, workbooks, a calendar marked with important events, a database with relevant literature to recovery, and other alumni contacts. The program also includes an option for

patients to email counselors at Hazelden and request a phone call. MORE was also designed to send an email to counselors if their patient exhibits warning signs of relapse within the check-ins, or if they stop using the MORE program (Kenney, 2008). Although there are no studies that evaluate the effectiveness of the MORE program, it is an exciting innovation in adapting continuing care programs to reach patients (McKay, 2009b).

Case management is a promising intervention within continuing care (Lindahl, Berglund, & Tønnesen, 2013). Lindahl et al. (2013) used the main principles of a case manager, planning, assessing, linking, and monitoring, and applied it to patients coerced into care with co-occurring substance use disorders along with another psychiatric disorder. The authors' goal was to assess the impact on substance use. This study took place in Skane, Sweden and recruited 36 patients from three different facilities. The majority of participants were single males with an average age of 40 years old (Lindahl et al., 2013). They randomly assigned participants to a case manager or treatment as usual (TAU). After being released, the TAU group received a social worker (with a caseload of 40 patients). After discharge from inpatient treatment, they were able to make appointments with case managers as needed to aid patients with any issues surrounding substance abuse, employment, or housing. The patients that were assigned a case manager (with a caseload of 6 patients) had weekly meetings, typically at patients' home. The case manager's main role was to support the patient and apply interventions as the case managers saw fit (Lindahl et al., 2013). At a six-month follow-up, patients who had a case manager had an abstinence rate of 46%, whereas the TAU group had an abstinence rate of 14% (Lindahl et al., 2013). These differences were considered to be statistically significant (Lindahl et al., 2013).

**Community Resources that Support Continuing Care.** The Red Road to Wellbriety (2002) is a Native American grassroots movement for treating addiction. The Red Road to

Wellbriety uses the example of a healing forest to encompass the relationship between individual and community, as well as the role of the community in healing individuals with substance use disorders (The Red Road to Wellbriety, 2002). This movement theorizes that a sick tree dug out of soil and transplanted into healthy soil will recover. However, once the tree is returned to the original soil, it will again resort to sickness. The Red Road to Wellbriety states that in order to facilitate wellness, the tree and the forest require healing.

White (2009) draws upon ideas introduced in the Red Road to Wellbriety, stressing the importance of the community in healing individuals with substance use disorders, as well as healing communities in order to heal the individual. He argues the perception that the role of the community is an adjunct to substance abuse treatment is misguided. White theorizes that professional treatment ought to be an adjunct of communities, with the goal of minimizing the need for future treatment in the professional setting. Integrating available community resources into treatment facilities and broadening the presence of treatment facilities into the community could accomplish this goal (White, 2009). White theorizes that by bridging services between the community and treatment facilities, advocacy for recovery and a stronger recovery community is created.

The inclusion of family in treatment and long-term recovery efforts is an important aspect of maintaining abstinence (White 2009). Incorporating families within initial treatment as well as continuing care programs, has shown to increase the likelihood of abstinence in recovery (White, 2009). It creates family cohesion (White, 2009), which has become increasingly important in treatment centers, with a lack of family cohesion correlating with worse drinking outcomes at a two-year follow-up (McKay, 2009b).

Attendance of 12-step meetings is a valuable community resource for individuals with substance use disorders (Gossop et al., 2008). The 12-steps originated from Alcoholics Anonymous (Lee, Engstrom, & Peterson, 2011). Members work with sponsors through the 12 steps (Lee et al., 2011). It also incorporates peer-based fellowship and service, with the goal of complete abstinence from all mind and mood altering substances (Lee et al., 2011). The 12-step fellowship and program is a free service, which offers patients the support required to maintain abstinence (Gossop et al., 2008).

Patients who have completed treatment have a decrease in relapse rates if they have a support network that encourages abstinence (White, 2009). The 12-steps are able to provide that support, illustrated by several studies demonstrating individuals who attend 12-step meetings have higher abstinence rates (Gossop et al., 2008; Lee et al., 2011; Moos & Timko, 2008). Gossop et al. (2008) followed 142 patients after they completed a 30-day residential treatment program, in order to demonstrate the effectiveness of 12-step programs in supporting recovery. At 1-year, 2-year, and 5-year follow-ups, the authors found that patients who attended one or more Narcotics Anonymous or Alcoholics Anonymous meetings, were more likely to be abstinent from opiates and alcohol. Opiate addicts who attended meetings were three to four times more likely to be abstinent at a five-year follow-up than those who did not attend any meetings. Alcoholics were four to five times more likely to be abstinent at the five-year follow-up, than those who did not attend any meetings (Gossop et al., 2008).

The 12-step fellowships use a mentorship program, referred to as sponsorship, in order to support members throughout recovery (Tracey et al., 2012). Tracey et al. (2012) created a mentorship pilot study used within outpatient substance abuse treatment services, with the purpose of creating healthy, positive relationships based on recovery. The authors recruited 10

treatment graduates from the Alcohol Dependency Clinic (ADC) at Bellevue Hospital Center in New York, New York. Mentors had a minimum of six months sober from drugs and alcohol and received mentorship training for a total of eight hours over a four-week period. The authors recruited 30 mentees from ADC who were enrolled in outpatient treatment with a diagnosis of Alcohol Dependence Disorder. Combined, the study included 40 participants with an age range of 19-70 years old, and an average age of 50.3 years old. The majority of the participants were men (62%). The participants' ethnicities were African American (38%), White (38%), and Hispanic (22%). Mentors were matched with mentees based on gender, and were asked to give 1-4 hours of mentoring to each mentee, for 12 weeks. Supervision was given to mentors to ensure that relationships upheld an ethical standard and to aid in trouble shooting any issues. The authors evaluated the mentorship program via surveys that looked at mentor and mentee safety, as well as the effect that the program had on abstinence rates (Tracey et al., 2012). Of the mentors, all stayed sober within the 12-week period, except for one female who relapsed for one day. Her mentees were reassigned to other mentors, and the relapsed mentor became a mentee, quickly achieving abstinence. All participants reported 100% satisfaction with safety. In addition, all mentees reported a decrease in substance use from baseline to week 12 of treatment (Tracey et al., 2012).

### **Application**

A model for a continuing care program was created based upon a literature review as well as an interview with a group of patients who had graduated from an intensive outpatient program. The proposed continuing care group aims to support patients with the diagnosis of substance use disorders. By extending the length of treatment and incorporating successful interventions, this group has the ability to increase patients' abstinence rates from drugs and

alcohol. In addition, the purposed group is based on a private pay agency that does not receive government funding.

### **Conclusion**

With immeasurable pain and suffering inflicted upon individuals, families, and communities struggling with the consequences of substance use disorders, continuing care is becoming increasingly important (Lash et al., 2004; McKay 2009b). Individuals who receive continuing care services were more likely to be abstinent at six month and one-year follow-ups (DeMarce et al., 2008). DeMarce et al (2008) and Sannibale et al. (2003) demonstrate correlations between continuing care and abstinence. Research is suggesting that substance abuse treatment last for a minimum of three months (Lash et al., 2004; Simpson et al., 1997) to seven months to be effective (Outmette et al., 1998; Ritsher, Moos, & Finney, 2002). Regardless, many patients receive 30 days of treatment or less (Lash et al., 2004). Poor attendance in continuing care programs is a barrier to effective treatment, with many patients not following through with treatment recommendation that included an aftercare service (McKay et al., 2004).

Researchers have examined specific interventions in attempts to increase attendance adherence to continuing care programs. Effective interventions are patient incentives, long-term monitoring of patients, incorporating alternative forms of delivery, and community supports (DeMarce et al., 2008; Lash et al., 2001; Lash et al., 2004; Sannibale et al., 2003; Schmit et al., 2003). By incorporating these interventions and current literature, the creation of a strong continuing care program that encourages attendance is available.

## References

- American Society of Addiction Medicine. (2001). *ASAM PPC-2R-ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders* (2<sup>nd</sup> ed., rev.). Chevy Chase, MD: Author.
- Bhugra D. (2006). Severe mental illness across cultures. *Acta Psychiatrica Scand*, 113 (Suppl. 429), 17–23. doi: 10.1111/j.1600-0447.2005.00712.x
- Brown, T., Seraganian P., Tremblay, J., Annis, H. (2002). Process and outcome changes with relapse prevention versus 12-Step aftercare programs for substance abuses. *Addiction*, 97(6), 585-604.
- Cacciola, J. S., Camilleri, A. C., Carise, D., Rikoon, S. H., McKay, J. R., McLellan, A., & ... Schwarzlose, J. T. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford center focused continuing care protocol. *Addictive Behaviors*, 33(9), 1208-1216. doi:10.1016/j.addbeh.2008.05.004
- Clarke, P. B., & Myers, J. E. (2012). Developmental counseling and therapy: A promising intervention for preventing relapse with substance-abusing clients. *Journal Of Mental Health Counseling*, 34(4), 308-321.
- Corey, M.S., Corey, G., & Corey, C. (2014). *Groups: Process and practice* (9<sup>th</sup> ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.
- DeMarce, J. M., Lash, S. J., Stephens, R. S., Grambow, S. C., & Burden, J. L. (2008). Promoting continuing care adherence among substance abusers with co-occurring psychiatric disorders following residential treatment. *Addictive Behaviors*, 33(9), 1104-1112. doi:10.1016/j.addbeh.2008.02.008
- Dingle, G. A., Gleadhill, L., & Baker, F. A. (2008). Can music therapy engage patients in



- group cognitive behaviour therapy for substance abuse treatment?. *Drug & Alcohol Review*, 27(2), 190-196. doi:10.1080/09595230701829371
- Doukas, N., & Cullen, J. (2010). Recovered addicts working in the addiction field: Pitfalls to substance abuse relapse. *Drugs: Education, Prevention & Policy*, 17(3), 216-231. doi:10.3109/09687630802378864
- Ekendahl, M. (2007). Time to change - an exploratory study of motivation among untreated and treated substance abusers. *Addiction Research & Theory*, 15(3), 247-261. doi:10.1080/16066350701292696
- Ershoff D., Radcliffe, A., & Gregory, M. (1996). The Southern California Kaiser-Permanente chemical dependence recovery program evaluation: Results of a treatment outcome in an HMO setting. *Journal of Addictive Disease*, 15, 1-25.
- Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotic Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, 103, 119-125. doi: 10.1111/j.1360-0443.2007.02050.x
- Kenney, C. (2008). Giving clients MORE after treatment. *Behavioral Healthcare*, 28(3), 36-38.
- King, V. L., Stoller, K. B., Kidorf, M., Kindbom, K., Hursh, S., Brady, T., & Brooner, R. K. (2009). Assessing the effectiveness of an internet-based videoconferencing platform for delivering intensified substance abuse counseling. *Journal Of Substance Abuse Treatment*, 36(3), 331-338. doi:10.1016/j.jsat.2008.06.011
- Kottler, J. A., & Shepard, D. S. (2011). *Introduction to counseling: Voices from the field* (7th ed.). Brooks/Cole.

- Lash, S. J., & Blosser, S. L. (1999). Increasing adherence to substance abuse aftercare group therapy. *Journal Of Substance Abuse Treatment, 16*(1), 55-60.
- Lash, S. J., Burden, J. L., Monteleone, B. R., & Lehmann, L. P. (2004). Social reinforcement of substance abuse treatment aftercare participation: Impact on outcome. *Addictive Behaviors, 29*(2), 337-342. doi:10.1016/j.addbeh.2003.08.008
- Lash, S.J., Peterson, G.E., O'Connor Jr., E.A., & Lehmann, L.P. (2001) Social reinforcement of substance abuse aftercare group therapy attendance. *Journal of Substance Abuse Treatment, 20*, 3-8.
- Lash, S. J., Timko, C., Curran, G. M., McKay, J. R., & Burden, J. L. (2011). Implementation of evidence-based substance use disorder continuing care interventions. *Psychology Of Addictive Behaviors, 25*(2), 238-251. doi:10.1037/a0022608
- Lee, H., Engstrom, M., & Petersen, S. R. (2011). Harm reduction and 12 steps: Complementary, oppositional, or something in-between? *Substance Use & Misuse, 46*(9), 1151-1161. doi:10.3109/10826084.2010.548435
- Lindahl, M., Berglund, M., & Tønnesen, H. (2013). Case management in aftercare of involuntarily committed patients with substance abuse: A randomized trial. *Nordic Journal Of Psychiatry, 67*(3), 197-203. doi:10.3109/08039488.2012.704068
- McKay, J. (2001). Effectiveness of continuing care interventions for substance abusers. *Evaluation Review, 25*(2), 211.
- McKay, J. (2009a). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment, 36*, 131-145.
- McKay, J. R. (2009b). *Treating substance use disorders with adaptive continuing care*. Washington, DC: American Psychological Association.

- McKay, J. R., Foltz, C., Leahy, P., Stephens, R. (2004). Step down continuing care in the treatment of substance abuse: Correlates of participation and outcome effects. *Evaluation and Program Planning*, 27, 321-331.
- McKay, J. R., & Hiller-Sturmhöfel, S. (2011). Telephone-based continuing care: A novel approach to adaptive continuing care. *Alcohol Research & Health*, 33(4), 366.
- McKay, J. R., Van Horn, D. A., Oslin, D. W., Lynch, K. G., Ivey, M., Ward, K., & ... Coviello, D. M. (2010). A randomized trial of extended telephone-based continuing care for alcohol dependence: Within-treatment substance use outcomes. *Journal Of Consulting And Clinical Psychology*, 78(6), 912-923. doi:10.1037/a0020700
- McClure, E. A., Acquavita, S. P., Harding, E., & Stitzer, M. L. (2013). Utilization of communication technology by patients enrolled in substance abuse treatment. *Drug & Alcohol Dependence*, 129(1/2), 145-150. doi:10.1016/j.drugalcdep.2012.10.003
- Moos, R.H., & Moos, B.S. (2004) Help-seeking careers: Connections between participation in professional treatment and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 26, 167-173. doi: 10.1016/S0740-5472(03)00190-9
- Moos, R., & Timko, C. (2008). Outcome research on twelve-step and other self-help programs. In M. Galanter, & H. O. Kleber (Eds.), *Textbook of substance abuse treatment* (4th ed. pp. 511-521). Washington, DC: American Psychiatric Press.
- Office of National Drug Control Policy (2004). *The economic costs of drug abuse in the United States, 1992-2002*. Washington, DC: Executive Office of the President (Publication No. 207303).
- Ouimette P.C., Moos, R.H., & Finney, J.W. (1998) Influence of outpatient treatment and 12-step

- group involvement on 1-year substance abuse treatment outcomes. *Journal of Studies on Alcohol*, 59, 513-522.
- Perkinson, R. (2008). *Chemical dependency counseling: A practical guide*. Thousand Oaks, CA: Sage.
- Peterson, K.A., Swindle R.W., Phibbs, C.S., Recine, B., & Moos R.H. (1994). Determinants of readmission following inpatient substance abuse treatment: A national study of VA programs. *Medical Care*, 32, 535-550.
- Ritsher, J.B., Moos, R.H., & Finney, J.W. (2002). Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatric Services*, 53, 595-601.
- Scott, C. K., & Dennis, M. L. (2002). *Recovery Management Checkup (RCM) protocol for people with chronic substance use disorders*. Bloomington, IL: Chestnut Health Systems.
- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Results from the 2009 national survey on drug use and health: Mental health findings*. (NSDUH Series H-39, No. SMA 10-4609). Retrieved from <http://oas.samhsa.gov/NSDUH/2k9NSDUH/MH/2K9MHResults.pdf>
- Sannibale, C., Hurkett P., Van den Bossche E., O'Connor D., Zador, D., Capus C.,...
- McKenzie, M. (2003). Aftercare attendance and post-treatment functioning of severely substance dependent residential treatment clients. *Drug & Alcohol Review*, 22(2), 181.
- Schaefer, J. A., Cronkite, R. C., & Hu, K. U. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among subgroups of patients with substance use and psychiatric disorders. *Journal Of Studies On Alcohol & Drugs*, 72(4), 611-621.

- Schaeffer, J. A., Harris, A. S., Cronkite, R. C., & Turrubiartes, P. (2008). Treatment staff's continuity of care practices, patients' engagement in continuing care, and abstinence following outpatient substance-use disorder treatment. *Journal Of Studies On Alcohol & Drugs*, 69(5), 747-756.
- Schmit, S., Phibbs, C., Pipette, J. (2003). The influence of distance on utilization of outpatient mental health aftercare following inpatient substance abuse treatment. *Addictive Behaviors*, 28(6), 1183-1192.
- Simpson, D., Joe, G., & Brown, B. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors* 11(4), 294-307.
- The Red Road to Wellbriety. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO: White Bison, Inc.
- Topor, D., Grosso, D., Burt, J., & Falcon, T. (2013). Skills for recovery: A recovery-oriented dual diagnosis group for veterans with serious mental illness and substance abuse. *Social Work With Groups*, 36(2/3), 222-235.
- Tracy, K., Burton, M., Miescher, A., Galanter, M., Babuscio, T., Frankforter, T., & ... Rounsaville, B. (2012). Mentorship for alcohol problems (MAP): A peer to peer modular intervention for outpatients. *Alcohol & Alcoholism*, 47(1), 42-47.
- Vanderplasschen, W., Bloor, M., & McKeganey, N. (2010). Long-term outcomes of aftercare participation following various forms of drug abuse treatment in Scotland. *Journal Of Drug Issues*, 40(3), 703-728.
- White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36(1), 146-158.

## Appendix A

### **The Continuing Care Group**

In order to increase attendance rates as well as offer effective treatment for substance use disorders, the following model for a continuing care group was created. The creation of this program expands upon basic principles of continuing care programs and proposes interventions to increase attendance adherence. The interventions used within this application are based upon the research described in the literature review. Important considerations when creating a continuing care group are as follows: a) long term monitoring of patients, b) incentives and consequences for patient's behavior, c) counselor incentives, d) alternative forms of service delivery, and e) utilization of available community supports.

#### **Program Overview**

The continuing care group developed as a result of this research meets once a week for an hour. When planning meeting times it is important to ensure that patients have adequate support from the group, but do not feel burdened with a time consuming program (McKay, 2009a). This program was developed as continuing care to an intensive outpatient program.

**Recruitment of members.** Due to continuing care aiming to sustain growth and goals achieved in a higher level of treatment (McKay, 2009b), completion of an intensive outpatient program is a prerequisite. Patients are referred to the continuing care group by their primary clinicians if they are in compliance with ASAM PC-II placement criteria and have completed the intensive outpatient program. In order to support patients' transitions into a less intensive program, it is helpful to enroll them in their last week of treatment at the higher intensity facility (Lash et al., 2004). For instance, this continuing care group encourages patients to enroll while they are in their last week of intensive outpatient treatment or residential treatment. In addition,

the facilitators of the continuing care group should be introduced during this phase to begin to build rapport as well as encourage participation. In order to maintain safety of the group environment and individual patients, if individuals are unable to maintain sobriety within the continuing care group, a referral made to a higher level of care ensures they receive the treatment they require.

When initially beginning the continuing care group, a program development meeting is held with alumni from an intensive outpatient program to ensure that the program has a core group of members with strong ownership of the group. Given the opportunity to name the continuing care group as well as plan other details, this ownership is established within alumni members. Turning Point Counseling Services in Fairbanks, Alaska held a program development meeting. Clinicians who had worked with individuals in an intensive outpatient program recruited them to participate in a “brainstorming session”. By incorporating patients within this stage of program development, members stated that it created a strong sense of cohesion (Turning Point Alumnus, personal communication, February, 4, 2014).

**Group facilitators.** The continuing care group is designed to have two masters level clinicians co-facilitate the group. Clinicians are to sit across from one another within the group in order to manage the dynamics occurring within the group process (Topor et al., 2013). When a patient is sharing, one clinician is able to keep eye contact with the patient, while the other counselor is able to glance around the group and see how other members are responding to the share (Corey et al., 2014). After every group session, co-facilitators meet privately to discuss any concerns or remarks about the patients and the group as a whole. This allows clinicians to share their perceptions, create a strong cohesion as co-facilitators, as well as process through any difficult thoughts or feelings that arise within the counselors (Corey et al., 2014).

Characteristics that facilitators of the continuing care group should exhibit are the ability to stay in the present moment, reflective listening, honesty, open-mindedness, genuineness, and a strong sense of humor (Corey et al., 2014). By conveying and modeling these characteristics in an empathetic and open manner, group members will begin to exhibit them as well (Corey et al., 2014). Eventually, these positive attributes can help individuals to excel not only in the group, but also within their everyday lives.

Within the “brainstorming” group held at Turning Point Counseling Services, alumni from the intensive outpatient program expressed interest in the opportunity to participate as co-facilitators (Turning Point alumnus, personal communication, February, 4, 2014). Members suggested that after being a part of the group for a pre-determined amount of time, they could volunteer to co-facilitate the meeting with another clinician. This option would require only one counselor versus two counselors, as well as encourage ownership of the continuing care group by its members.

The continuing care group encourages the hire of counselors who are in recovery from substance abuse. Although it is not a requirement for clinicians, this is a beneficial addition to substance abuse treatment programs (Doukas & Cullen, 2010). The creditability and therapeutic bonds between patients and counselors in recovery is an important addition to the continuing care group (Doukas & Cullen, 2010). Alumni from the intensive outpatient program at Turning Point Counseling Services stated that they preferred clinicians who were in recovery (Turning Point alumnus, personal communication, February, 4, 2014). They believe that recovering addicts working as counselors are better able to empathize and sense relapse warning signs. Lastly, with a strong stigma that accompanies substance use disorders, alumni reported feeling



less judgment from counselors who were in recovery compared to counselors who were not addicts (Turning Point alumnus, personal communication, February, 4, 2014).

**Group Development.** The continuing care group is an open group, meaning there is no start and finish date for the group, with new members continuously entering, and more experienced members discontinuing services (Corey et al., 2014; Perkinson, 2008). This process allows members who are new to the group to transition into a working stage more quickly with seasoned members modeling that it is a safe environment (Corey et al., 2014). In order to intermesh new group members Corey et al. (2014) suggests encouraging new members to discuss their fears during the group session. This allows members who have already worked through the initial fear and anxiety the opportunity to offer feedback and coping skills as to what worked to quell their anxiety.

In order to create a safe environment for patients, group members are asked to pledge confidentiality at the beginning of every group (See Appendix B) (Kottler & Shepard, 2011). By facilitating the conversation of the importance of confidentiality throughout treatment, patients are provided a better assurance of security (Corey et al., 2014). It becomes a constant reminder and commitment to group members that what they are saying within the group is not shared with any third party.

**Group guidelines.** The continuing care group is not a 12-step program, but utilizes spiritual principles embodied within the 12-steps. The continuing care group refers to these as guiding principles within the group. Guiding principles are honesty, hope, faith, courage, integrity, willingness, humility, justice, restitution, perseverance, awareness, and service. Members will create additional group norms for the continuing care group within the first session.

**Moving on.** It is suggested that members attend continuing care groups for their first year in recovery (McKay, 2009b). However, patients may attend the continuing care group for as long as they choose. Participants in the brainstorming group at Turning Point Counseling Services stated that they would be interested in having the option of attending a weekly continuing care group for longer than a year (Turning Point alumnus, personal communication, February, 4, 2014). The majority of the participants also regularly attend 12-step meetings. However, they stated that they appreciate the added structure that clinician facilitators add as well as receiving feedback within the group process. For these reasons participants were eager to integrate a weekly continuing care meeting into their recovery routine (Turning Point alumnus, personal communication, February, 4, 2014).

### **Patient Incentives**

Patients are presented with a behavioral contract (See Appendix C) within their last week of their intensive outpatient program. This contract states they will participate in the continuing care group for an agreed upon number of weeks. This contract also presents them with important research regarding continuing care, such as abstinence rates of patients who engage in this service versus those who do not (DeMarce et al., 2008). Those who sign the contract will have their name put on a list for reminder phone calls and emails regarding the time and date of the meetings.

Social reinforcement interventions are used to increase patients' attendance adherence rates (Lash et al., 2004). The lead facilitator of the group recognizes patients by name during their first continuing care group, and again during the third continuing care group (Lash et al., 2004). Patients earn medallions at one month, three months, six months, nine months, and one year of sobriety. In addition, patients receive a celebration when they have one year of sobriety

with a cake. This occasion is also an opportunity for celebrating patients to tell their story to the group. Turning Point Counseling Service's alumni from the intensive outpatient program reported that celebrating recovery milestones were of great importance to them (Turning Point alumnus, personal communication, February 4, 2014). The alumni members believe that only other individuals who have substance use disorders will appreciate the struggle and accomplishment these milestones signify. They stated that the medallions are of little importance, but it is the recognition within the group that they deemed as powerful to their recovery process (Turning Point alumnus, personal communication, February 4, 2014).

### **Long-term Monitoring of Patients**

Facilitators within the continuing care group monitor their patients. If facilitators have concerns for patients, individual appointments give clinicians the opportunity to discuss options for treatment. In this setting, facilitators gain information through a self-report interviews. The use of this information allows facilitators/clinicians to make treatment recommendations. If patients require further treatment, motivational interviewing is used to process barriers or ambivalence to entering a higher level of care (Scott & Dennis, 2002).

If patients stop attending treatment within the first year, facilitators attempt to make contact with patients via telephone. This contact has the goal of reengaging patients back into treatment and decreasing drop out rates (Scott & Dennis, 2002). Facilitators assigned to patients conduct phone calls, to ensure that they speak with the same person on the phone each time, enforcing a continuity of care (McKay, 2009b). This is an effective way to communicate with patients, given that the majority of patients have access to personal telephones (McClure et al., 2013).

### **Alternative Forms of Delivery**

Alumni of the intensive outpatient program at Turning Point Services voiced interest in having a private Facebook page, or some form of an web based group page, dedicated to the continuing care group (Turning Point alumnus, personal communication, February 4, 2014). Facebook offers a privacy setting in which groups can only be viewed by individuals if they are invited to the group. If individuals are not added to the group, they will not be able to see the page. This would allow patients who consent to the Facebook page to connect with other members. Social media offers a unique opportunity, as a forum to offer support to individuals struggling with substance use disorders.

### **Community Supports**

**Involvement in 12-step programs.** While patients attend the continuing care group, they are encouraged to attend 12-step meetings. It is not a requirement, and if they choose to go to meetings, they are not required to get any documentation. They may attend any form of 12-step including Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Alanon, or Codependents Anonymous. Currently, 60-70% of treatment facilities incorporate the 12-steps into treatment (Lee et al., 2011). The continuing care group does not integrate the steps into treatment, but chooses to have a relationship with the 12-step program. This relationship fosters a strong encouragement given to patients to attend meetings, obtain a sponsor, and work the 12-steps.

**Family Involvement.** In order to encourage a stronger support system within the family, and facilitate family cohesion, every eighth continuing care session, the families are invited to join the group. Within the family continuing care group, family members are able to communicate with the patient about any issues that have arisen. It is also an opportunity for families to gain support from other families that are sharing similar experiences.

**Mentors.** Members of the continuing care group who have been in recovery for six months or longer are valuable resources for patients initially entering the continuing care program (Tracey et al., 2012; White, 2009). These members have the opportunity to volunteer as mentors. Mentors assigned to newer members act as a guide through their early sobriety (White, 2009). Alumni from Turning Point's intensive outpatient program reported they perceived a mentoring program as extremely useful (Turning Point alumnus, personal communication, February 4, 2014). Several alumni also showed interest in volunteering as mentors. They stated that giving back to the community, building their self esteem, and getting out of self are main motivators for wanting to serve as mentors within the continuing care group (Turning Point alumnus, personal communication, February 4, 2014).

By creating this continuing care group, patients are given the opportunity to come together to share in their recovery from drug and alcohol addiction. These patients come from different background and experiences, but have a common goal: to improve their lives. This group acts as a forum for them to share their strengths, challenges, and celebrations within their journey in recovery. By providing this service, it appears patients have a higher rate of success maintaining abstinence from drugs and alcohol, and decreasing the pain that is inflicted upon the individual, the families, and the communities.

## Appendix B

**Informed Consent**

Welcome to the Continuing Care Group! This group is a powerful tool in order to facilitate and maintain healing from substance use disorders. In order for the group to serve its intended purpose, it must be a safe environment. Confidentiality is the cornerstone of creating an environment that inspires growth. Facilitators of the group are ethically and legally bound to confidentiality EXCEPT in the following circumstances:

1. If I have reason to believe that a client is likely to inflict bodily harm to another individual. In this instance, I am required to inform the police.
2. If I have reason to believe a client is likely to commit suicide. In this instance, I am required to inform the police or arrange for hospitalization.
3. I am obligated to report any abuse of a protected population, i.e. children, elderly, or handicapped individuals.
4. There are legal situations that may result in a subpoena of counseling records into a court of law.

If I am required to release this information for any of the above reasons, only the minimum, relevant information will be provided.

In addition, group members are not held to the same legal standards. We ask that as group members of the continuing care group, you do not breach any other member's confidentiality. If a member breaches the confidentiality within in the group, it will result in removal from the group.

I have read the above information, understand the information, and agree to these terms.

Client Signature	Printed Name	Date
Facilitator Signature	Printed Name	Date

## Appendix C

**Behavioral Contract**

Continuing care treatment is a crucial part of our program. It ensures you remain supported in your recovery. Research has shown that individuals who participate in continuing care programs have higher abstinence rates, longer periods of time in between relapses, and less readmissions to inpatient treatment facilities than individuals who do not participate in continuing care services. In addition, abstinence rates of people attending continuing care increase by 20% every consecutive month that they are engaged in treatment.

After reading this information, I agree to enroll in the Continuing Care Group and beginning to attend after my graduation from intensive outpatient/inpatient treatment.

Client Signature	Printed Name	Date
Facilitator Signature	Printed Name	Date