Continuing care for addiction: Implementation

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INTRODUCTION

Addiction is a chronic condition for many patients. Yet the traditional treatment model for addiction has emphasized intensive treatment for medically supervised withdrawal from substances/stabilization, followed by time-limited outpatient care. In recent years, public and private health care systems and clinicians have begun recognizing that chronic or relapsing addiction, like chronic physical conditions such as diabetes or hypertension, typically requires continuing, long-term care.

Continuing care for addiction includes routine assessment and treatment customized to the needs and preferences of the individual patient. The patient's clinical status and risk of relapse are monitored systematically. The intensiveness of treatment is adjusted as the addiction waxes and wanes over time. Patients receive training in self-management skills and linkage to other sources of professional and community support.

This topic describes the implementation of continuing care in chronic or relapsing addiction and strategies for treatment-resistant patients. Other topics describe indications for continuing care in addiction, components of continuing care, and the efficacy of multimodal continuing-care interventions; treatment issues specific to individual substance use disorders (SUDs); and determining the appropriate level of care for patients with SUDs.

- (See "Continuing care for addiction: Components and efficacy".)
- (See "Opioid use disorder: Pharmacologic management".)
- (See "Alcohol use disorder: Pharmacologic management".)

- (See "Alcohol use disorder: Psychosocial management".)
- (See "Cannabis use disorder: Clinical features, screening, diagnosis, and treatment".)
- (See "Cocaine use disorder: Epidemiology, clinical features, and diagnosis".)
- (See "Stimulant use disorder: Psychosocial management".)
- (See "Benzodiazepine use disorder".)
- (See "Substance use disorders: Determining appropriate level of care for treatment".)

FIRST-LINE INTERVENTIONS

Intensity of care — The intensiveness of care for patients with chronic addiction is based on the severity of the patient's substance use disorder, risk of relapse, and willingness to engage in treatment. Below we describe our general, initial approach to care for patients with three levels of substance use disorder (SUD) severity, consistent with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) subtypes [1]. There is an absence of research evidence of the optimal frequency and duration of continuing care [2]; the suggestions below are based largely on our clinical experience. (See "Continuing care for addiction: Components and efficacy".)

These initial continuing care plans are proposed for the patient who remains abstinent as care proceeds through successively less intensive levels of care. The frequency and duration of the latter stages of continuing care would be adjusted based on the patient's response to earlier stages. A patient who has a poor response to initial treatment or has repeated relapses, for example, will need longer continuing care at a higher intensity than the patient who responds well to treatment.

- **Low intensity** – Patients who have received treatment for a mild SUD are not typically candidates for continuing care, but should be monitored for 12 months and offered additional treatment if they fail to maintain their initial improvement.

- **Moderate intensity** – Patients with a moderate SUD and one or more co-occurring problems (such as poor sleep or insufficient support for recovery) would receive continuing care consisting of:

    - Intensive outpatient treatment (IOP) for one to two months, followed by
    - Weekly counseling sessions for at least another four to six months, followed by
    - Monthly check-ins for six months
    - Less frequent check-ins thereafter

- **High intensity** – Patients who are physically dependent on alcohol or drugs, have a severe SUD, or have an SUD with an active co-occurring psychiatric disorder may require:

  - Inpatient or residential treatment to address withdrawal and achieve initial abstinence
  - IOP three times per week for one to two months, followed by
  - Outpatient treatment one to two times per week for four to six months
  - Monthly check-ins for six months and less frequent check-ins thereafter

Research indicates that for patients receiving outpatient treatment, the first few weeks are critical for determining the optimal intensity of continuing care. In three clinical trials of continuing care for patients with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnoses of alcohol and/or cocaine dependence, patients who are able to stop using alcohol and drugs during the first weeks of IOP were more likely to do well with less intensive continuing care [3-5]. Patients who continued using the substances were likely to require more intensive continuing care. The failure to achieve other early treatment goals — such as committing to abstinence, attending Alcoholics Anonymous meetings, developing better coping behaviors and increased confidence in their efficacy, and identifying reliable sources of social support — may indicate a need for more intensive continuing care [3,6].

Treatment components — The principal components of SUD treatment in continuing care are addiction counseling and mutual help groups. The use of these and other treatment components are described briefly below in the context of implementing continuing care, and in greater detail separately. (See "Continuing care for addiction: Components and efficacy".)

Choosing among components — In general, a patient with a less severe SUD can begin continuing care at a lower intensity; the type of treatment selected is less important. If the patient deteriorates, then a more structured, evidence-based approach is warranted. Higher severity patients should start with the most structured and evidence-based program available. If such a patient fails in that kind of continuing care, the clinician should switch to a different approach.

Selection among treatment components is subject to patient preference. Use of mutual help groups should always be stressed for more severe patients; however, if the patient is adamant about not going to, for example, Alcoholics Anonymous, further pressure from the clinician may be counterproductive. Availability of some treatments (eg, certain medications and therapists trained in specific forms of psychotherapy) varies geographically and is based on patients' health insurance and other resources.

Addiction counseling — The vast majority of continuing care provided in community-based clinics and rehabilitation programs consists of group counseling based on a 12-step approach.

This is discussed in greater detail separately. (See "Continuing care for addiction: Components and efficacy".)

Mutual help groups — Patients with a moderate to severe SUD participating in continuing care should be encouraged to participate in a 12-step or other abstinence oriented mutual help group, at least three times per week. Mutual help groups are described in more detail separately. (See "Alcohol use disorder: Psychosocial management", section on 'Mutual help groups'.)

Pharmacotherapy — Patients with moderate to severe opioid use disorder (in DSM-5; opioid dependence in DSM-IV) almost always need pharmacotherapy, with adjunctive psychosocial treatment (ie, counseling/psychotherapy and other continuing care) to prevent relapse. (See "Opioid use disorder: Pharmacologic management" and "Continuing care for addiction: Components and efficacy".)

Patients with moderate-to-severe alcohol use disorder (in DSM-5; alcohol dependence in DSM-IV) should initially be offered both pharmacotherapy (eg, naltrexone, vivitrol, disulfiram, or acamprosate) and psychosocial treatment. For patients who do not achieve remission or an adequate reduction in heavy drinking, switching or combining modalities is recommended. (See "Alcohol use disorder: Pharmacologic management" and "Continuing care for addiction: Components and efficacy".)

Psychotherapy — For patients in continuing care who prefer treatment other than group counseling based on a 12-step approach, or do not achieve their treatment goals with this approach, an individual psychotherapy such as cognitive-behavioral therapy can be used. (See "Alcohol use disorder: Psychosocial management" and "Stimulant use disorder: Psychosocial management" and "Opioid use disorder: Psychosocial management" and "Continuing care for addiction: Components and efficacy".)

Research indicates that there are common factors that cut across different evidence-based therapies, which may account for much of the variance in outcome. Therapists who know how to work with ambivalent patients, and who are warm, supportive, non-judgmental, and non-confrontational, typically get better results, regardless of what kind of therapy they provide.

Subsequent continuing care — Following the completion of more intensive continuing care, described above, routine clinical contacts should be maintained to monitor the patient's clinical status and substance use. As the patient remains abstinent, these contacts can become successively infrequent and less burdensome (eg, by telephone). If the patient relapses or shows early warning signs of potential relapse, the patient should receive more intensive care. (See "Continuing care for addiction: Components and efficacy".)

After the completion of weekly outpatient visits for low-severity patients, continuing care can be provided through the patient's participation in a mutual help group and occasional brief visits with an addiction-treatment counselor (eg, a 20-minute visit or telephone contact every three months). (See 'Mutual help groups' above.)

For a patient who has maintained abstinence for a very prolonged period (eg, two years), and does not have many risk factors for relapse, the frequency of brief check-ins would be reduced further, for example, to twice yearly visits with a primary care clinician; these should continue indefinitely.

STRATEGIES FOR TREATMENT-RESISTANT PATIENTS

For patients who do not respond to first-line continuing care, or are at high risk for relapse, additional approaches are described below, with varying levels of supporting evidence. (See "Continuing care for addiction: Components and efficacy", section on 'Customization'.)

Contingency management — Contingency management interventions for substance use disorders (SUDs), which offer incentives to encourage abstinence or discourage substance use., are reviewed separately. (See "Substance use disorders: Training, implementation, and efficacy of treatment with contingency management" and "Substance use disorders: Principles, components, and monitoring during treatment with contingency management".)

Intensive referral to mutual help groups — A three-session intervention, delivered by a substance abuse counselor during outpatient treatment for an SUD, has been used to encourage attendance at mutual help groups [7]. Components of the intervention include providing:

- Detailed lists of local self-help meetings that had been preferred by other patients
- Directions to the meetings
- Materials that described self-help meetings and addressed common questions and typical concerns about the program

The counselor also arranges a meeting between the patient and a participating member of the group. (See "Continuing care for addiction: Components and efficacy".)

Other interventions designed to increase participation in mutual help programs are described separately. (See "Substance use disorders: Psychosocial management", section on 'Facilitating mutual help group engagement' and 'Network support' below.)

Stepped care — Stepped care or "adaptive treatment" formalizes the principles of flexible customization of care based on patient clinical status and risk of relapse. Components include [8]:

- Patient clinical status is monitored in a systematic and standardized fashion, using validated assessment tools.
- Algorithms are used that specify the scores on these measures indicating a need for more intensive treatment.
- Guidance is provided on what changes to the frequency or levels of care the clinician should consider making, or what treatment modalities they should consider adding or switching to.

Social reinforcement — An intervention employing contracts, prompts, and social reinforcements have been found to increase attendance in continuing care [9]. In the contracting procedures, patients are provided with information on the success rates of patients who do and do not attend continuing care, and are asked to commit to participate in a specified amount of continuing care using specified modalities (eg, Alcoholics Anonymous and individual therapy). Social reinforcement consisted of personal letters from counselors with congratulations for attending sessions, certificates for completion of treatment milestones (eg, 90 days of treatment), and medallions for attending specified numbers of sessions. Certificates and medallions are typically presented in front of other patients in therapy groups.

Network support — A treatment intervention, referred to as "network support," was designed to help patients change their larger social networks to become more supportive of abstinence [10-12]. The intervention provided help with identifying and engaging in mutual help programs and with identifying other positive sources of social support in the community. Barriers to involvement with these groups were identified and addressed.

Intensive continuing care — Intensive continuing care programs, as long as 12 months, are modeled after extended SUD-treatment programs for pilots and medical personnel. Most of these interventions consist of the same core components:

- Random urine testing for drug and alcohol use
- Outpatient continuing care
- Recovery coaching
- Family involvement
- Use of web platforms to monitor progress and connect the patient to others (eg, treatment providers, family members, and employers)

An observational study of the program, "My First Year in Recovery," included 198 participants with a mix of substance use disorders. Participants completed 70 percent of random urine tests. During the 12 follow up period, 54 percent relapsed. Of those, 70 percent remained engaged in the intervention after relapsing and were able to complete the intervention [13].

Technological innovations — Online resources are playing a growing role in continuing care. Text messaging, video telephony, and smartphone applications have begun to be tested [14-16] and used in much the same way as the telephone in continuing care [17,18]. The diminished burden and added convenience of these new technologies has the potential to increase rates of sustained participation in extended treatment.

As examples:

- A smartphone app supporting recovery increased the proportion of subjects with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) alcohol dependence who achieved abstinence during eight months of treatment as usual [19]. The app, the Addiction-Comprehensive Health Enhancement Support System (A-CHESS), has multiple functions:
  - A "panic button" that provides immediate connections to family, peers, and others in recovery
  - A GPS function that alerts others when individuals get near a location where they formerly used alcohol or drugs
  - A library of suggestions for ways to deal with stressful situations
  - A locator of nearby Alcoholics Anonymous/Narcotics Anonymous meetings
  - Access to a chat room where others using the app can communicate
  - Inspirational stories
  - Daily and weekly assessments of status and progress than can be seen by counselors via a "dashboard"

  The clinical trial randomly assigned 349 participants with DSM-IV alcohol dependence who had completed residential treatment to receive treatment as usual (ie, continuing care referral) or treatment as usual plus use of A-CHESS for eight months [19]. Patients receiving A-CHESS reported 49 percent fewer days risky drinking in the prior 30 days at 4-, 8-, and 12-month assessments compared with those in treatment as usual (mean of 1.39

versus 2.75 days respectively). Rates of alcohol abstinence within the prior 30 days were higher with A-CHESS compared with treatment as usual at 8-month (78 versus 67 percent) and 12-month (79 versus 66 percent) assessments [15]. In addition, A-CHESS increased participation in outpatient continuing care during the follow-up period, which partially mediating the positive effect of the app [19].

Several other apps designed to address SUDs or risky substance use have been developed and marketed. Two apps, reSET and reSET-O, are US Food and Drug Administration-approved for the treatment of drug use disorders and opioid use disorders along with medication-assisted treatment, respectively. These apps are available only with a prescription. A monthly fee is paid to use them. Another app is available that has range of components, including self-assessments, cognitive-behavioral therapy tutorials, contingency management, and recovery coaches. This app has also generated some preliminary evidence of efficacy in pilot trials. It does not require a prescription. However, it should be noted that these apps have not been evaluated for efficacy as continuing care interventions.

- To provide technological facilitation of continuing care, Hazelden, available at their website, is a well-known, nonprofit addiction treatment center, developed an online recovery support program called “My Ongoing Recovery Experience,” which provides recovery services including:

  - Access to online communities of persons in recovery
  - Educational videos and articles
  - Help with identifying coping strategies
  - Links to recovery coaches

Primary care settings — Some primary care practices provide an alternative to addiction treatment centers as a setting in which to receive continuing care for addiction. Some patients are reluctant to receive treatment at SUD specialty setting, which they associate with stigma or do not like aspects of traditional programs, such as the emphasis on total abstinence, pressure to embrace the 12-step philosophy, and/or reliance on group therapy. These patient preferences need to be taken seriously and not viewed as simply indicative of resistance or denial.

Continuing care is provided in some primary care clinics or practices by a primary care clinician with specialized training and in other sites by a behavioral health clinician [20-27]. Primary care clinicians can receive training in continuing care at continuing medical education courses, and in workshops or courses at meetings of the American Society of Addiction Medicine, Society of

General Internal Medicine, or similar organizations. Finding clinicians who are well trained in this or similar models of addiction care can be difficult in many geographic areas.

Primary care clinicians without specialized training in continuing care can participate in such care for selected patients, such as milder patients who are doing well, or check-ins with patients with more severe SUDs who have successfully completed more intensive continuing care.

Although a number of research studies supported the efficacy of primary care for the provision of continuing care for SUD [20-22], a 2013 large trial did not generate positive outcomes [28]. The trial randomly assigned 563 individuals with alcohol or drug dependence to receive chronic care management for their substance use disorders in primary care versus standard primary care only. No differences were seen between groups on primary self-report measures or biological substance use outcomes.

Specialized populations — Principles of continuing care for addictions have been incorporated into extensive programs for specialized populations, including homeless persons with SUDs [29-31] and clinician health programs, which coordinate oversight and treatment of substance-impaired clinicians. (See "Substance use disorders in physicians: Assessment and treatment", section on 'Physician health programs' and "Health care of people experiencing homelessness in the United States", section on 'Housing interventions'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Opioid use disorder and withdrawal" and "Society guideline links: Alcohol use disorders and withdrawal" and "Society guideline links: Benzodiazepine use disorder and withdrawal" and "Society guideline links: Cannabis use disorder and withdrawal" and "Society guideline links: Stimulant use disorder and withdrawal".)

SUMMARY AND RECOMMENDATIONS

- **Intensity of care** – Continuing care for addiction includes routine assessment and treatment customized to the needs and preferences of the individual. The intensiveness of treatment is adjusted as the addiction waxes and wanes over time based on the individual's substance use disorder (SUD) severity, risk of relapse, and treatment engagement. Patients receive training in self-management skills and linkage to other

sources of professional and community support. (See 'Introduction' above and "Continuing care for addiction: Components and efficacy" and 'Intensity of care' above.)

- Individuals who have received treatment for mild SUD are typically not candidates for continuing care but should be monitored for 12 months and offered additional treatment if they fail to maintain their improvement.

- For individuals with moderate to severe SUD who are stabilized or in those who have gone through acute medically supervised withdrawal we suggest continuing care rather than short-term treatment of acute exacerbation (**Grade 2C**). (See "Continuing care for addiction: Components and efficacy".)

- **Treatment components** – Patients receiving continuing care for a chronic, relapsing SUD should be encouraged to participate in a mutual help group for such addictions as part of continuing care. Daily attendance is recommended for the first three months, followed by attendance three times weekly thereafter. (See "Alcohol use disorder: Psychosocial management", section on 'Mutual help groups' and "Continuing care for addiction: Components and efficacy".)

  Patients in continuing care for addiction who relapse, or show early warning signs that they may relapse, should receive more intensive treatment. This may include:

  - A greater frequency of counseling or psychotherapy sessions and mutual help group meetings. (See 'Intensity of care' above and 'Mutual help groups' above.)

  - Additional treatment modalities. (See 'Pharmacotherapy' above and 'Psychotherapy' above.)

  - Treatment at a higher level of care. (See 'Intensity of care' above and "Continuing care for addiction: Components and efficacy".)

- **Strategies for treatment-resistant individuals** – Patients who experience multiple relapses despite high intensity continuing care may benefit from the addition of approaches such as intensive referral to a mutual help group, financial or other incentives, or more structured stepped care. Further investigation of these interventions in the context of continuing care is needed. (See 'Strategies for treatment-resistant patients' above.)

- **Subsequent continuing care** – Following the completion of more intensive continuing care, abstinent patients should continue to have routine clinical contacts to monitor the patient's clinical status and substance use. As the patient remains abstinent, these

contacts can become successively infrequent and less burdensome (eg, by telephone). If the patient relapses or shows early warning signs of potential relapse, the patient should receive more intensive care. (See 'Subsequent continuing care' above.)

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